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SICKNESS INSURANCE AND
RURAL MEDICAL ASSISTANCE

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15

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SICKNESS INSURANCE AND RURAL MEDICAL ASSISTANCE

INTRODUCTION

Conditions of life and employment in rural areas differ from those in towns : the opportunities of earning are more limited, and the incomes of wage-earners and small farmers are often barely sufficient to provide them with a precarious livelihood.

It is true that rural occupations in general are essentially healthy, although often exhausting, but, on the other hand, defective housing and an inadequate supply of drinking-water, the lack of proper sanitary equipment, and often, also, the difficulty of obtaining medical aid, expose the inhabitants of country districts to serious risks affecting their health and working capacity.

Those who live in the country wish to share in the general progress of the community and long for a greater degree of economic and social security ; they also demand more effective protection for their health and, to this end, they develop organisations for mutual aid. The need for constant efforts to preserve their health and prevent any avoidable loss of producing capacity is as imperative for those in rural districts as for town dwellers.

At the present stage of evolution, it seems inevitable that steps should be taken for the scientific organisation of human labour in rural areas, which have been neglected as compared with urban centres. An interest in the problems of country life is now growing, and the degree of improvement in rural conditions has become a criterion of the stage of progress of a nation, for the prosperity of any people depends on the harmonious development of conditions both in towns and in rural areas and on each taking a due share in production and consumption.

In country districts, there are very definite limits to the possibilities of individual protective measures against disease. An effective system of medical assistance in these districts can be obtained only by collective organisation combining the activities of the public health service and the activities of the social insurance institutions set up on a mutual basis by the groups concerned. Social insurance has the advantage over the

other possible methods of collective organisation in that it gives those concerned a fuller material and psychological share in the work of protecting the health of the population.

The extension of social insurance and, more particularly, sickness insurance to agricultural occupations is one of the most important measures that can be taken to protect the health and working ability of persons in rural areas.

The present report is intended to bring out the nature of the contribution which sickness insurance can make to the establishment of a sound and effective rural medico-social policy.

The first part deals with the various possible methods of extending the advantages of sickness insurance to country districts. The purpose of the insurance is to preserve the health of the population, prevent such diseases as can be avoided, cure the sick and restore them to health and fitness. The extent of its action depends on the absolute number of insured persons and on the proportion of insured persons in the whole population ; the intensity of its action depends on the system of benefits, their nature and the conditions for granting them.

The second part gives an analysis of the organisation of rural medical assistance by means of sickness insurance. The insurance scheme comprises a number of services and material means through which it contributes substantially to the organisation of medical assistance. Although individual medical attention is the main purpose of sickness insurance schemes, the scheme may also be called upon to collaborate systematically with the public health services and other social organisations in the campaign against social diseases and for the improvement of local hygienic conditions.

I. PURPOSE AND FORMS OF SICKNESS INSURANCE IN RURAL AREAS

I. PURPOSE OF SICKNESS INSURANCE

The agricultural worker runs serious risks of losing his health and earning capacity on account of his hard physical toil, his exposure to the weather and his unsatisfactory conditions of life and housing.

As the incidence and gravity of disease in rural areas are being studied in special reports, it will suffice here to mention two general points. Mortality and morbidity statistics give the lie to the idea that country life is necessarily healthy and wholesome. On the other hand, the assertion that the country is unhealthy and its inhabitants exposed to the risk of losing their working power because of the defective sanitary conditions is also unfounded. While avoiding both these exaggerated statements, one must admit that the amount of avoidable disease in rural districts is still considerable, and that systematic efforts are required to improve conditions and raise the standard of health.

This is the task undertaken by sickness insurance in accordance with the special rules governing its social functions. It gives insured persons a definite right to benefits, based on the contribution paid by each insured person; but, at the same time, it restricts its activities to those services and material supplies which are both necessary and adequate to achieve the purpose in view.

Workers are constantly exposed to the risk of losing their earning capacity: the human constitution is frail and subject to natural wear and to organic and functional defects due to external influences or internal causes. A morbid state demands attention, so as to prevent any aggravation of the disease and to restore the patient to health.

