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NEW ZEALAND SOCIAL INSURANCE SYSTEM

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For those interested in social and economic problems, New Zealand has always been one of the most fascinating laboratory exhibits—if a country may be so called. New Zealand was the first English-speaking country having pension legislation (1898), and some half century ago introduced other "social legislation" providing for improved working conditions, arbitration of labor disputes, and other governmental participation in the general economy of the country. Until the 1930's New Zealand more or less continued these basic programs without change, but during the depression years much social security legislation was passed. The entire philosophy of their system may be summed up by saying that it aims to provide for all who, through misfortune beyond their control, need help. The amounts involved are generally well above minimum subsistence or a mere "floor of protection."

BACKGROUND INFORMATION ON NEW ZEALAND

New Zealand is a small isolated country in the South Pacific, approximately 1,200 miles east of Australia and 1,600 miles north of the Antarctic Continent. It consists primarily of two main islands, having a total length of about 1,000 miles and an average width of about 100 miles.

New Zealand's total population is now about 1.9 million. The country is sparsely populated, with only about 18 people to the square mile; virtually the entire growth in population and development of the country has occurred in the past century. Because of the renowned favorable mortality in New Zealand the population is aging quite rapidly and surprisingly enough the proportion of persons aged 65 and over is higher than in the United States.

The mainstay of New Zealand's economy is agricultural products, primarily wool, mutton, lamb, beef, butter and cheese. The great majority of the production of these items is exported, with the percentage running over 95% for wool and lamb.

From a social viewpoint New Zealand is about as close to a classless society as can be found in any developed country. All of the people are well-fed, well-housed, and well-clothed, and there are few extremes. Probably in large part this arises from the favorable economic resources of the country, namely, those based on "a blade of grass" in combination with the world-wide market for the products.

Wage rates vary generally from a minimum of £6 per week to a virtual maximum of £10 per week (the New Zealand pound is valued at approximately the same as the British pound, namely, $2.80). However, when prices are converted into dollars or, in other words, when prices are measured relative to wages, they are low, especially as to meat and basic foods. Rentals are quite reasonable, but clothing is moderately expensive. On the other hand, there is not the variety of luxury items to which we are accustomed, and mechanical and electrical products are expensive—not only when converted to dollars but also in relation to wage levels.

In regard to social security problems, New Zealand is in a much more fortunate position than most other countries of the world which are thickly populated or overpopulated and which depend on imports for the basic necessities of life. The small size of the country and the homogeneity of the population, not only demographically but also socially and economically, have enabled benefit levels and eligibility conditions to be relatively standardized. This, of course, at the same time permits the advantage of administrative simplicity.

SUMMARY OF PERIODIC BENEFIT PROVISIONS

The New Zealand system in general provides periodic benefits for the whole population for various categories of risk on a flat basis with no variation by wage level or length of coverage. Naturally, the administration is on the whole relatively simple; however, eligibility requirements and particularly the means test introduce certain difficulties, as will be indicated.

Considerable administrative action and discretion is freely allowed the Social Security Department. Moreover, since the benefit amounts and conditions are in almost all instances the same for different types of programs, it is really immaterial whether individuals qualify under one category or another. Furthermore, there is a general "catch-all" category of "emergency benefits" for those who do not meet all the requirements for other types of benefits, and the amounts of these emergency benefits may be as large.

The social security benefits are not subject to either the social security tax or the general income tax.

(a) *Family Allowances.* These are payable for all children under age 16 (or if in school, up to 18) as a right without any means test. The amount payable is at the rate of £½ per week for each child although payments are actually made monthly by taking $\frac{1}{1}\frac{1}{2}$ of the £26 annual rate. Birth, or one year's residence, in New Zealand is required.

(b) *Old-Age Benefits.* These are of two types, universal superannuation

benefits payable as a right after age 65, and old-age pensions payable with a means test after age 60.

(1) *Universal Superannuation Benefits.* These are payable for all persons age 65 and over (meeting certain residence requirements) as a right without means, income, or retirement tests, except that they are not payable for persons eligible for age pensions of larger amount payable on the basis of a means test. The superannuation benefit is now £35 per year but increases £2½ per year (as of April 1) until the ultimate level of £130 per year, or £2½ per week, is reached in 1988 (this benefit was begun at £10 per year in 1940). At present the superannuation benefit is payable quarterly, but eventually when it reaches a larger amount it will probably be payable monthly. The amount payable is not dependent on the year of entry to the roll but rather on the year of payment, so that for a particular individual the amount increases from year to year. The ultimate figure is the same as the present old-age pension and was increased in June 1949 when the old-age pension was increased from £2¼ to £2½ per week. This increase in the ultimate superannuation benefit was achieved by lengthening the period of increase or, in other words, allowing the annual increase of £2½ to run for a few years more than under the original provision.

If in the future wage and price levels increase steadily, the old-age pension will probably be similarly increased. In such a case, the ultimate amount of the superannuation benefit may be a "will-o'-the-wisp," never to be attained, as it is increased to equal the steadily increasing old-age pension but with the promised date of equalization pushed farther and farther into the future. Thus in 1939 there was the "promise" that the ultimate superannuation benefit would equal the then-current old-age pension in 29 years; now, 11 years later, the period of deferment has increased to 38 years!

The residence requirement is 10 years for persons in New Zealand on March 15, 1938, and 20 years for all others. (If the residence requirement is not met at age 65, but is met at some later date, the benefit is payable thereafter.)

(2) *Old-Age Pensions.* These are payable for persons age 60 and over, with a means test. The pension prior to reduction for income (as described later) is at the rate of £2½ per week, but is payable monthly. Both husband and wife, if eligible, may receive the pension in their own right. A married man whose wife does not qualify (because of not meeting the age or residence requirements) receives an additional £2½ for his wife, bringing his benefit up to £5 per week. If only the wife is eligible (by reason of age or otherwise), only £2½ is paid.

Under the means test, total assets (such items as the home and its

furnishings or an automobile are not counted) of £500 for single persons and £1,000 for married couples are allowed without any reduction in pension; also disregarded is weekly income up to £1½ per family. For a married applicant, the income and assets of both husband and wife are taken into account in all instances. If only the wife is eligible, the combined income is nevertheless considered, but the exempt amount is raised to £3½ per week. The pension is reduced on a "one for one" basis for any excess income, while the reduction in the pension for excess assets amounts, on an annual basis, to 10% of their value. Where an income-producing asset is present, the deduction on an annual basis is the greater of (1) total income in excess of £78, or (2) 10% of the assets over the exempt amount, plus the excess, if any, of other income (*i.e.*, other than from assets, such as a pension or annuity) over £78. The pension when affected by the means test is readjusted annually, or oftener, if the beneficiary gives notification of a drastic change in status.

Transfer of assets to obtain eligibility is prevented by the broad powers given to the Social Security Department; for instance, it may on its own initiative refuse benefits to anyone and instead give emergency benefits. Individuals are freely permitted to spend sufficient of their assets so as to obtain eligibility, such as for household goods or a trip. One difficult problem is in regard to the transfer of ownership of farms. These cases are examined very closely because some of them are really quite legitimate in that the farmer may have been underpaying his sons in relation to the true worth of their services. In such instances, it may properly be found that a sizable proportion, if not all, of the farm rightfully belonged to the children and that no transfer of assets was involved.

The residence requirement is the same as for the universal superannuation benefits. Reciprocal arrangements for residence and other requirements have been made between New Zealand and Australia, and negotiations are under way between New Zealand and Great Britain.

(c) *Invalidity Pensions.* These are payable to persons who are totally and permanently disabled and at least 16 years old. In general, the payments cease at age 60 when the individuals are transferred to the old-age pension roll, although if a person does not meet the residence requirements for the latter he will be kept on the disability roll until he does. Invalidity pensions are the same size as the old-age pensions and are payable in the same way except as follows:

(1) For disabled married women, the amount payable is reduced from the rate of £2½ a week by the excess of the family income over £4 per week, or, if a caretaker must be hired, by the excess over £6 per week.

(2) For blind persons, the first £3 per week of earnings, in addition to

the first £1½ of other income, is ignored in determining any reduction in the pension. An additional payment equal to 25% of the individual's earnings is made, provided that his total income, including his additional payment and including the pension, does not exceed £6 per week.

(3) For persons age 16–19, the invalidity pension is only £2 per week rather than £2½, except for a married male who receives the full £5.

Except as indicated above, the same means test applies as for old-age pensions. There is no specific waiting period or period of duration of sickness benefits, but rather the individual is transferred from sickness benefits whenever the Social Security Department deems that permanent incapacity for work is established; in many cases, the individual might go directly on the invalidity pension roll without ever having been on sickness benefits. (During the year ended March 31, 1949 about 30% of the new invalidity pensions granted were transfers from sickness benefits, while another 13% were transfers from emergency benefits.) There is no specific re-examination period for determination of continued disability, re-examination being dependent upon the type of case.

The residence requirement is 10 years unless the invalidity arose outside of New Zealand, in which case it is 20 years. Thus, it may be seen that an individual might meet the residence requirements for invalidity pension, although not for old-age pension.

(d) *Survivor Pensions.* These are payable primarily to surviving widows, with no payment at all for partial orphans (other than the universal family allowances) but with certain supplementary payments for full orphans. The widow's pensions are payable monthly at the rate of £2½ per week plus an additional £1½ if the widow is the mother of a child who is receiving the universal family allowance.

There is the same means test as for the pensions discussed previously, with the important exception that there is no deduction for assets (other than in respect to any income which they may produce) for widows under age 60. Widows transfer to the old-age pension roll at age 60 if eligible therefor.

The requirements for eligibility for widow's pensions may be summarized as follows:

(1) Regardless of age while there is a child present; or

(2) Regardless of age, if ever having had a child (even though the child may have died before the husband) if the period of marriage plus any subsequent period of care of a child receiving family allowances was at least 15 years; or

(3) Regardless of ever having had a child if age 50 or over at widowhood and at least 5 years of marriage; or

(4) Regardless of ever having had a child if age 40–49 at widowhood with the pension deferred until attainment of age 50 or until 15 years following the date of marriage, if later, and with a requirement of at least 10 years of marriage. (For any woman widowed at age 40–44, the latter requirement will mean that the 15 years since the date of marriage requirement will automatically be satisfied by age 50, but for a woman widowed at 45–49, the pension would be deferred beyond age 50, if marriage took place after age 35.)

The eligibility requirement for widow's pensions is either having had a child born in New Zealand, or residence of the husband and wife in New Zealand for the 3 years prior to his death.

Full orphans receive a special pension in lieu of the universal family allowance, with the same limits as to duration of payment. The pension is at the rate of £1¼ a week (payable monthly) as compared with the £½ family allowance. However, orphans' benefits are subject to a "one for one" deduction for income received from the deceased parents or from employment (subject, of course, to the condition that the reduction will not lower the amount below the universal family allowance).

(e) *Miners' Pensions.* These are payable for disability due to so-called "miner's diseases" (roughly 60% disability is required for a "direct" disease, such as miner's phthisis, and 100% for any associated disease, such as heart disease). The pension is the same size as old-age or invalidity pensions, but with no age requirement and payable as a right with no means or earnings test.

Eligibility requirements are 5 years of residence and 2½ years of mining service. The widow of such a pensioner, in lieu of a survivor pension, may receive a pension at a rate of £2 per week with no means test, age requirement, or requirement of having children.