In agriculture, manual labour predominates, and a wage-earner who loses his earning capacity is thereby deprived of his means of subsistence unless he continues to receive a substantial fraction of his wage. The situation is essentially the same for persons in an intermediate category, working sometimes on their own account and sometimes for other people. Small holders are also dependent on their working capacity for their livelihood. Hence the necessity—in varying degree—for those different groups of agricultural workers, when incapacitated as a result of sickness, to obtain relief in the form of an allowance to take the place of their wage or income, which has been suspended or greatly diminished.

Sickness insurance also provides for mothers and infants. Maternity as a biological function is so important for the maintenance and improvement of the race that social measures must be taken to ensure the best possible conditions for its fulfilment. That is why in very many countries maternity benefits are paid by sickness insurance schemes.

Originally, insurance schemes merely covered the risks run by insured persons; but the insured person is a member of a family, and the conditions of accommodation and hygiene in his home have serious effects on his health and on his physical and moral power of resistance. In view of this interdependence, the insurance schemes have extended their activities to the families of insured persons.

The essential task of sickness insurance in rural areas is to help in the organisation of an adequate system of medical assistance by facilitating the visits of doctors and nurses, organising the supply of drugs, providing greater opportunities for hospital treatment, and placing at the disposal of the rural population all the other means known to modern medicine for detecting disease and treating it in its early stages.

Sickness insurance has, in particular, to provide individual medical assistance of a curative and preventive character, the various aspects of which must be defined in a generous spirit. The sickness insurance schemes also participate in preventive work by extending to the rural population preventive measures of proved efficacy. They take part also in the campaign against social diseases and co-operate in the improvement of local hygienic conditions.

The cash benefits of sickness insurance schemes are intended to provide for the subsistence of the insured person and his family when income has been lost as a result of incapacity for work. These benefits are of special importance in the case of social diseases of long duration, for the treatment and prevention of which medical and social action must be combined. It is these diseases which are the commonest cause of invalidity in rural districts.

In its early days, sickness insurance considered only the consequences of disease and provided more or less adequate compensation to insured persons who had suffered a loss of earnings or some other injury. Since that time, however, progress has been made. Insurance schemes began to place medical attention in the foreground and to provide curative treatment rather than compensation. They have now reached a final phase in which they engage in individual and general preventive measures to preserve the health of the population and protect insured persons against possible disease. Thus, sickness insurance has gradually become an organised system for the protection and development of health.

This brief survey of the purpose of sickness insurance must be followed by some account of the main forms in which it has been put into effect in rural areas.

2. NATIONAL COMPULSORY SICKNESS INSURANCE

National insurance schemes make insurance compulsory in principle for the whole population without distinction of occupation or social status.

Subject to certain possible limits of income or wealth, the scheme covers wage-earners, independent workers and those intermediate grades sometimes working for others and sometimes on their own account. National insurance is conceived on a wide basis and if fully applied would protect practically all persons in rural areas.

Exception has sometimes been taken to the principle of national compulsory insurance on the grounds that the population of a country or district constitutes a group which is not homogeneous on many points that are of importance for insurance, such as mode of life, ability to pay contributions, need for protection, and economic significance of the risks in question.

In reply to this argument, it is pointed out that, especially in countries in which wage-earners form a rather small proportion of the rural population, there are difficulties in organising insurance institutions for wage-earners alone. National schemes, on the other hand, covering the whole population of wage-earners and independent workers, make it possible to establish insurance institutions with a sufficiently large and stable membership. The frequent changes of occupation or employment (as when a peasant's son, who has been working in the town, comes home to take over his father's holding, or a share farmer becomes an agricultural labourer or, on the other hand, acquires a holding) do not interrupt the course of insurance, which can continue irrespective of such changes.

National insurance schemes obtain their funds from a levy on all income, wages, remuneration or profit, subject to a certain minimum which is exempt. In other words, every inhabitant is obliged to contribute to the expense of the insurance scheme according to his means, the contribution being graded, whereas the benefits in kind are the same for all insured persons.

These benefits, which include medical assistance, drugs and treatment in hospitals or sanatoria, are provided for the whole insured population by the insurance scheme; cash benefits are paid to insured persons who are unfit for work or who have suffered a loss or reduction of income as a result of illness.

With the exception of certain *Swiss* cantons in which sickness insurance is largely compulsory, there is no example of a national compulsory sickness insurance scheme in European legislation.