(f) *Sickness Benefits.* These are payable to persons who are sick and at least 16 years old. As mentioned previously, these may be replaced after varying durations by invalidity pensions.

The sickness benefit, payable weekly, is the same basic amount as the pensions, except that the amount payable may in no case be more than the loss of earnings and, further, for those age 16–19 the amount is £1½ per week except for married males, who receive the full £5.

The only means test is as to income, with the exempt amount being £1½ per week, with a "one for one" reduction for excess income. In addition, there is a further exemption from income of up to £1 per week for sickness benefits coming from friendly societies (no longer a particularly important element in the New Zealand economy). For a married employed woman the sickness benefit of £2½ per week is subject to the fur-

ther limitation that the benefit plus the family income cannot total more than £6½ per week; thus if the husband is employed full-time, there would likely be no sickness benefit payable. For a married couple, with both working, it is probable that no sickness benefit would be payable if the husband became sick, because the wife's earnings would very likely exceed the limitation of £6½ (based on the general exemption of £1½ and on the "one for one" reduction for excess income up to the total of the £5 benefit); of course, if the wife were earning less, a residual benefit would be payable.

The provision that the sickness benefit shall not exceed the loss of earnings has relatively little effect since full-time employment at the least pays somewhat in excess of the benefit rates. However, for part-time employment, this provision does have some effect. In general, in considering the loss of earnings the period of the previous 4 weeks is considered, and a certificate as to the earnings is obtained from the employer.

For sickness benefits there is a waiting period of 7 days from the date of incapacity. This waiting period may be waived administratively, as is usually done for what appear to be recurrences of the same illness or for those transferring from unemployment insurance. Following the waiting period, benefits are paid for individual days of sickness thereafter. Many private employers continue the worker's wages until the end of the calendar week in which the employee became sick, resulting in a loss of income for only a few days of the succeeding calendar week.

The definition of sickness is inability to perform any work. The residence requirement is 1 year in New Zealand at any time, not necessarily just prior to becoming ill.

(g) *Unemployment Benefits.* These are payable to persons who are unemployed and are at least 16 years old if they are ready and able to work at any job within their capabilities regardless of whether they have had previous employment. Persons who are unemployable for either physical or mental reasons do not receive unemployment benefits but are rather classified under emergency benefits. Accordingly, with the very full employment conditions now prevailing in New Zealand, only a small number of people are on the rolls each week (generally less than 50 and in some weeks as few as 15 or 20; on a comparable population basis in the United States this would mean only 4,000 unemployed as compared with what is considered to be the minimum of 2 million).

The unemployment benefit is exactly the same size as the sickness benefit, and there is the same means test other than that all earnings are deducted from the basic amount, and other than that there is a deduction in respect to assets, on a basis similar to that for age and invalidity pen-

sions. Just as for sickness benefits, in most instances where there is a married couple, both working, the unemployment of one of them would not result in any benefits. The waiting period for unemployment benefits is up to the discretion of the Social Security Department but is usually 7 days from date of application. Certain problems arise for seasonal employment. In such instances, the waiting period may be as much as 6 weeks. Benefits are payable for single days of unemployment, with the payments generally being made weekly.

There appears to be close relation with the employment services and a fairly strict concept of the individual being ready and able to work at any job within his capabilities so that down-grading of an individual may be required; the benefit will not be payable in the event of failure to accept such down-grading. Further, a nonmarried person may be required to move to another locality for an available job. In case of refusal the benefit will not be paid. The residence requirement is the same as for sickness benefits.

(h) *Workmen's Compensation.* Benefits for industrial injuries do not fall within the scope of the social insurance system administered by the Social Security Department. These benefits are administered by a State insurance fund, with the employer paying all the cost (the new Government in the 1949 campaign pledged to allow private carriers to enter this business). The weekly benefit for total disablement, in general, is 75% of wages, with a minimum of £2 and a maximum of £6; the aggregate payments may not exceed £1,750. These weekly benefits are payable until the worker's condition has become stationary, after which time the general procedure is to give a lump-sum settlement based on the degree of permanent disability and on a maximum of £1,750, deducting first therefrom all weekly payments made in excess of £250. After this the individual may qualify for social security benefits, usually invalidity pension. A lump-sum payment for death due to industrial injury is available.

In addition to the above benefits, there is the further possibility of claim at common law by the injured worker after permanency of disability has been established, or by his survivors after death occurring prior to such establishment of permanency. But in such cases the workmen's compensation benefits paid would be deductible from the damages awarded.

(i) *Civil Service Retirement.* This program is not administered by the Social Security Department. The compulsory retirement age is 65 for men and 55 for women, with optional retirement being permitted after 40 years of service and attainment of age 60 for men and after 30 years of service for women, and also at the option of both the employer and em-

ployee after age 60 for men and age 50 for women. Earlier retirement regardless of age is permitted for permanent and total disability. In general, the benefit formula is $\frac{1}{60}$ of average salary during the last 5 years times years of service.

For voluntary withdrawal from service the only benefit is return of contributions without interest. As to death benefits, widow's and orphan's pensions are available or, if there are no such survivors, a lump-sum return of contributions without interest.

An interesting feature is that since all Civil Service benefits are counted as income for social security purposes, some low-salaried employees withdraw from service just prior to retirement so as to obtain a cash refund, rather than the Civil Service pension. The latter would have a much greater actuarial value but would disqualify for social security benefits, so that by proper maneuvering a larger total benefit can be obtained by sacrificing the government's share of the Civil Service pension.

The contribution rate is graded by age, being 5% of salary for entrants before age 30, increasing up to 10% for entrants at age 50 and over. The system is not funded and is on a more or less pay-as-you-go basis since government appropriations have not been made to any great extent in the past. The system seems to be a rather costly one since withdrawals from government service are relatively few and since retirement is possible, and is done, at relatively low ages, all of this being coupled with the very low mortality in New Zealand.

SUMMARY OF MEDICAL SERVICE BENEFIT PROVISIONS

A portion of the medical service benefits are on a cash reimbursement basis, while the remainder are on a service basis. All benefits are available without a means test.

(a) *Medical Benefits.* In practically all instances there is a payment of $7\frac{1}{2}$ shillings for each consultation with a general practitioner. There are two methods of making this payment: (1) the doctor may bill the fund and (2) the patient may pay the full bill and obtain a refund of $7\frac{1}{2}s.$ from the fund (at present about $\frac{1}{3}$ of the cases are under the latter method). Under either method the doctor may (and generally does) charge the patient more than $7\frac{1}{2}s.$, the extra charge usually being $3s.$, so that the claim may be said to be about 75% reimbursable.

In addition to this fee-for-service basis, doctors have the option of a capitation remuneration of a flat amount of $15s.$ per patient for a year's medical service. This is an average of only two consultations per year per

individual, and so would not appear to be very attractive in competition with the fee-for-service basis. Accordingly, only about 1% of the approximately 1,800 doctors have chosen this basis.

The above benefit refers only to general practitioner services and does not include specialists. At first glance, this would appear to be a major gap in protection, but according to the traditional New Zealand medical system specialists are almost entirely in the hospitals, and with the free hospitalization (described later) goes all medical attention while in the hospital. Also, out-patient treatment is available from the hospitals.

(b) *Pharmaceutical Benefits.* Practically all medicines and drugs prescribed by a doctor are supplied "free," the notable exception being patent medicines. Accordingly, many manufacturers and pharmacies tend to stress in their advertising that their particular products are "free under social security," which, of course, tends to create demand and use. Also available are various types of artificial aids. Because of the widespread use of the system, there has been a considerable demand, particularly from the doctors, for the basis to be changed from a completely "free" one to a partial reimbursement basis.

In order to obtain pharmaceutical benefits the patient merely takes the prescription to a pharmacy and receives the medicine without payment. The pharmacist then sends the prescription to the Department of Health, which prices the ingredients and sends payment to him. The government has not entered into the pharmaceutical field as a supplier, although it has fixed the prices to be charged by manufacturers.

(c) *Hospital Benefits.* Hospitalization in a public hospital is available without limit on duration and without charge to the patient (beds in public hospitals represent about 90% of the total hospital beds in the country). For those using a private hospital a cash benefit of 9*s.* per day is payable as a partial reimbursement. Similarly, the fund pays the public hospital 9*s.* per day per patient, but this does not meet the full cost of treatment, and, in fact, represents probably less than $\frac{1}{3}$, the remainder coming from general taxation.

(d) *Maternity Benefits.* Combined with the general medical and hospital benefits, maternity medical care is available. As in the United States, many doctors operate on a flat fee basis and, accordingly, the fund pays a flat amount of £6. 6*s.* although an obstetric specialist may collect more from the patient.

(e) *Dental Benefits.* The biggest gap in the health benefits available is in regard to dental benefits, since the only social security provisions therefor are for school children.

SUMMARY OF FINANCING PROVISIONS

Although the benefits, whether cash or service, are on a flat basis, the system is unique in that it is financed directly by a percentage contribution rate ($7\frac{1}{2}\%$) on all net income, and indirectly by a grant from the general treasury (currently about $\frac{2}{3}$ from the former and $\frac{1}{3}$ from the latter). The $7\frac{1}{2}\%$ contribution rate applies to all salaries and wages and to all other net income whether of self-employed individuals or companies. The chief items exempt from contributions are social security benefits, workmen's compensation benefits, veterans' pensions, and dividends received by individuals from companies which have paid the social security tax on their net income. It will be noted that the employer does not match the contribution of his employee, but rather pays according to his net income from his business.

The contributions from salaries and wages are deducted by the employer and are reported promptly on payroll forms, except for very small employers, who may use a stamp system. The contributions on all other types of income are obtained on the basis of annual reporting.

No reserve funds are built up, there being only a very small contingency fund, currently amounting to less than 3 months' benefit payments. No long-range actuarial analysis is made as to the future trend of the cost of the system, which will certainly be increasing for a number of years. The $7\frac{1}{2}\%$ contribution rate is not expected to remain unchanged, but there is a general feeling that it should more or less finance $\frac{2}{3}$ of the cost and accordingly might be raised in the future when necessary.

ANALYSIS OF STATISTICAL DATA

(a) *Operational Statistics.* The great increase in family allowances from 1941 to 1947 (see Table 1) reflects the fact that in the former year a means test was involved. The number of invalidity pensions remained fairly constant from 1941 to 1947, but then declined by about 20%, in large part because tuberculosis cases are no longer given invalidity benefits, but rather generally sickness benefits at the same rate.

As of March 31, 1949, there were about 465,000 periodic benefits in force, representing about 780,000 persons (of whom about 550,000, or 70%, were children). These 780,000 beneficiaries represent 42% of the total population of the country.

Over 80% of the periodic benefit disbursements are in respect to family allowances as a right and old-age pensions based on needs (Table 2). Disbursements for physician's services have risen steadily from £1 million in the first year of operation (1943) to £2.3 million in 1949. Part of this increase is because more medical personnel is available now than during

the war years but, as stated officially, "at the present time the public are demanding or willingly accepting an alarming amount of medical services"; of course, a partial explanation could be that doctors are "overtreating." Similarly, for pharmaceutical benefits the cost rose from £.6 million in the first full year of operation (1943) to £1.8 million in 1949.