Among recent oversea laws, the Social Security Act of *New Zealand* (1938) represents an effort to cover all the inhabitants of urban and rural areas over the age of 16 years by a sickness and invalidity insurance scheme providing benefits in cash and in kind.

The benefits in kind include free general medical treatment, hospital or sanatorium treatment, drugs and treatment and maintenance in maternity homes. At a later stage, when the financial situation of the scheme permits, the following additional services may be provided: visiting nurses and domestic helps, the transport of patients to and from hospital, dental and ophthalmological treatment, physio-therapy, laboratory and radiological services and the services of medical consultants and specialists.

Every registered doctor in the country is entitled to provide medical benefits to insured persons if he is prepared to comply with the conditions of the scheme; every insured person will be entitled to select his own medical attendant. Similarly, every chemist will be entitled to supply drugs to insured persons if he indicates his willingness to comply with the conditions laid down by the competent minister.

An insured person who is incapacitated by illness and thus loses a fraction of his earnings will be entitled to compensation as from the second week of sickness. The weekly benefit is 10s. for insured persons under the age of 20 years without family responsibilities and £1 for insured persons over the age of 20 years; a supplement of 15s. a week is paid in respect of a wife and 5s. in respect of every child under the age of 16 years maintained by the insured person, up to a total of £4 a week. In case of prolonged incapacity, the invalidity pension is fixed at 30s. for persons over the age of 21, with a supplement of 10s. for a wife and the same for each child maintained.

The main source of income of the scheme is a social security contribution at the rate of 1s. in the £ on all wages or other income. If the expenditure of the scheme exceeds the yield of this levy on income, the deficit will be met by the public authorities out of the general budget.

3. COMPULSORY SICKNESS INSURANCE FOR WAGE-EARNERS

The economic consequences of illness are often different for wage-earners and for persons working on their own account. The wage-earner depends entirely or mainly on his remunera-

tion for his subsistence ; when illness reduces him to inactivity, he generally loses his income. The position is not the same in the case of the small farmer, who may be in a position, with the help of members of his family or of servants, to continue the working of his farm without any loss of income. Sickness insurance laws take account of the economic weakness of wage-earners and of the difference in the consequences of illness for independent workers and wage-paid workers.

At the present time, most compulsory sickness insurance laws apply in principle to all wage-earners and only to certain groups of independent workers and small farmers.

(a) *Scope.*

Sickness insurance was originally intended for the urban population, but it has now been largely extended to agricultural workers. For many years, it was alleged that sickness insurance could not be extended to agriculture, because of difficulties of organisation resulting from the scattered nature of the rural population ; but experience has shown that those difficulties could be overcome.

In most countries which have set up a general sickness insurance scheme, agricultural workers were included in the scheme or covered by a special scheme either from the outset or by gradual stages.

Insurance is compulsory for agricultural wage-earners in the same way as for those in other occupations in the following countries among others : Australia, the United Kingdom, Bulgaria, Chile, Czecho-Slovakia, France, Germany, Ireland, the Netherlands, Norway, Peru and the Union of Soviet Socialist Republics.

In Italy, maternity and tuberculosis insurance are now compulsory for agricultural wage-earners, tenant farmers and share farmers ; all collective agreements in agriculture must contain provisions concerning the protection of workers in the event of sickness.

In those countries, no distinction is made between different categories of agricultural wage-earners, and those whose remuneration is paid partly or wholly in cash are insured in the same way as those for whom the employer provides board and lodging.

There may, however, be various restrictions on the general rule whereby insurance is compulsory for all persons engaging in wage-paid employment. If wage-paid employment is taken as a criterion for liability to insurance, it must constitute the usual source of subsistence or be at least of considerable economic importance for the worker. It follows that mere casual employment or jobs in which the remuneration provides only a small

fraction of the amount required for subsistence may be excluded from the scope of the insurance scheme. Moreover, the application of the scheme, and in particular the deduction of the worker's fraction of the contribution from his wages by the employer, may be difficult if the worker frequently changes from one employer to another or is employed by several employers. Seasonal work, which is particularly common in agriculture, may also be exempt from compulsory insurance, and this greatly restricts the universality of any scheme of compulsory insurance for wage-earners.

On the other hand, the scope of insurance often goes beyond wage-earners and covers certain categories of independent workers or certain groups who are in an intermediate position, such as share farmers and small tenant farmers whose economic situation is very similar to that of wage-earners.

Persons who were formerly compulsorily insured are usually allowed to continue in insurance after ceasing to engage in employment rendering them liable to the scheme. Voluntary insurance for persons who have not passed through the compulsory phase is less common; still, quite a number of sickness insurance laws give independent farmers and certain intermediate groups the possibility of becoming voluntarily affiliated to the insurance scheme.

A study of the trend of development of compulsory sickness insurance legislation for wage-earners shows that the number of compulsorily insured persons in agricultural occupations is growing. All agricultural wage-earners, whether or not they live in the employer's household, are covered by compulsory insurance, irrespective of the nature and form of their remuneration. Members of the employer's family working for remuneration are, as a general rule, not exempt from insurance save in the case of the wife (or husband) of an insured person. The limit of earnings laid down in quite a number of laws as a criterion for liability to insurance does not affect the great majority of agricultural workers, and even the salaried employees responsible for the supervision of agricultural work are rarely exempt from compulsory insurance because of the limit of earnings.

Although there is no doubt that the spread of compulsory sickness insurance in rural areas has made appreciable progress, it is none the less true that millions of small independent farmers are still unprotected by sickness insurance and that, in many predominantly agricultural countries, compulsory sickness insurance has not yet been extended to agricultural occupations.

(b) *Benefits.*

In the event of sickness, what is required may be—according to the gravity of the disease—to prevent loss of life, to prevent the disease from becoming more serious, to localise it or make

its effects bearable or to restore the patient to a state in which he can do without medical attendance and return to his normal activities. This restoration of the patient to his normal condition generally necessitates the intervention of a medical practitioner and sometimes also that of a surgeon or specialist, the provision of medicines and therapeutic appliances, and possibly the attendance of a nurse. The nature of the disease or the family situation and housing conditions of the patient may make it necessary to send him to hospital, or he may require special treatment which cannot easily be given at home.

In addition to medical and pharmaceutical assistance, a wage-paid worker and, as a general rule, a share farmer or small tenant farmer also, requires some compensation during illness for the total or partial loss of income resulting from his forced inactivity.

Maternity, like illness, creates additional needs. Special care is required and additional financial resources to enable the woman to obtain the rest which is necessary for her own sake and that of the child. The insurance scheme provides obstetrical assistance and meets the cost. After childbirth and during the period of nursing, it is essential that the mother and infant should be well housed and fed. An allowance must be paid to the mother in place of her wages in order to enable her to remain away from work.

Medical assistance is the most important benefit provided by sickness insurance. It comprises medical attendance and the provision of drugs and other therapeutic appliances. In most compulsory sickness insurance schemes, insured persons are entitled, in addition, to the services of specialists, laboratory services, dental care and preventive treatment.

Medical and pharmaceutical assistance is usually granted by sickness insurance schemes for a specified period (twenty-six, thirty-nine or fifty-two consecutive weeks) for any given illness, but certain laws, such as that of the United Kingdom, do not prescribe any time-limit for the granting of medical assistance.

The provision of hospital treatment is particularly important for agricultural workers; whether they are farm servants living with the employer, or workers with their own homes, it is often impracticable to provide the necessary treatment at home, and they must be sent to hospital when ill. The insurance scheme pays the whole or part of the cost of hospital treatment and also of the conveyance of the patient, unless this expense is borne by the employer.

Medical and pharmaceutical assistance was originally provided only for insured persons, but it is now being extended in an increasing number of countries to the insured person's family, and this is particularly valuable in rural areas. When the benefits of sickness insurance are thus extended, the entire

household—its wage-earning head and his dependants—is covered by the medical service of the insurance scheme.

Sickness insurance schemes help to develop an adequate system of rural medical assistance, and from this point of view they are of value to the whole rural population, and not only to wage-earning workers. The schemes facilitate the establishment of medical practitioners in country districts, in which there is often a scarcity of doctors; in many countries, the sickness funds help to provide suitable accommodation for the doctor, or a consulting room, or an allowance for his travelling expenses or supplementary fees when he visits very remote districts. In some cases, special advantages are granted to doctors who undertake the treatment of insured persons in sparsely populated areas.