Hospitalization cost increased by about 50% from the first full year of operation (1941) to 1947–49. This increase was primarily due to the

TABLE 1

NUMBER OF PERIODIC BENEFITS IN FORCE IN NEW ZEALAND SOCIAL INSURANCE SYSTEM AS OF MARCH 31

Category	1941	1947	1949
Family Allowances*	16,626	230,021	248,726
Superannuation Benefits	36,602	57,992	65,839
Old-Age Pensions†	97,606	115,287	116,254
Widow's Pensions	10,569	13,133	14,883
Orphan's Pensions‡	350	397	371
Invalidity Pensions†	11,936	12,466	10,051
Miner's Pensions†	931	718	660
Unemployment Benefits†	1,906	35	30
Sickness Benefits†	3,452	4,273	4,945
Emergency Benefits§	2,034	1,845	2,026
Total	182,012	436,167	463,785

* Represents number of families and not number of children (548,330 children in March 1949).

† Represents number of eligible beneficiaries, and does not include wife where she is not eligible but husband receives additional benefit for her (as of March 31, 1949, such wives numbered 7,154 for old-age pensions, an estimated 1,900 for invalidity pensions, 313 for miner's pensions, 22 for unemployment benefits, and 2,209 for sickness benefits).

‡ Represents number of families and not number of children (518 children in March 1949).

§ Number of families.

SOURCE: *The Growth and Development of Social Security in New Zealand*, Social Security Department, Wellington, N.Z., 1950, p. 115.

raising by 50% in 1943 of the amount paid from the fund to the hospitals. Hospitalization expenses reached a peak of £2.3 million in 1945 and declined thereafter to the £2.0 million level for 1947–49, since after 1945 the available beds declined, largely because of difficulties in obtaining staff. Thus, at the present time it is officially stated that "serious abuse of hospital beds is limited by the shortage of hospital beds."

The trend of the disbursements for maternity benefits tends to follow that for hospitalization benefits except that the rising birth trend played an important role. Disbursements for supplementary benefits have increased as more and more types of such benefits have become available.

For 1940–45 the total social insurance benefit disbursements were

slightly over 5% of national income (Table 3). During this period the costs were met, roughly, 75% from various contributions on individuals and companies and 25% out of the general treasury. After 1945, as benefits were broadened and increased (especially due to placing the family benefits on a universal basis, rather than a means test basis, in 1946), the charge relative to national income rose, and for each of the three years,

TABLE 2

BENEFIT DISBURSEMENTS IN NEW ZEALAND SOCIAL INSURANCE SYSTEM, FOR YEARS ENDING MARCH 31
(In Millions)

CATEGORY	1941	1947	1949
	Periodic Benefits		
Family Allowances	£ .4	£12.7	£14.2
Superannuation Benefits	.2	1.3	1.9
Old-Age Pensions	7.1	11.9	13.8
Widow's Pensions	.8	1.5	1.9
Orphan's Pensions	*	*	*
Invalidity Pensions	1.0	1.3	1.3
Miner's Pensions	.1	.1	.1
Unemployment Benefits	.3	*	*
Sickness Benefits	.3	.9	.9
Emergency Benefits	.1	.1	.3
Total Periodic Benefits	10.4	29.9	34.5
	Medical Care Benefits		
Physicians†	‡	1.8	2.3
Hospitalization	1.3	2.0	2.0
Maternity	.5	.7	.9
Pharmaceutical	‡	1.4	1.8
Supplementary§	‡	.4	.9
Total Medical Benefits	1.8	6.2	7.9
	Total Benefits		
Grand Total	12.2	36.1	42.3

* Less than £50,000.

† Other than for maternity care.

‡ Not in effect.

§ Includes X-ray diagnostic services, massage services, dental benefits for children, etc. (introduced in stages).

SOURCE: *The Growth and Development of Social Security in New Zealand*, Social Security Department, Wellington, N.Z., pp. 117, 118.

1947–49, amounted to about 10%, of which contributions have met about $\frac{2}{3}$.

For the year ending March 31, 1949, the accounting picture of the social security fund is as follows (in millions):

Fund at beginning of year	£ 7.2
Contributions	29.4
From general treasury	15.0
Miscellaneous receipts	.1
Periodic benefits	34.5
Medical care benefits	7.9
Administrative expenses	.7
Fund at end of year	8.7

(b) *The Effect of the Means Test.* In regard to old-age pensions, as of March 31, 1949, there were 123,408 beneficiaries (including 7,154 wives for whom an additional benefit was granted to the husband) receiving

TABLE 3

SOCIAL INSURANCE BENEFIT DISBURSEMENTS* RELATIVE TO NATIONAL INCOME, NEW ZEALAND FOR YEARS ENDING MARCH 31

Year	National Income (Millions)	Benefit Disbursements* (Millions)	Benefits as Percentage of Income
1940	£211	£10.4	4.9%
1941	232	12.2	5.3
1942	254	13.1	5.2
1943	294	15.4	5.3
1944	327	17.1	5.2
1945	330	18.8	5.7
1946	350	22.2	6.4
1947	365	36.1	9.9
1948	411	39.8	9.7
1949	419	42.3	10.1

* Including both periodic benefits and medical care benefits.

SOURCE: *The Growth and Development of Social Security in New Zealand*, Social Security Department, Wellington, N.Z., p. 119.

pensions at an annual rate of £14,009,000. The average annual payment was £113.5, or 87.3% of the maximum of £130 per year. However, the maximum exempt income as of March 31, 1949 was £52 per year, whereas now it is £78, so that a current analysis would indicate a higher ratio.

As to widow's benefits payable before age 60, there were 14,883 on the benefit roll as of March 31, 1949. The maximum rate for the 10,200 widows

without children was £130 per year, while that for the 4,683 widows with children was £195, yielding a weighted average maximum of £150.5. The average actually payable was £134.5, or 89.4% of the weighted maximum. The means test now is the same as in March 1949 so this proportion probably still holds.

No data are currently available to make any analysis of the effect of the means test for invalidity pensions. As to sickness benefits where only the income test is applicable, analysis made of beneficiaries indicated that almost ⅔ of the beneficiaries during the year ended March 31, 1949 had no chargeable income, while another 20% to 25% had some income but less than the exempt amount. Since 1949, the exempted income has been raised from £1 to £1½ per week, so that the proportion receiving full benefits is now probably well over 90%.

(c) *Age Analysis of Old-Age Beneficiaries.* Data are available from a special study made as of September 30, 1948, giving single ages of old-age pensioners; as of the same date there is also available the aggregate number of superannuation beneficiaries. A summary comparison of the two types of beneficiaries is given below:

	Age 60–64		Age 65 and Over	
	Number	Percent	Number	Percent
Old-age pensioners	25,262	32	92,258	57
Superannuation beneficiaries	.....	.....	63,814	39
All others	54,558	68	6,778	4
Total	79,820	100	162,850	100

All except about 6,800 of the population age 65 and over were receiving benefits. In view of the superannuation benefit being paid as a right, this number seems relatively large. This may be due in part to the natural errors involved in estimating population and in part to such actual factors as some individuals not meeting the residence requirements and others not claiming benefits promptly, possibly because of their relatively small size. Further, these benefits are not paid to aged inmates of mental hospitals (approximately 1,600), or to those aged receiving miners' benefits (approximately 400).

Table 4 summarizes data for old-age pensioners as compared with estimated total population by quinquennial age groups and sex. Old-age pensioners represented 49% of the population age 60 and over, with the proportion being higher for women (54%) than for men (43%). The ratio for

men is 10% for age 60, 21% for age 61, increasing steadily until for ages 70 and over it is close to 60%. For women the ratio is 26% at age 60, 38% at age 61, increasing steadily to close to 65% for ages 70 and over.

(d) *Comparison of Actual and Expected Number of Child Beneficiaries.* The actual number of child beneficiaries should compare very closely with the total population under age 16, since there is no means test for universal family allowances and the residence requirement is very liberal. There were an estimated 551,000 children under age 16 in New Zealand as of March 31, 1949, and 538,372 children under 16 receiving family allow-

TABLE 4

COMPARISON OF AGE-PENSIONERS* WITH TOTAL POPULATION† IN NEW ZEALAND, BY AGE, SEPTEMBER 30, 1948

Age Last Birthday	Men			Women		
	Old-Age Pensioners	Total Population	Ratio	Old-Age Pensioners	Total Population	Ratio
60–64	9,570	39,684	24%	15,692	40,136	39%
65–69	14,906	34,388	43	19,317	35,304	55
70–74	13,330	22,987	58	15,612	24,183	65
75–79	7,877	13,187	60	9,495	14,479	66
80–84	3,482	5,651	62	4,682	6,840	68
85 and over	1,337	2,498	54	2,220	3,333	67
60 and over	50,502	118,395	43%	67,018	124,275	54%

* SOURCE: *The Growth and Development of Social Security in New Zealand,* Social Security Department, Wellington, N.Z., 1950, p. 57.

† Estimated by single ages by projecting 1945 census with New Zealand mortality rates for 1945 and then adjusting to agree with official estimates of the population age 60–64 and age 65 and over (the necessary adjustment factor was about ½% for age 60–64 and ¼% for age 65 and over).

ances. In addition there were 518 children receiving orphan's benefits and 3,954 children receiving benefits as dependents of veterans, making a total of 542,844 children under age 16 receiving social insurance benefits—8,200 or 1½% less than the population estimate.

(e) *Analysis of the Cost Effect of Maturing the Superannuation Benefits.* For the 162,850 persons age 65 and over as of September 30, 1948, the additional cost of paying the full £130 old-age pension without a means test is as follows: For the 6,778 persons not getting any benefits, the additional cost is £130 each, or £.9 million per year in the aggregate. For the 63,814 persons getting superannuation benefits but not pensions, the additional cost is £100 each (since as of that date, the superannuation benefit was £30 per year), resulting in an aggregate additional cost of £6.4 million. For the 92,258 persons getting old-age pensions the additional cost

is roughly £16½ each (representing the reduction due to the means test), or £1.5 million per year in the aggregate. The grand total increase is £8.8 million per year, or roughly a 20% increase in the total outgo of the system, or 2% of national income.

Accordingly, if the superannuation benefits were matured immediately as to amount, the social insurance tax would have to be increased from 7½% to 9½% if no additional funds were obtained from the general treasury. Further, the percentage of the population who are aged will increase by perhaps 25% in the future, which factor would add another 1¼% of national income to the total cost. Thus, the cost of the system will, over the next 40 years, be increased by over 3% of national income due solely to the aging of the population and the maturing of the superannuation benefits (if the benefits generally maintain their relative position with national income and superannuation benefits maintain at least the same relative degree of realism as they are now promised to possess).

(f) *Real Costs of the New Zealand Social Insurance System.* The reported cost of the system now is roughly 10% of national income. However, this should be adjusted upward to allow for a major portion of the expenditures for hospitalization not coming out of the social security fund but rather from the general treasury, which would add about 1½%, making a total present cost of 11½%.

Now, consider the long-range picture, necessarily neglecting as unmeasurable (1) any possible cost increases due to greater use of medical benefits, (2) any changes in the economic situation, which could either increase costs by lowering the taxable income base and at the same time increasing retirement and unemployment claims, or else lower costs if national income increased faster than benefits were liberalized, and (3) further extension of the programs (such as dental benefits). The chief increase in cost results from the maturing of the superannuation benefits, namely 3% of national income. Combining all these indicates an ultimate cost of about 15%. This figure is probably on the low side, especially since in normal times unemployment benefits would have some significant cost, but now they are virtually nonexistent.

DISCUSSION OF PRECEDING PAPER

KERMIT LANG:

Next to its long expectation of life and low infant mortality rate, New Zealand is probably most famous for its social security program. As a result of Mr. Myers' research during his visit to the Dominion to attend an international conference on social security, held in Wellington last February, there is now available a comprehensive report on this system from the viewpoint of an actuary.[1]

While stationed in Wellington for three years during and after World War II, I became interested in studying the history and evolution of social security in New Zealand, and it is the purpose of this discussion to present some of the background material which this study disclosed and to review recent developments and present trends.

Mr. Myers' paper contains a large amount of accurate factual data, but there are two observations in his opening paragraph which I think might be misleading. His statement that "during the depression years much social security legislation was passed" might lead one to the erroneous conclusion that the present legislation had been enacted during the depression and that relatively little development had taken place since. Actually the present Social Security Act is dated 1938, which I believe would be considered a postdepression year, and the most important amendments are dated in 1941 and 1945.

Also, the qualifying clause in the statement that "The entire philosophy of their system may be summed up by saying that it aims to provide for all who, through misfortune beyond their control, need help" applies only to those benefits subject to a means test. The wonder to students of political science is that "to retain a means test for some basic benefits has been politically possible for a Labor Party in New Zealand, whereas it would be politically most difficult, if not impossible, for British Labor."[2]

The philosophy of their system is much more accurately expressed, it seems to me, by the statement that "the New Zealand scheme definitely

[1] A review covering quite similar ground was prepared for the Social Security Board by Jacob Fisher, "The New Zealand Social Security Program," Social Security Bulletin, Volume 8, September, 1945, pp. 3–11. A separate review of the cash benefits by Mr. Fisher appeared in a pamphlet entitled, "Cash Benefits under the New Zealand Social Security Program," Social Security Board, Bureau of Research and Statistics, Bureau Report No. 13 (U.S. Government Printing Office, 1945).

[2] Leslie Lipson, "The New Zealand Means Test: An Appraisal," *Public Administration* (London), Winter Number 1944/45.

succeeds in its object of redistributing wealth and mitigating poverty." This appraisal appears in a paper published in 1944 entitled "How Social Security Works in New Zealand," by Leslie Lipson, then Professor of Political Science at Victoria College, University of New Zealand.[3]

Early History of Social Security in New Zealand

Compulsory contributory social security benefits, including not only old age benefits but also widows', orphans' and sickness benefits, were first proposed in New Zealand by Prime Minister Atkinson in 1882.

W. B. Sutch, author of numerous articles on New Zealand's social and economic problems, in his book, *The Quest for Security in New Zealand*, says:

> Atkinson's ideas were not based on those of his contemporary, Bismarck, but on those of Canon Blackley, who in 1878, in an article in the *Nineteenth Century* entitled "National Insurance—A Cheap Practical and Popular Means of Abolishing Poor Rates," had put forward a scheme for a compulsory national friendly society, which in turn had been based on a suggestion made to the Friendly Societies Commission. His scheme included a means test, but Atkinson's, being on an actuarial insurance basis, gave universal payments for the hazards insured against.

Atkinson's proposal was rejected but the idea persisted and the first legislation was adopted in 1898. Instead of universal benefits financed on a contributory basis, however, the Old Age Pension Act of 1898 merely set up a noncontributory system of old age pensions subject to a strict means test.

Gradually the idea of supplementary contributory pension plans began to emerge, resulting in the Government Railways Superannuation Fund of 1903, the Teachers' Superannuation Fund of 1906, and the Public Service Superannuation Fund of 1908. All three funds are similar in that they were established on actuarial principles, contribution rates are graded by age at entry, reserves are accumulated, and periodical valuations have been made. Likewise the funds are similar in that members' contributions are matched to a certain extent by the State as employer. These funds are referred to by Mr. Myers under the heading of Civil Service Retirement.

A very interesting companion plan to these Civil Service plans was established in 1910. Known as the National Provident Fund, it was open to the general public on a purely voluntary basis. Any New Zealand resident could become a contributor, provided his average annual income during the three years prior to his joining did not exceed £300. All contribu-

[3] Leslie Lipson, "How Social Security Works in New Zealand," *Public Administration* (London), Summer Number, 1944.

tions paid by contributors attracted a 25% State subsidy, and the State guaranteed the solvency of the fund.

Meanwhile, social security benefits were evolving slowly. Pensions for widows with children were first provided in 1911, pensions for the blind were started in 1924, and so-called family allowances were introduced in 1926. This latter benefit consisted of a payment of 2*s.* a week to the parents on behalf of the third and every subsequent child under 15 on the condition that the family income did not exceed £4 a week. A program of unemployment relief was enacted in 1930 but no benefits were provided for unemployed women. In 1936, "invalidity pensions," or pensions for invalids and their dependents, were adopted, absorbing the blind pensions program.

The unemployment relief program was financed partly by a poll tax but mainly by a tax on wages, salaries and incomes, which rose to 5%, or 1*s.* in the pound, in 1932, but this rate was reduced to 10*d.* in 1934 and 8*d.* in 1935. Pensions and family allowances were financed from general revenue.

Social Security Act. 1938

The Act of 1938 created the Social Security Department, as a successor to the Pensions Department, unified the pre-existing schemes of benefits, liberalized many of the qualifying requirements for these benefits, and broadened the coverage through new types of benefits, including: (1) orphans' benefits, (2) benefits for widows without children, (3) sickness benefits, (4) emergency benefits, (5) maternity benefits, (6) hospital benefits.

So as to give the promise of something to everyone, there was tossed in, some say "as a political afterthought," a deferred annuity at age 65, starting at £10 per year in 1940 and increasing in amount each year by £2. 10*s.* This is known as the "universal superannuation benefit," and since it is paid as a matter of right it is the counterpart of old age benefits in the United States.

The Social Security Act of 1938 also contemplated a free general practitioner service, but this was, in effect, a benefit in kind, not a monetary benefit, and was not destined to become a reality without a long period of negotiation between the Government and the New Zealand branch of the British Medical Association. Since so-called "socialized medicine" in New Zealand has received so much publicity, it seems worth while to quote Prof. Lipson at some length on the history of the negotiations which resulted in the State assuming the obligation of paying for private medical service.

The conflict between the medical profession and the Labor Government was born of that interplay of social and economic forces which inevitably assumes a political character. The Government came to power with the votes of the working and lower-middle classes. Their social outlook predisposed them to favor public enterprise as against private competition. . . . Politically and socially most of the medical profession were opposed to the Government anyway, and in the Social Security scheme the majority chose to see a fatal blow to their status and salaries. The general aim of the government is to organize a national medical service for the whole population. As a corollary they seek to allot the doctors a defined salary scale and to eliminate the profit motive from their calling.

According to Prof. Lipson, "The original Act envisaged a system of contracts between the Minister of Health and the general practitioners." This the New Zealand branch of the B. M. A. rejected. In 1940 the Government brought forward new legislation providing for a capitation scheme or panel system, at the rate of 15*s*. a head per annum. It was a permissive, not a compulsory, system and very few doctors signed up. From the financial point of view the doctors felt the proposed fee was too low and should have been about 31*s*. 6*d*. a head.

Finally, in 1941, when the Labor party leaders had not yet been able to fulfill their platform promise of a general practitioner service and an election was again in the offing, yet another alternative was drafted, centering around a "fee-for-service" plan. The standard charge for an office call had long been half a guinea, or 10*s*. 6*d*. The Government's proposal was for the State to pay a flat fee of 5*s*. per visit with no further amount to be charged the patient, but this was opposed by the B. M. A. Prof. Lipson's account of subsequent developments is as follows:

"Much of this opposition was silenced when the Government, during the debate on the second reading of the Bill, announced major compromises. They agreed to allow the doctors to be paid directly by their patients, whilst the latter had to claim repayment from the social security fund. Moreover, the legal rate of 5*s*. a visit was raised to 7*s*. 6*d*., and it was left to the doctors to charge over this rate if the patient was willing to pay. In this form the Bill became law." Thus State-subsidized medical service came to New Zealand, not on a panel system, not on a salary basis, but on the fee-for-service principle.

Free choice of doctors is one of the features which has made the system popular with most New Zealanders. Although the doctors themselves are by no means so happy with the system, they have no bad debts since the Government has underwritten the cost of medical benefits and their average income has increased substantially.

A Few Sidelights on Details of Administration

The means of collecting the Social Security tax will perhaps be of interest to those who are studying the possibility of further extensions of Social Security in the United States. So far as wages and salaries are concerned, the Social Security contribution is levied as a withholding tax, and is therefore on a "pay as you earn" basis. In the case of larger employers the amounts withheld are remitted to the Land and Income Tax Department.

Side by side with this is a stamp system. In the case of the small shopkeeper, for example, the employer must take the funds withheld from the wages of an employee and buy either special Social Security stamps for the larger amounts, or ordinary "postage and revenue" stamps for the smaller amounts, from the Post Office. These stamps are defaced and pasted in a book (any kind of little notebook seems to do). Periodically inspectors come around and check the books to see that the shopkeepers are actually buying the stamps. The stamp system is also used in the case of domestics and farm hands. The stamp revenue, of course, is collected by the Post Office Department instead of the Land and Income Tax Department, but can be readily segregated to the extent that the special Social Security stamps are sold.

Farmers, shopkeepers and other self-employed individuals and the companies remit their Social Security tax to the Land and Income Tax Department after the close of the regular fiscal year when they pay their income tax. There is, of course, some confusion in the case of individuals shifting from an employed to a self-employed status, because of the "pay as you earn" system on the one hand and the "pay in arrears" system on the other. Because of this and because of the possibilities of evasion in the stamp system, a certain amount of revenue is lost. More important, however, is the income which is not reported. On this point, Prof. Lipson makes the following observations:

> To levy the full amount due from fixed salaries and wages is easy. To enforce the same contribution from all other earnings (*e.g.*, rents, temporary jobs, intermittent fees) as well as from small shopkeepers, farmers, and such like, is impossible. . . . If all types of earnings were in fact disclosed, the proceeds of the tax would probably be raised by at least 20 percent.

In any event, the Social Security Department officials point out, there is no necessity for any individual records of taxable wages or social security tax payments to be kept because there is no relationship between benefits and earnings as in the American system. There is no limit on the amount of earnings subject to the Social Security tax, and benefit eligibility is not conditioned on the payment of the tax.

Recent Developments

Mr. Myers has refrained from mentioning the political climate in which social security in New Zealand has flourished, but it is fairly obvious that the development and extension of social security benefits and the political history of New Zealand are intimately related. The Labor party came into power in 1935 and won successive elections in 1938, 1943 and 1946, losing finally in 1949. To quote Prof. Lipson's view of the intimate relationship of these dates and the successive stages of development of the present social security legislation in New Zealand:

> Many of the Dominion's social services were originated in years that coincided with general elections. . . . Conforming to precedent, the Labor party did not bring in its security bill until the election of 1938 was in the offing. Their victory, highly probable in any event, thereby became a landslide. For similar reasons the amending Act, which extended the medical benefits to cover the general practitioner service, was passed in 1941, when an election was again due and would have been held but for a late postponement.