The cash benefits of sickness insurance schemes are intended to take the place of the wages or income lost as the result of illness. An agricultural worker who is obliged by illness to give up work generally suffers a direct economic loss unless his employer provides him with board and lodging or he continues to receive in kind the whole or most of his remuneration.

There are two types of sickness benefit: benefit proportionate to wages, and a flat rate of benefit.

The proportionate benefit bears a certain ratio to the normal standard of living of the patient, which is generally determined by his wage or other income from his employment. An allowance corresponding to his normal standard of living is paid so as to prevent the patient from being reduced to a lower social grade.

As, however, agricultural wages tend to concentrate about certain levels, agricultural workers are often divided into groups by sex and age. Consequently, in several sickness insurance schemes in which the sickness benefit is in general calculated according to actual individual wages or the average wage of the insured person, there are, for agricultural workers, only three or four rates of benefit (for men under or over 21 years and for women under or over 18 years, for example).

This solution is comparable to that in which a flat rate of benefit independent of wages is paid; the rate must then be lower than the lowest wage rate and the benefit cannot be considered as anything more than a contribution towards the maintenance of the strict minimum of subsistence.

Sickness benefit is paid so long as incapacity resulting from the illness persists, but only up to a maximum which varies from twenty-six to fifty-two weeks according to the scheme. An insured person who is still unfit for work after that period is generally granted an invalidity pension at a lower rate than sickness benefit.

One special problem in sickness schemes for agricultural workers is that of the rights to be granted to workers who, when ill, are still provided with board and lodging by the employer. Various solutions have been found: sickness benefit may be suspended so long as the employer provides for the maintenance of the insured person, or the employer may obtain a refund from the scheme of a fraction of the wage paid to the sick worker, or an employer who provides for the maintenance of his worker when ill may be exempted from a fraction of the contribution which he would normally be required to pay.

Sickness insurance schemes usually provide maternity benefits for insured women and the wives of insured agricultural workers. It was found best to entrust the provision of these benefits to the medical service of the rural sickness scheme. These benefits usually include obstetrical assistance, medical attendance if necessary, cash benefits payable during the rest period before and after childbirth, and nursing bonuses.

The ratio of benefits in kind to benefits in cash reflects the trend of any sickness insurance scheme. Although it is impossible to compare the two types of benefit from one country to another, it may be instructive to compare the expenditure on benefits in kind with that on benefits in cash at a recent date in a certain number of insurance schemes applying to agricultural workers.

Relative Importance of Benefits in Kind and Cash Benefits.

Country	Year	Percentage of expenditure on benefits devoted to	
		Benefits in kind	Cash benefits
United Kingdom	1936	42.30	57.70
Bulgaria	1937	70.56	29.44
Chile	1936	62.97	37.03
Czecho-Slovakia	1936	62.30	37.70
Germany	1936	72.46	27.54
Norway	1935	74.06	25.94

(c) *Resources.*

Compulsory sickness insurance requires large resources, which may be contributed by the insured persons, their employers and the community as a whole.

In schemes for wage-earners, contributions are usually required of insured persons and their employers, who are the persons most directly interested in the working of the scheme. In many countries, the State supplements those contributions out of the general budget.

The three groups—insured persons; employers and public authorities—contribute to the schemes in the following countries: Australia, the United Kingdom, Bulgaria, Chile, France, Ireland, Norway and Peru.

The employers and the insured persons meet the cost of insurance in Czecho-Slovakia, Germany, Italy and the Netherlands.

In the Union of Soviet Socialist Republics, the whole contribution is paid by the undertakings.

In most countries, the contribution is proportionate to the wages of the insured persons, who are classified for insurance purposes in a certain number of wage groups, the total contribution being generally shared equally by the employer and the insured person.

There are, however, schemes in which the contribution is fixed independently of wages, varying only according to sex.

There is an intermediate solution to be met with in quite a number of schemes applying to agricultural workers, in which the workers are classified in a few (generally three or four) groups according to sex and age.

The financial assistance of the public authorities may take a variety of forms: the payment of a lump sum in respect of each insured person; a contribution proportionate to the insured person's contributions; meeting the cost of certain benefits, such as medical assistance, benefits to insured persons' families, etc.