Late in 1945, with the war over, with the prospect of sharp curtailment in war expenditures, and with a general election coming up in 1946, the Labor party passed the Amendments of 1945 which entirely freed the Family Allowances or children's benefits from a means test, effective April 1, 1946, and increased the Social Security tax from 5% to 7½% from May 12, 1946. Whereas the family benefits had cost 2.6 million pounds for the fiscal year ending March 31, 1946, the cost jumped to 12.7 million pounds for the fiscal year ending March 31, 1947, thereby surpassing Old-Age Pensions as the most costly, most numerous and currently most important of all benefits (see Mr. Myers' Tables 1 and 2).

Labor party leaders had first planned to remove the exemptions for children in computing individual income and thereby calculated to collect 2¼ million pounds additional income tax as an offset. However, it was found that too many anomalous situations would arise if the income tax base were altered, so exemptions for children were allowed to stand. This serves to bring out the point, however, that although children's benefits would sound like a strange new idea to most people in the United States, yet a quite similar philosophy is evident in our system of income tax deductions for dependents.

In New Zealand during the war a total withholding tax of 12½% of wages had been imposed, 7½% going to National Defense and 5% to Social Security. At the same time that the Social Security tax was increased to 7½%, the National Defense tax was reduced to 2½%, the net effect being a reduction of 2½% in the aggregate. Since the public is still conditioned to the idea of a 10% withholding tax, it would be a relatively pain-

less process to erase the National Defense tax, increase the Social Security tax to 10%, and in exchange "mature" the universal superannuation benefit immediately for the amount of the maximum old age pension, if the government in power should choose to do so. It is unlikely that the new government will be disposed to do this, but inevitably there will be pressure groups which will urge such a move on both parties. As Prof. Lipson observes, "There is a snowball tendency to ask for more, and to do so concertedly."

When the Social Security Act of 1938 was enacted, some 20% of the population was enrolled in friendly societies, which were the principal vehicle for providing prepaid medical care. New Zealand had nothing comparable to our group insurance, group hospitalization, group surgical benefits, or hospital service insurance. Since practically all of the benefits which these societies had to offer have been superseded by social security benefits, the friendly societies have been unable to recruit new members and are gradually winding up their affairs.

On the other hand, the effect of the Social Security Act on life insurance companies, as in the United States, has been to stimulate rather than hamper sales. Universal superannuation has been especially important in this respect because other income does not disqualify the individual from receiving this benefit and a retirement program can therefore be integrated around it.

Conclusion

The swing to the left, during the Labor party administration in New Zealand from 1935 to 1949, has had many interesting aspects. To understand the particular objectives of this movement in New Zealand it is enlightening to examine the thesis of the Labor party which was well stated by the former Prime Minister, Peter Fraser, after the National party took office in November 1949:

> If the new Government's promised freedom will enable the people to improve their lot without impairing or diminishing the freedom of others it will have the whole-hearted support of the Labor party; but, if it means greater freedom to exploit in rents and prices, to speculate in land, homes, and commodities . . . then the Labor party will just as strenuously oppose (the program of the National party).

Thus, the extension of social security benefits during the period from 1935 to 1949 was only one phase of a program, the full discussion of which would require an examination of such measures as state housing, land sales courts, import controls, price fixing, food subsidies, bulk sales of agricultural exports, a full employment policy, and minimum wage awards. In general, it may be stated that it was the Labor party's re-

luctance to do away with these controls—which were instituted for the most part as wartime measures but which the party leaders felt it necessary to continue in order to avoid what they termed "the exploitation of labor"—which led to ultimate defeat at the polls.

It is, however, noteworthy that, while state housing policy is being modified, land sales courts are being abolished, and price fixing and food subsidies are being removed, the new administration has made no move to reduce the social security benefits, but rather such changes as have been made since November 1949 have been in the opposite direction. Due to removal of subsidies, food prices have risen, and certain benefits subject to a means test have been increased to meet rising living costs. Thus it is evident that economic as well as political elements are bound to affect the future cost of social security benefits.

Social Security in New Zealand has been financed on a strictly "pay as you go" basis. There is no thought of accumulating reserves or "saving up for a rainy day" or providing a cushion for future emergencies. There is no actuarial relationship between benefits and taxes. Benefits are either a flat amount, if not subject to a means test, or an amount sufficient to bring the recipient's income up to a flat amount, if subject to a means test. Taxes on the other hand are a flat percentage of income, with no limit on taxable income. Therefore the soundness of the New Zealand social security program does not appear to be an actuarial question.

About all the actuarial consultant could do would be to estimate probable future disbursements and the ratio of these disbursements to future national income. However, neither the actuary nor anyone else could have foreseen in 1940, for example, the future pattern of liberalization of benefits or the fact that the national income would triple in ten years.

The real test of soundness must be whether the New Zealand economy can stand the cost of the benefits. At the present time, when the Dominion is enjoying unprecedented national income, spends less than 4% of this income on defense, and has no unemployment, it is not a serious strain on the economy to pay out 50 million pounds annually, or 10% of national income, for social security benefits. In the fiscal year ending March 31, 1950, the national income exceeded that for the previous year by 13%, largely due to the fact that prices realized at wool sales had increased 45% over the previous year.

This dramatizes the fact that New Zealand's prosperity depends upon the price obtained for its exports, which are agricultural only. The ever-present threat of synthetic fibres to replace wool and the possibility of sheep or cattle disease in epidemic proportions are other factors which might have a disastrous effect on its economic future. Having practically

"all its eggs in one basket," New Zealand's continued prosperity is peculiarly vulnerable to forces beyond its control.

W. RULON WILLIAMSON:

Mr. Myers has now become our actuarial John Gunther. His story from "Inside New Zealand," supplementing the official ILO report recently released (written, I understand, by the New Zealanders) carries a laconic tabulation of data, and gains from an almost British quality of understatement. As we face the heavily-sponsored "welfare state" from Japan (where Mr. Myers is now studying) to Haiti, this story of New Zealand is, as Mr. Myers reports, a record of a laboratory experiment. This experiment is from what the ILO calls "an advanced economy."

Social Security barges in simply everywhere—on the one hand at low economic levels, because there is need, and on the other hand in more developed countries, because there are economic resources to tap. In both cases, today, there is an open and methodical laying of the ground-work for an all-purpose social security system.

When Sir George Maddex was here with the visiting British actuaries in 1938, and we were discussing Social Security, there was some warning from other actuaries that we should be alert to the machinations of the Keynesians, but Sir George told me about his assignment to New Zealand in the preparation for the law of 1938, where they had tried to "go the British one better," and how concerned he was as to their nonchalance. Somewhat later Walter Nash, who had been the Minister of Finance in New Zealand before he came to Washington as Minister, was addressing a world economic conference on their recently enacted Social Security program, and went out of his way to warn about the pessimism of actuaries as to future costs—"so unnecessary a pessimism." Later he told me that the Labor Leader who had ridden to power on his Social Security promises (it must have been Michael J. Savage) found it necessary to defer some of the promises till later, and made the deferment a sort of cornerstone. They gave small age pensions—flat amounts—these to be advanced slowly and steadily over time, but to be supplemented by needs-test pensions at once. The system seemed to me like one of uniform flat benefits—in which I still believe—so I liked that aspect. It looked to Mr. Lewis Meriam like a practical relief plan, with its needs tests, and he regarded it very highly too, for his convictions were backed up there. In short the system is a political winner—"all things to all men."

Mr. Myers shows that over a ten year period, 1940 through 1949 (fiscal years), the trend has been steadily up in benefits—which have quadrupled in pounds and doubled as a percentage of a doubling national in-

come. Fiscal year 1950 report is now out, and the trend has continued another year too. The report just released shows one item that interested both Mr. Lewis Meriam and myself: they cut the Treasury's kick-in by 20% and used up about a third of the "reserve"—an interesting "living on the fat" for a while. The ten year story only reached 10%, but Mr. Myers shows there are other outlays that belong in the account, and he estimates going to an ultimate of 15%. That is where he seems unguardedly optimistic. Should the Conservatives halt the inflationary trend, as I should hope they would *plan* to do, but honor the rising commitments under Social Security, which they may feel their responsibility, another doubling of ratio of benefits to national income seems more plausible than a mere increase of 50%. We might remember that France, with children's benefits also, is reported as alloting 34.5% of wages to Social Security (a bit different than the ratio of benefits to national income, but a bit breath-taking when you first think about it—and more breath-taking as you think about it more).

The monotony in an economy with so nearly uniform an income is in line with making one thoroughly sick of his job by the age of 60, especially when lack of extra possessions above a house and a car is an open sesame to a pretty liberal needs-test pension. In the age group 60 to 65, 25% of the men and 40% of the women draw superannuation benefits as of 1949; and beyond 65, 95% draw either superannuation or age benefits. Incentives to effort must have waned, and the difference between low permissive earnings for work and a rather high compensation for nonwork appeals to my imagination as offering fellowships for the better use of the car and the house, which have not blocked the qualification for benefit. A Conference on Aging over there might either stress the value of a normal occupation as a method of adding years to the life which bids fair, in that low mortality paradise, to be very lengthy—or it could encourage just "living the life of Riley."

But New Zealand isn't alone in thinking of age 60 as a good time to retire. On October 31, Senator Kilgore of this state of West Virginia wrote me, saying: "The new Social Security Law, enacted by the 81st Congress, is undoubtedly a great step forward in social welfare legislation. From all angles—coverage, benefits and administrative details—it is a more realistic and helpful law. Unfortunately it could and should have been even better. As you know, I introduced an amendment to reduce from 65 to 60 years the age of eligibility for benefits, and sponsored an amendment providing for disability insurance. Although both these amendments were defeated and other liberalizing provisions were also omitted, I feel confident that within the next few years we shall see them incorporated in the law."

Against such hypnotic words, a more effective opposition than has yet appeared is needed.

The recent ILO reports make much of the point that it doesn't much matter whether you start with something called *insurance* or something called *assistance* or *relief*. You come out sooner or later to the same regimentation, which you can then call what you please. Always, it is indicated, *some* plans lead to *more* plans, and you come out with *security*, instead of *insurance*. Insurance labels will have served their purpose and can be dropped.

Mr. Myers, in his trips abroad, is a little unusual. Actuaries have not been the usual missionaries from the ILO and the Social Security Administration. As Dr. Schoenbaum of the ILO pointed out to me as he was attempting to indoctrinate me, they are not quite flexible enough to further the governmental plans. The more flexible nonactuarial people are getting in quite a lot of travel too, and there is perhaps as much bringing them in from around the world for indoctrination in Washington. The tone of this indoctrination can be judged from the comment of Dr. Ouchi of Japan: "Social Security is now the voices of the age and also the high sound of footsteps of the movement of the World. . . . It is of course inevitable that we could not expect our social security to be so splendid and perfect as those in England and the U.S.A., owing to our feeble financial strength and the fact of being too far behind in this system, notwithstanding Japan is in urgent need for its further growth." A Japanese relief administrator from either Tokyo or Yokohama visited New York City to study their relief setup (the one a Socialist judge said was doing great harm) and said the two problems of urban relief in the two countries were alike, save for one thing: Japan had no money.

Not only in New Zealand and Japan, but in Greece and Turkey, Egypt and Iran, literally everywhere, the ILO seems to be urging the solution of making promises for our (their) children to redeem. My paper on Selection, my story of the 16 rectangles, applies to the awkwardness in such practices. Commitments are being made that *today's* economy cannot afford, against the money that is to be made later. There is a buying of regimentation on credit. This is basic dishonesty in any language and in any country.

GEOFFREY N. CALVERT:

I myself was born in New Zealand and spent 34 years there. I saw this whole social security program start and develop. I worked under Sir George Maddex on the estimates of the original social security plan which got rolling about 1938. I watched it sprout from that time through to 1946. It may be helpful in understanding that system to have a little more

background about New Zealand than has been presented in Mr. Myers' paper.

It should be recognized that New Zealand is a country which has had to withstand tremendous economic tides of prosperity and depression, generated from overseas. New Zealand's income has depended very much on the price of agricultural products in England, and those prices have risen and fallen tremendously. The farming population, which forms the backbone of New Zealand, has had great rises and falls in its economic situation, which have made the whole country very conscious of the need for some kind of security. I think that applies more there than in most places.

The government in New Zealand has at all times, since the very beginning, been a great pioneer. It has built railroads; it has built the hydroelectric system; it has taken a great part in the development of the farming industries. And the people tend to look to the government for more things than in this country.

The people are made up of 96 percent British and 4 percent Maoris. The 96 percent are homogeneous and live at a uniform standard in all parts of the country. There are not the extreme geographical contrasts, such as exist in America.

There has been a long history of sociological thinking and a gradual trend toward this type of thing. The social security plan was not actually started by the Labor Party. The first beginnings of the comprehensive social security plan were started by the conservative party of the time, which was thrown out by the Labor Party. The Labor Party went further and faster with the inauguration of the plan. When the voting population threw the Labor Party out of power later, it was on the basis that the conservative party, known as the National Party, would retain intact the system then in force and would not dispense with it.

The people as a whole support the system; they are conscious of abuses and defects in it, which they want to cure rather than to see the whole system thrown overboard. That is a practically universal sentiment. The benefits are quite generous in comparison with the cost of living in the farming areas and in the Maori settlements in particular. That has had a very interesting effect on the willingness of the Maoris to work. I myself, traveling around on vacation, have noticed Maori adult workers, who should have been working, lounging around in their little settlements, obviously living on the income that their dependents derive from the social security plan.

I remember a very interesting incident reported to me by a social security officer located in a Maori area, who said that a Maori had reported to him a claim that he now had 8 children. The previous year he had only

had 5 children. The social security officer told him, "You cannot do that. You haven't had triplets."

He said, "Oh yes, Boss. My wife's sister, she home, too, helping out."

The birth rate in practically every country fell during the depression and stayed down, and there were all kinds of gloomy forecasts about falling populations and national suicide. New Zealand was one of the first countries to reverse that trend. The birth rate rose very noticeably with the introduction of the social security plan. Whether there is clear evidence there of direct causation, I am not sure; but the New Zealand rise in the birth rate went a little ahead of the rise in most countries and did seem to be linked to the social security plan. Since the enlarged children's allowances have become available, I believe there has been a very noticeable tendency for the further increased birth rate which came along with the war to be sustained.

In England the social security or National Health system was built around the existence of the friendly societies. New Zealand also had friendly societies, but chose the alternative course of establishing an entirely independent government department to run the system. That has been the death knell of the friendly societies, but has resulted in a possibly more efficient, uniform, and fully supervised system of distributing the benefits. I think that New Zealand feels that the course chosen was a better alternative than to use the rather heterogeneous collection of friendly societies which were previously in existence.

There is a great deal of publicity, or propaganda, connected with the idea that social security—or should I say socialized medicine—means that you do not have free choice of doctor. The New Zealand system does provide a completely free choice of doctor.

Since the social security plan went into effect many insurance people have been anxious about the future of life insurance. Apparently, there has been no tendency to curtail the growth in volume of life insurance in force. There has been a steady increase in the amount of life insurance in force since the inception of the social security plan.

Mr. Myers' paper suggests that there will be a rise in the cost of the social security plan from about 10 percent, or more than that, to something like 15 percent of the national income. Mr. Williamson has pointed out the large growth in cost since the plan was started. I think the past growth was mainly due to the fact that there were two great extensions of coverage during that period—medical service and universal children's allowances. There is also a point in the gradually growing universal superannuation benefit.

If the benefit program is stabilized at this point, I do not think that a continuation of that kind of growth is to be anticipated at all. With re-

gard to that prognostication that the plan will take 15 percent of the national income, I think that should be linked very much to the possibilities of curbing inflation. My own personal view is that the great threat ahead of the Western world at this time is inflation. I do not think that anything like enough attention is given by actuaries in all phases of actuarial work to the impact of inflation on all sorts of activities that we are connected with. If the inflation trend continues, as I believe it will, and as a fully employed economy would tend to make it, then there is the probability that, with a conservative party in power in New Zealand, the benefits might tend to be stabilized more, and to grow less rapidly in relation to the rest of the levels of prices and wages, and hence the tendency to proportionate growth in the size of the social security cost, in relation to national income, may be offset by the inflation.

I do not think that a conservative party would be inclined to permit the benefits to grow as fast as, for example, a Labor Party would do. That may completely offset the tendency which, undoubtedly, would exist otherwise because of the growing universal superannuation feature. It is going to be interesting, as the years go by, to see just exactly how that works out. I myself would not be greatly surprised to see the proportion of the national income absorbed by the social security plan fail to rise to the levels indicated by Mr. Myers, let alone go racing ahead of it, as indicated by Mr. Williamson.

GEORGE W. K. GRANGE:

This account of the New Zealand Social Insurance System by the Chief Actuary of our Social Security Administration, presumably inspired by his recent trip to that far land, is both interesting and timely. It is interesting because social security and its problems are looming ever larger on the social and economic horizons of more and more people, so that the efforts of others to reach large solutions in this field cannot fail to be of vital interest, whether by way of stimulus or caution. Mr. Myers' account is also timely because, with a view to ascertaining what further changes should be made in our social security legislation, our Senate is committed to, and presumably preparing to embark on, a thorough-going study of that subject, with special attention to the advantages and problems of a pay-as-you-go universal coverage system—a description commonly applied to the New Zealand system.

An interesting comparison between certain concepts underlying the New Zealand plan and the approaches which have been quite generally accepted on this continent was recently made by Dr. G. F. Davidson, Deputy Minister of Welfare in the Canadian Department of National Health and Welfare, in testifying before the Joint Committee of the

Senate and the House of Commons on Old-Age Security—a body which recently completed an extensive investigation of that subject (Session 1950, Minutes of Proceedings and Evidence, No. 5, pp. 194 ff.).

Dr. Davidson pointed out that in Canadian and American thinking on social security there is a clear-cut separation in the methods deemed appropriate for financing, respectively, benefits subject to a means test and benefits payable as a right. Where benefits are subject to a means test, so that they are largely discretionary and involve no absolute right, it is commonly felt on this continent that they should be financed out of general funds (consolidated revenues he calls them) without any special contribution being required. Where, however, benefits are due as a matter of right, subject to prescribed qualifying conditions (*e.g.*, attainment of age 65 and retirement from gainful work) a contributory approach is felt to be the appropriate one. Conversely, requiring an individual to make contributions is certainly felt to involve "the receipt of benefits as a contractual right."

In the New Zealand system, on the other hand, no such clear-cut lines of separation are to be found. Instead, there is found a social security program which lumps together a wide variety of benefits, some payable as a right, others subject to a test of means—the whole to be financed out of a common fund supported for the most part by contributory taxes, mainly on salaries and wages but also on other income of individuals and on company income, and with general revenue furnishing a variable but large proportion of the total. There is no attempt to earmark any portion of this common fund for any particular class or classes of benefit—no reason to suppose that any particular part of the program, whether means test or nonmeans test, is less dependent on contributory taxes than any other. While the fund's income for the fiscal year 1948–49 was two-thirds contributory, its outgo was only 47% free of a means test if cash benefits alone are considered, or only 57% on the basis of cash and health benefits combined.

The general attitude of the New Zealanders in thus getting their drinks mixed, so to speak, would seem to be that, while it would no doubt be nice to have all or the great bulk of benefits payable as a right out of their predominantly contributory pool, considerations of cost make this entirely out of the question under existing conditions. However, long steps in this direction have been or are being taken, such as making family benefits universal (in 1946) and the initiation (in 1940) of small but increasing superannuation payments calculated some day to catch up with and supersede means-test benefits for all persons 65 and over (though not for those aged 60–64).

On the very unlikely assumption that the present limit of £130 per

annum for the means-test age benefits will continue at that figure, the superannuation benefit would indeed catch up in 1988. It seems much more likely, however, as Mr. Myers suggests, that this event will be deferred, perhaps indefinitely. He would attribute this to increases in the above limit brought about by increasing wage and price levels. However, there will also be the ever-tightening task of supporting an aged population that is inexorably growing, not only in relation to the entire population (Mr. Myers mentions a future increase of perhaps 25%), but in relation to the workers on whom they must count for support. It does not, therefore, seem reasonable to expect that forty years hence considerations of cost will make dispensing with a means test any easier than today. Rather it would seem that the chances of the superannuation payment overtaking a probably rising age-benefit limit, even if the amount of its annual increment (now £2½) is stepped up, will diminish rather than increase.

One important reason why benefits as a right, if cost difficulties can be overcome, are generally considered preferable to means-test benefits is that they do not impair the individual's incentive to supplement his benefits through other channels. Especially is this true if right to benefit is conditioned on retirement as it is in this country (though not in New Zealand). Under means-test benefits, on the other hand, there is an income range, following the point at which allowable income is exceeded, within which there is no advantage in supplementing the benefit with private income, since any such excess income would only mean a corresponding reduction in the benefit. It is not until private income, from whatever source, exceeds the combined amount of social security benefit and allowable income, so that benefit will no longer be payable, that private income can once more operate to improve an individual's standard of living.

In particular, where the proportion drawing means-test age benefits is as high as it is in New Zealand, it would seem that the incentive of the population to seek additional protection through private pension plans would be greatly impaired. It would be interesting, therefore, to have information as to the extent of special pension plans in New Zealand as compared with the United States or Canada. An inquiry on this very point at the Canadian Hearings elicited from Dr. Davidson the impression (which he warned could be quite wrong) "that there is nothing like the development in New Zealand of nongovernmental pension schemes such as we have in Canada and certainly nothing like the development they have in the United States." A committee member thereupon made the point, which also may have been a mere impression since he gave no supporting facts, that "since these universal (guaranteed) benefits have come into

effect the tendency has been for New Zealand people to provide additional benefits to quite a considerable extent." Perhaps the author, through his New Zealand friends, can procure something more than impressions regarding this important matter.

It is of interest in this connection that, in addition to the normal income exemption for sickness benefit, there is, as Mr. Myers notes, "a further exemption from income of up to £1 per week for sickness benefits coming from friendly societies (no longer an important element in the New Zealand economy)." There are in New Zealand approximately 1,000 registered friendly societies with approximately 83,000 members. Moreover, the Social Security Commission is authorized to approve as "like" societies other organizations administering sickness benefit schemes, but not registered as friendly societies. Sixty-eight such organizations with approximately 41,000 members have been approved. Out of 26,673 individuals who received sickness benefit during the fiscal year 1948–49, some 4,237 were members of friendly and "like" societies. These figures are taken from *The Growth and Development of Social Security in New Zealand*, an authoritative survey of that country's plan recently put out by their Social Security Department with the cooperation of their Health Department. Mr. Myers found it a valuable source of facts and figures, and this writer will make considerable use of it in the rest of this discussion. For brevity, it will be referred to as *GDSS*.