The regular and punctual collection of contributions is essential for rural sickness insurance schemes, because they must be able to count on the periodical receipt of a large number of small contributions spread over a very large number of farms of unequal size. Usually, the insured person's contributions are deducted from wages and paid along with the employer's contributions, either directly or by means of insurance stamps; deduction at source is the only means of collecting the resources required by the insurance scheme without any special expense.

(d) *Organisation.*

On the average, every insured person applies twice a year to the insurance scheme for medical assistance or daily benefit. It is therefore obvious that the sickness fund must be within easy reach of the worker, and, consequently, sickness insurance schemes must to a great extent be decentralised.

The sickness funds responsible for agricultural workers must be adapted to the requirements of those persons and do their best to organise effective medical assistance in rural areas. It is clear that rural funds which specialise in providing assistance

for agricultural workers can be of very special value to the rural population.

Nevertheless, agricultural workers are not affiliated to special rural sickness funds in every country. There are three main methods of organising sickness insurance for rural areas.

The first is a system of occupational organisation, in which agricultural workers are all affiliated to rural sickness funds or other insurance institutions, the majority of, if not all, the members of which are agricultural workers. An occupational system of organisation exists in France, Italy and the Union of Soviet Socialist Republics.

The second system is inter-occupational. There are no special institutions for dealing with agricultural workers, who are grouped with other workers in inter-occupational bodies, although the agricultural element predominates in rural areas. This is the case, for example, in the United Kingdom, Bulgaria, Chile, and Norway.

The third method of organisation is a mixed system. Agricultural funds are set up in essentially agricultural districts in which agricultural workers are more numerous than elsewhere. The insurance scheme is on an occupational basis wherever agriculture predominates, whereas, in other districts, the agricultural workers are affiliated to inter-occupational funds. This mixed form can be found, for example, in Czecho-Slovakia, Germany and the Netherlands.

The importance of special insurance institutions for agricultural occupations (rural sickness funds, agricultural mutual benefit societies and agricultural sections of departmental or general funds) for the development of rural medical assistance is being increasingly recognised. These institutions are managed by, or with the assistance of, representatives of agricultural workers and employers, who are thus given a part to play in the curative and preventive activities of the insurance scheme.

4. VOLUNTARY SUBSIDISED SICKNESS INSURANCE

In many countries in which there is no general compulsory sickness insurance scheme, agricultural workers may become affiliated to a voluntary sickness scheme subsidised by the public authorities.

Agricultural workers have taken advantage of this possibility in Belgium, Denmark, Sweden and Switzerland among other countries.

In those countries, the sickness funds or mutual benefit societies the rules of which grant certain specified advantages to members are "recognised" by the public authorities and therefore receive considerable subsidies, which permit them

to supplement the benefits that could be granted out of the contributions of insured persons.

The laws governing voluntary insurance generally leave the funds free to draw up their own rules for admission, and these funds or mutual benefit societies may accept any individuals, irrespective of their economic situation, or may reserve admission to any given group of persons. In some countries, however, recognised funds are not permitted to accept as members any persons except those in a dependent economic position, with earnings not exceeding a specified limit, and independent persons whose incomes do not exceed a certain amount.

The following table shows the membership of recognised funds and mutual benefit societies in the four countries mentioned :

Country	Number of insured persons	Percentage of the total population
Belgium	3,200,000 (1936)	41
Denmark	2,200,000 (1936)	58
Sweden	1,100,000 (1936)	17
Switzerland.. ..	1,937,000 (1935)	48

The statistics do not reveal the social constituents of the insured population. It is questionable whether voluntary insurance is, in essence, a workers' insurance scheme or whether it is not rather a general insurance scheme including large numbers of independent workers belonging to the economically weaker groups of the population. Most of the funds do not record the occupational or social situation of their insured persons, but there can be little doubt that when the density of the insured population exceeds 40% of the total population, rural elements—both wage-earners and small independent workers—must be largely represented.

Voluntary insurance obtains most of its resources from the contributions of insured persons. In addition to this main source of income, it receives subsidies from the public authorities and sometimes voluntary contributions from employers.