It is no doubt a matter of administrative convenience that, as Mr. Myers points out, universal superannuation benefits available as a right from age 65 "are not payable for persons eligible for age pensions of larger amount payable on the basis of a means test." For this reason, as well as because the superannuation benefit is now at a much lower rate and the age-benefit is available at a younger age, expenditure in respect of the latter is several times expenditure on the former. Thus Mr. Myers' Table 2 shows for the fiscal year 1948–49 an expenditure on age benefits (£13.8 million) which is about seven times that on superannuation (£1.9 million) and figures now to hand for 1949–50 show about the same ratio. If, however, superannuation payments were currently to be made to the fullest extent practicable (*i.e.*, to virtually all persons age 65 and over), and means-test age-benefits correspondingly reduced, the ratio of age benefit outgo to superannuation benefit outgo would be considerably lowered, thereby furnishing a more realistic index of the current financial relationship between these benefits. An estimate made for the Canadian Joint Committee (Session 1950, Minutes of Proceedings and Evidence, Ottawa, p. 181) puts the ratio on this basis at $2\frac{1}{4}$. Exclusion of age benefits payable before age 65 would, of course, reduce the ratio still further.

Mr. Myers makes only passing reference to "emergency benefits" as a

"catch-all." An interesting account of the history and scope of this category of benefits is given in *GDSS* (pp. 88–92). The original proposal was for a "disability" benefit (not to be confused with "invalidity" or "sickness" benefits) for physically or mentally handicapped persons unable to support themselves or their dependents, but who could not qualify for any other type of benefit.

The Select Parliamentary Committee, to whom the proposal was submitted in 1938, felt that many of those who would come within this benefit would be persons who for one reason or another "had not had a fair chance of establishing themselves in the economic life of the community and who without a special kind of assistance would have little chance in the future." Accordingly the Committee recommended that "where necessary, individuals applying for this benefit should be examined by a board of specialists in psychology, medicine, and social welfare, who would decide the form of assistance to be given, whether by way of individual training or the affording of special opportunities as well as monetary or other assistance." (Quotations are from *GDSS*, p. 89.)

In view of the attention being paid in this country to rehabilitation as an alternative or adjunct to long-term disability benefits, it is interesting to read further on (p. 92):

> Circumstances of the war prevented the (Social Security) Commission from implementing that important section of the Act relating to the vocational training and occupational readjustment of beneficiaries who would benefit from this class of treatment. However, the training of disabled civilians has not been lost sight of. A Government Departmental Committee is exploring the possibility of establishing unified training for this class of person on a national basis.

The Commission is already empowered to transfer any person from any other class of benefit to emergency benefit, with a view to his undergoing physical or mental rehabilitation. Apparently it only lacks the facilities that would permit such action.

GDSS illustrates the various uses to which "emergency benefits" can be put by noting a number of different types of cases. "Where it is possible," according to this source, "to establish specific conditions applicable to a special class of case the Commission does so, so that all cases of hardship arising out of similar circumstances are treated in a comparable manner." By way of example, "the Commission's action in establishing on a uniform basis the grant of emergency benefits to dependents of men serving a gaol sentence" is described (pp. 90, 91). These are now paid at the full unemployment benefit rates for dependents, which are much higher in general than payments formerly provided for such persons by the Prisons Department.

In keeping with the general character of his paper, Mr. Myers gives

only the barest outline of the medical service benefits available under the New Zealand Plan to the entire resident population, and merely touches on some outstanding features of the expenditures for the different types of service. New Zealand, though closely followed by Britain, was the first English-speaking country to introduce a thorough-going system of "socialized medicine" in the literal sense of that emotionally supercharged term, without any pretense of its being "health insurance" financed by a special earmarked contribution.

Volumes have been, are being, and no doubt are yet to be written on the alleged merits or demerits of "socialized medicine," and practically any claim that can be advanced for or against can invoke in its support one or another element of actual experience under some plan. New Zealand is no exception. Any protagonist of whatever persuasion can doubtless find grist for his mill in the workings of this plan, now past the "ripe" age of 10 years. Here are reflected in greater or less degree most of the issues and dilemmas of the world-wide struggle between socialism and free enterprise, issues which we in this country are increasingly having to face up to and resolve.

Usually we do so by our characteristic route of compromise, which may incline to one side or the other, but seldom if ever goes the "whole hog" in either direction. This sort of approach at least has the great merit that, without too deep commitment to an extreme philosophy, some of its implications are tried out, while time is gained for further study and for reflection on the consequences and deeper meanings of the doctrine in question. Particularly fortunate is the country that is in a position to profit from the experience of others with social, economic and political innovations. Mr. Myers' description of New Zealand as a "fascinating laboratory exhibit" is therefore especially apt in this field of health benefits. We should be grateful to that country for providing us with an object lesson which we can observe and reflect upon.

In connection with hospital benefits, it may be worth bringing out that, while the cost of hospitalization over and above the 9*s*. a day payable from the social security fund is borne by general taxation and local rates when treatment is in a public hospital, patients of private hospitals must bear the balance of the cost themselves. For the fiscal year 1948–49 expenditures from the Fund on in-patient treatment in public and private hospitals were respectively £1,560,000 and £245,000 (*GDSS*, p. 134). The ratio of 6.4 to 1 which this represents has remained about the same, at any rate since the daily benefit rate was raised to 9*s*. in 1943. It looks, therefore, as though the inverse ratio might be a rough measure of the extent to which the people of New Zealand are prepared to meet personally the additional (two-thirds) of cost for the privilege of using a

private rather than a public hospital. The fact that this ratio is not decreasing, as one might expect, might perhaps be interpreted to mean that about this proportion of the population can be counted upon to seek private rather than public accommodations.

Again, in reference to maternity benefits, it might be noted that, while treatment in public hospitals is entirely free to the patient, in private hospitals maternity benefit payments from the Social Security Fund are applied in reduction of charges. A licensee of such a hospital must enter into a contract with the Minister of Health, which contract must set out the gross daily or weekly fee chargeable to the patient and undertake to apply the maternity benefit in its reduction. Such benefits are now at the rate of £1 for the day of birth and £1 for each of up to 14 succeeding days (maximum of £15), having been changed in 1947 from £2¼ for the day or days of labor and 12*s.* 6*d.* for each of the 14 days succeeding the day of birth (maximum £11). However, there still remains a gap between the value of the free treatment available in public hospitals and the amounts, including benefit, collected by private maternity hospitals (*GDSS*, pp. 131, 132).

Free service and a tendency for doctors unduly to pass on cases to the hospital would clearly seem to be factors in the pressure on hospital accommodations noted by Mr. Myers. However, other contributory factors complicate the situation, as appears to be borne out by the fact that increased hospitalization is not confined to countries where hospital benefits are in effect. Two such contributory factors (noted in *GDSS*, p. 134) are:

(a) Social and economic conditions which have lessened facilities for the domiciliary treatment of the sick (less ample housing, more wage-earners in the family).

(b) Tendency of modern treatment toward hospitalization (up-to-date diagnostic aids obtainable in well-equipped hospitals; new forms of medication calling for administration under continuous skilled observation).

The continuing heavy growth in pharmaceutical expenditures under the plan has been a source of charges and countercharges between the Government, which makes the rules for prescribing, and the medical profession responsible for operating them. The Government, which is under political pressure to avoid restrictions in prescribing, would like the doctors to assume the main responsibility for safeguarding the Fund through economy in prescribing. The doctors, on the other hand, would like the list of free prescriptions to be strictly defined, and the patient to be required to pay part of the cost. Here again unnecessary prescribing is only one factor in a complicated situation. Other factors (*GDSS*, p. 143) are increases in the wholesale cost of ingredients, in duties and sales taxes, and in labor

costs (*e.g.*, dispensing fees), and the introduction of new and expensive drugs and preparations (vitamins, hormones, antibiotics, etc.).

Mr. Myers barely touches on a very important question which cuts to the heart of the socialism vs. free enterprise issue, and therefore also to the heart of the problem of so associating quantity with quality of service that quantity will be maximized without loss of but rather with continuing improvement in quality. That is the question of how the doctor should be remunerated for his services. The following account of the situation in New Zealand as this writer has been able to piece it together from *GDSS* and other sources, with an attempt to indicate (though not to assess the relative importance of) the advantages and disadvantages of each method used, may be a worth-while supplement to Mr. Myers' brief statement. At least it will serve to illustrate some of the questions that arise when a third party intervenes in the financial relationships of doctor and patient.

As members of this Society are well aware, there are three primary approaches to paying the doctor out of a social security fund under a plan for "free" medical care—salary, capitation, and fee-for-service. All three have been utilized in New Zealand.

As regards the salary approach, the New Zealand Act empowers the Minister of Health to introduce a salaried service into a particular area if this appears to be necessary for efficient service. Only a few remote and scattered rural areas have been so treated. Organized medicine considers that on the whole the method represents an advance in these areas, since service had previously been nonexistent or very poor.

Following the precedent of Great Britain under National Health Insurance (then in effect), the New Zealand Medical Benefit Regulations of 1941 envisaged capitation as the primary method of remuneration. The doctor was offered a capitation fee of 15*s.* per annum per person contracting with him for service, together with a payment to represent "mileage." About 50 doctors out of a possible 700 or 800 in the country adopted this method at the start, but the number has declined to the 1% of 1,800 mentioned by Mr. Myers. Payments under capitation fell from £115,000 in 1941–42 to £17,000 in 1948–49.

Mr. Myers indicates one reason for the unpopularity of this method among doctors—*viz.*, that the annual capitation fee corresponds to only two statutory consultation fees of 7*s.* 6*d.* under the fee-for-service method. In general, the doctors appear to have felt that the Government was attempting to transfer to them an unlimited risk at a fixed fee, and that a plan based on a fixed fee and a fixed panel of patients would leave them holding the bag; also that it was unfair to set up a fixed panel of patients with perhaps one-third of the doctors—and those the most active—still

away in service. Moreover, under a panel system only those who could afford to buy a practice would be in a position to enter the profession.

The method is reported to have worked well in certain cases where the doctor was predisposed in its favor, *e.g.*, one-doctor country areas. On the other hand, critics have charged that it permits doctors to build up unduly large panels and to pass on difficult or chronic cases to the hospital, and that it leads to "mutual irresponsibility" as between patient and doctor.

In any case, it failed as a general solution for the country and the government was forced to fall back on the fee-for-service approach, an amending act being necessary to permit this. With this compromise, general medical services were introduced on November 1, 1941. Basic fees were established at 7*s.* 6*d.* for a home or office visit, and 12*s.* 6*d.* for night or Sunday attendance. An additional 1*s.* 6*d.* was allowed for each 5 minutes after half-an-hour spent with each patient. Mileage, at the rate of 1*s.* 3*d.* per mile each way, was expected to redress the absence of a differential as between home and office visits. In addition, patient and doctor were left free to enter into any private arrangement they liked.