In the four countries mentioned, the public authorities make a regular contribution to recognised insurance funds and mutual benefit societies, but the amount of the subsidy depends on a variety of factors and, in particular, on the rate of the guaranteed benefit and on the composition of the insured population by sex and age. In addition to the basic subsidies, special grants are made to groups or unions of funds or mutual benefit societies which take an active part in the campaign against social diseases and to individual funds or societies which grant maternity benefit. Geographical factors are sometimes also taken into account and special subsidies paid to institutions working in districts with a scattered population or where communications

are difficult, as, for example, in mountainous districts where the organisation of a medical service is particularly costly.

Voluntary sickness schemes usually provide cash benefits and benefits in kind, including medical and pharmaceutical assistance and hospital treatment. As in the case of compulsory insurance, benefits in kind are becoming increasingly important, and a growing proportion of the expenditure of funds is devoted to this purpose. The policy followed in the granting of subsidies is also calculated to further this development.

The characteristic features of a subsidised voluntary sickness insurance scheme may be illustrated by a study of the *Danish* system.

In Denmark, the whole of that section of the population which is entitled to be insured with the financial assistance of the State has applied for and obtained admission to sickness funds.

The scheme is based on the promotion of individual effort by the State. Applicants for admission to a fund must be between the ages of 14 and 60 years and must come within certain limits of means and income if they are to be members of a recognised sickness fund. These limits are fixed on the basis of the incomes of the best paid workers, so that all wage-earners and persons in a similar economic situation may become affiliated. The rural population has taken full advantage of this possibility. Sickness insurance for persons whose income exceeds the prescribed limits is organised by special "continuation funds", which must admit to membership any persons who cannot be admitted to or retained in a recognised fund because their income exceeds the prescribed limits.

The contribution is fixed for each fund in accordance with the benefits which it guarantees. In 1936, the average contribution per member per annum for all the recognised funds was 23 kroner. Members are entitled to the following benefits: free medical attendance; admission to hospitals and tuberculosis sanatoria; sickness benefit; maternity assistance and the payment for certain necessary drugs (insulin and hepatic preparations).

In addition to the statutory benefits, the funds may grant additional benefits such as treatment by specialists, admission to convalescent homes, dental treatment, nursing at home and the payment of 75% of the expenditure on drugs.

The following advantages are granted to recognised funds by the public authorities: an annual Government subsidy of 2 kroner per member and a grant equal to a fourth of the expenditure of recognised funds on medical attention, hospital treatment, cash benefit, dental treatment, nursing at home and obstetrical assistance. The fixed subsidy and the proportionate grant together amount to 8 kroner per member per annum.

In addition to the Government subsidy, the recognised funds receive voluntary subsidies from the communes, special grants for the treatment of chronic diseases, considerable reductions in the rates charged for hospital treatment, a refund of the price of certain drugs, the payment of contributions when insured persons are ill or unemployed for a long period, transport for doctors and midwives and free transport for patients being admitted to hospital.

In a certain number of countries, voluntary sickness schemes now cover a large proportion of the urban and rural population, but this is probably due to specially favourable conditions and to the material and other advantages granted by the public authorities to recognised funds and mutual benefit societies.

A new type of scheme is represented by the recent Japanese legislation concerning national sickness insurance for wage-earners and small independent workers who are not covered by the compulsory insurance scheme instituted for persons employed in industrial and mining undertakings. The new national scheme, which is subsidised by the authorities and which is intended mainly to provide free medical assistance and drugs, will, in principle, be voluntary; but when two-thirds of the inhabitants in any locality have voluntarily become members, the scheme may be made compulsory for all the inhabitants.

5. SPECIAL RURAL MEDICAL ASSISTANCE SCHEMES

Several European countries which are largely agricultural in character and have compulsory general sickness insurance schemes for workers in non-agricultural occupations have instituted special medical assistance schemes for agricultural workers, which have certain analogies with compulsory sickness schemes. The advantages of these systems are granted to workers without their being required to pay any contributions, but beneficiaries must meet a fraction of the cost of medical and pharmaceutical assistance, the remainder of the cost being defrayed by the public authorities or by agricultural employers.

The characteristic features of the rural medical assistance schemes in Latvia, Lithuania and Poland are analysed below, so as to show the connection between their system of benefits and that of compulsory insurance schemes.