The doctor could utilize the fee-for-service approach in one of three different ways. Two of these—the refund and direct claim methods—were specifically provided for in the law; the third, or direct claim plus token method, only by implication.

1. *The Refund Method*

Under this method the doctor continues to render his customary account to the patient in full (usually at the rate of 10*s.* 6*d.* per attendance). On receiving payment he gives the patient a statement showing the number and dates of services rendered. Each service constitutes a claim for the appropriate statutory fee (usually 7*s.* 6*d.*), which the patient may collect at the post office. Mileage is also refundable.

A substantial majority of doctors adhered to this method at the outset as involving "least interference with the normal conduct of medical practice." It was in fact favored by the New Zealand Branch of the British Medical Association (B.M.A. for short) for the reason, among others, that it made it hard to conceal income (presumably with income taxes in mind). It was also claimed that the method allows the patient to "retain some responsibility for his own treatment and to obtain a return for his social security payments without any temptation to make unnecessary calls on the doctor's time or upon the Fund" (*GDSS*, p. 139).

Administratively, however, the method is cumbersome and costly. A large staff is needed to check and pay, through the various post offices,

the many individual claims for refund, often in small amounts. The doctor, moreover, still has to keep accounts, bill patients, and write receipts. He still has the problem of bad debts, intensified by the fact that he cannot sue to recover more than the basic fee of 7*s*. 6*d*. The patient, too, becomes increasingly reluctant to play the game. He is likely to resent the "surcharge" of 3*s*. and having to go to the post office to collect, fill out forms, etc.

The result has been a steady swing to the other two methods. According to *GDSS* (p. 139), only 34% of medical men now favor the refund method, leaving virtually all of the remaining 66% to the direct claim and token methods.

2. *The Direct Claim Method (Fee-for-Service Proper)*

Under this method, also known as the "free doctor" system, the doctor is paid directly at the statutory rate (normally 7*s*. 6*d*.) from the Social Security Fund, and in general makes no additional charge on the patient. The patient certifies on a form that service was given, and the doctor submits these forms once a month to the Department of Health, which pays him accordingly. Mileage is also claimed. It was the intention of the government that this would be the standard method. It was assumed that assurance of the statutory fee (say, 7*s*. 6*d*.) would more than offset the larger customary fee (say, 10*s*. 6*d*.) as diminished by bad debts and the doctor's reluctance to charge for brief follow-up attendances.

Although the method was officially opposed by the B.M.A., which called on its members not to adopt it, yet it proved popular and has gained ground. According to *GDSS* (p. 150), the doctor using it "became so besieged with patients (going over to it from the refund method) that the measure of service he was able to give to each fell in value far below the statutory fee of 7*s*. 6*d*." Further, "the gross incomes of some of these doctors became the object of public criticism, and it cannot be denied that in some cases the measure of service given to patients was little more than perfunctory."

With the exception of capitation, now virtually abandoned in New Zealand, the direct claim method is simplest for both doctor and patient. The doctor has no individual billing to hamper him, and no problem of collecting bad debts. In general, a doctor starting out can build up a practice easily and quickly. The patient need not stand in line at the post office to obtain refunds. Nor does he encounter a financial barrier between him and his physician.

On the other hand, the method is particularly open to abuse—over-attendance on the part of the doctor, frivolous calls and demands for un-

necessary medicine on the part of the patient. Many such abuses, it is argued, must get by the officers of the Health Department, however conscientious they may be, to the detriment of the Social Security Fund, which must be "bottomless" if it is to meet an unknown number of calls. Also the B.M.A. objected to a third party, in the form of a government paying low rates of remuneration for the services rendered, coming between doctor and patient.

3. *Direct Claim plus Token Method* (Token for short)

Under this method the doctor continues to charge his customary fee. However, he collects from the patient personally only the excess (usually 3*s*.) over the statutory fee (usually 7*s*. 6*d*.). This excess charge came to be known as a "token" payment. On the basis of the patient's signature the doctor collects the remaining 7*s*. 6*d*. from the Fund under the direct claim arrangement.

Though the Act implicitly approved this method, organized medicine disapproved. From the doctor's viewpoint it retains many of the disadvantages of the refund method. Also, as in the refund method, the patient may resent being called upon to make the extra (token) payment. However, the method is claimed to be a barrier to unnecessary calls.

Generally speaking, whatever the method of utilizing the fee-for-service approach, paying the doctor on the basis of a fixed fee for service rendered would seem to place the emphasis on number of medical acts rather than on their quality. Doctors are induced to perform personally many trivial services which ought to be performed by a nurse or secretary, since each is worth 7*s*. 6*d*. if *the doctor* does it. Moreover, even though the plan does not cover specialist services outside the hospital, it is apparently possible for a doctor to get paid for such work through the plan by arranging for more attendances than are really necessary.

Among undesirable consequences which the New Zealand experience is claimed to exemplify—consequences largely attributable to one or both of (a) high earnings, or the prospect of high earnings, in general practice (and obstetrics) as a result of attention to quantity rather than quality, and (b) the "free" character of the service—are:

1. Temptation for doctors to refuse inconvenient calls (night, week-end, etc.).
2. Neglect of specialist work and salaried posts.
3. Lack of stimulus for preventive and educational work.
4. Diversion to general practitioners of funds that could more profitably have been spent on research, postgraduate teaching, refresher courses, etc.
5. Opportunity for young doctors to earn much more than, say, professors in medical school.

6. Decline in standards of treatment, with less time, on the average, spent on a case than formerly.
7. Deterioration in doctor-patient relationships.
8. Nuisance visits to the doctor by people whose ailments are largely imaginary, or by "shopper" patients who go from one doctor to another seeking a particular type of treatment.
9. Overliberal prescribing.
10. Tendency for doctors to pass on their responsibilities to the hospital.

The generally unsatisfactory situation which appears to have prevailed in connection with the provision of health services in New Zealand can to some extent be explained by the fact that the greatly increased demand consequent upon the introduction of "free" or "partially free" service came about in wartime, when the availability of medical personnel for civilian needs was greatly restricted. The resulting easy earnings, and the high war and postwar taxes, enhanced the opportunities for abuse already inherent in the nature of the plan.

The plan, however, had enough inherent defects to arouse deep concern in New Zealand. In 1947 a special committee, consisting of representatives of the B.M.A. and the Department of Health, was set up to inquire into the workings of the health benefits with special reference to the operation of the general medical services system. This committee was limited by its terms of reference to "what alterations are necessary to give effect to the Government's policy of making available adequate and proper medical services (general and specialist) free or substantially free of cost." Nevertheless, in an interesting report to the New Zealand Parliament, the committee came up with important recommendations, which were largely given effect to in the Social Security Amendment Act of 1949. The gist of the Report and consequent legislation is set out in Chapter XIX of *GDSS* (pp. 150–155).

The amendments provide:

(1) As from a date to be fixed by the Minister of Health, the present refund method to cease in favor of a direct claim method. (However, as a transitional measure certain doctors may be authorized by the B.M.A., after consultation with the Minister, to continue using the refund method.)
(2) The fixed statutory fee of 7*s*. 6*d*. is replaced by "a reasonable fee not exceeding 7*s*. 6*d*."
(3) Divisional Disciplinary Committees may be appointed under the Medical Practitioners Act, 1949, to conduct investigations and to hear complaints.
(4) Restriction on the doctor's right to sue for fees in excess of the statutory amount is removed. However, no doctor can recover until one month following presentation of a detailed account to the patient, who meanwhile may call on the Divisional Disciplinary Committee to examine the account

and pass on its reasonableness. Legal action for recovery is suspended until the Committee's opinion is made known to the Court. The Court is not bound by this opinion, but must, if it differs, give the Committee an opportunity to appear by counsel before entering judgment for a higher fee.

(5) Higher mileage fees in certain cases.

(6) Concurrent practice by a doctor under both the capitation scheme and the general medical services arrangement is prohibited unless the Minister otherwise determines.

(7) That regulations be introduced for payment for specialist medical services in accordance with a scale to be determined by agreement between the Minister and the B.M.A. The regulations may include provisions for the official recognition of doctors as specialists in any branch of medicine or surgery.

It will be interesting to observe the effect of these amendments in improving the provision of medical care in New Zealand.

In conclusion, the latest indication to hand on the course of events in that country is a press item (*Christian Science Monitor* for May 15, 1950) which states:

New Zealand's Conservative government, in power only a few months, has begun already to overhaul the socialists' medical care program with the avowed purpose of cutting the country's annual health bill which it believes has got out of bounds. In the past seven years, for instance, free prescriptions under the national health scheme have doubled. . . . Reduction of these costs is the Conservative government's No. 1 priority in its house-cleaning program.

(AUTHOR'S REVIEW OF DISCUSSION)

ROBERT J. MYERS:

I should like to thank the four individuals who discussed my paper and have added so materially to the contents thereof. The several discussions give both considerable additional background information about New Zealand and also some very interesting personal philosophical views. It is interesting to note that each of the discussers represents a different background, and yet all are well qualified to give helpful information.

Mr. Lang, who was stationed in New Zealand for a considerable period during the war, gives a very enlightening early history of social security in New Zealand. His discussion seems to indicate that there probably will be considerably more development of the socialization program there over the long range. He well points out the danger present in that the financing is not only on a "pay as you go" basis but also on the philosophy of "not even looking where you are going" which may be

especially dangerous in New Zealand where prosperity depends upon a relatively few products. Mr. Lang questions my statement that the social security legislation was passed during the depression years. Personally, I would consider 1938 to be still a depression year although, as he does indicate, important amendments were made during the war years.

Mr. Williamson, who is a long-time student of social security the world around, sets forth some interesting background about the personalities involved. He well points out the dilemma of a program which is planned to be universal but which, because of the cost factor, is limited by the means test so that it is thereby "all things to all men" and so can bear many labels.

Mr. Calvert, who is a native New Zealander, gives some very interesting material about the basic population structure of the country and especially as to how the social security program affects the Maoris. Mr. Calvert questions my rough estimate that the cost of the social security plan may well rise from the present level of more than 10% of national income to 15%; interestingly enough, Mr. Williamson had doubted whether my ultimate figure was high enough! Mr. Calvert believes that there may not be any such rise because inflation will occur but, with the Conservative Party in power, benefits may be more stabilized and grow less rapidly in relation to price and wage levels. In my opinion, this is a very dangerous view which is often used to promote programs inherently having a large cost, by saying that that cost will really not develop. I cannot believe that, regardless of what party is in power, benefits will not be adjusted to wages and prices so as to at least maintain the same relative standard of adequacy as when they were instituted. Anything less than this would certainly seem to be a "shyster" policy on the part of the planners. Further, I would add the final insult by calling such a plan "actuarially unsound"!

Mr. Grange, who has made many studies of foreign social insurance plans, has given a fine discussion of the New Zealand system, especially as to the medical care features, which I intentionally treated rather in brief. As Mr. Grange points out, there are many valuable pointers to be found in the New Zealand experience as we in the United States and Canada give further consideration to the direction in which social security will move in the future. Mr. Grange raises the question whether friendly societies are still of considerable importance in New Zealand and quotes some statistics which seem to indicate that they are. However, I believe that in the very recent past there has been a great downward trend among these societies, as I was informed when I was in New Zealand; further, this same tendency is noted by Mr. Lang in his discussion.