In *Latvia*, under the Act of May 10th, 1938, agricultural workers who are entitled to family allowances are affiliated to a central institution, the Agricultural Workers' Sickness Fund. The benefits in kind include medical assistance, provided by the district medical officers in rural districts and by practitioners who have a contract with the Fund in towns and the immediate vicinity of towns; pharmaceutical assistance;

physio-therapeutic treatment; admission to hospital; and maintenance in sanatoria or other curative establishments. The insured person pays a fixed fee of 0.25 lat for each consultation or visit and 15% of the expenditure on drugs. Sickness benefit equal to 60% of wages is paid as from the fourth day of incapacity, if the illness lasts for not less than seven days; it is payable for not more than twenty-six weeks during the year for any one illness and for not more than thirty-three weeks for two or more illnesses diagnosed during the year.

Apart from the fraction of the cost of medical and pharmaceutical assistance borne by the patients, the expenditure of the fund is met out of the State budget.

In *Lithuania*, sickness insurance is not compulsory for agricultural workers, but they may receive medical assistance under the scheme for the rural population organised by the rural health centres under the Act of January 14th, 1938.

Each rural health centre has at its disposal the services of a doctor and a midwife, appointed by the district authorities at the suggestion of the district medical officer. The doctor attached to the centre must provide medical attendance for the inhabitants of the district and be at the disposal of persons benefiting by the medical assistance scheme for not less than four hours a day, for purposes of consultation.

The doctors, midwives and nurses attached to the rural health centres are guaranteed a minimum salary by the State, and the patients participate in the cost of medical assistance in accordance with a scale drawn up by the Ministry of Home Affairs. Indigent persons are exempt from payment. The fraction of the cost of medical assistance paid by the public authorities is met by a supplement to the land tax.

In *Poland*, under sections 212 and 213 of the Act of March 28th, 1933, a system of medical and pharmaceutical assistance provided by the employer was established for agricultural and forestry workers, and began to take effect as from September 1st, 1933. At the same date, agricultural and forestry workers in the western departments ceased to be members of the compulsory sickness insurance scheme, but workers in Upper Silesia remained liable to compulsory insurance.

Medical and pharmaceutical assistance at the expense of the employer is provided for workers employed in agricultural, forestry, horticultural and fishing undertakings and their ancillary establishments. The scheme does not apply to persons engaging in agricultural work as casual employment and not employed for more than twenty-five consecutive days with the same employer; assistance at the employer's expense is not provided for persons whose wage-paid employment is merely a subsidiary source of income and does not represent more than 0.50 zloty a day.

When a worker is entitled to medical and pharmaceutical assistance, the same right is granted to his wife and to his children under the age of 15 years. The assistance covers cases of sickness calling for medical intervention or involving incapacity for work; maternity assistance is also provided for women agricultural workers or domestic servants and the wives of agricultural workers.

The employer is required to provide, for not more than twenty-six consecutive weeks, the following benefits for a worker who falls sick: (a) medical and pharmaceutical assistance and, if necessary, hospital treatment; the medical fees to be paid by the employer were laid down in an official scale and the employer is entitled, except in the case of hospital treatment, to deduct from the worker's wages one-tenth of the medical and pharmaceutical expenses; (b) transport for the sick person to hospital or for the doctor to the home of the sick person; (c) that fraction of the remuneration which is paid in kind. If that fraction is less than half the total remuneration, the employer must pay the difference in cash. The wife of a worker and his children under the age of 15 years are entitled to medical and pharmaceutical assistance at the employer's expense for not more than thirteen weeks during the year.

Every person employing more than five agricultural workers with the right to medical and pharmaceutical benefits must conclude an agreement with one or more medical practitioners or adhere to a collective agreement governing medical assistance for agricultural workers and their families. Employers must also reach an agreement with pharmacies as to the supply of the drugs prescribed by medical practitioners or else directly purchase those drugs themselves.

Investigations made by the Warsaw Institute of Social Employment into medical assistance for agricultural workers show that the scheme introduced by the Act of 1933 has been more satisfactorily applied in the western departments than in those of the centre and south and that, in the eastern departments, there are still very few contracts between farmers and medical practitioners for the provision of medical assistance.

The existence of these various schemes of medical assistance for agricultural workers shows that the need for facilitating access to the doctor in rural areas is widely felt. The schemes in question had to be introduced as a substitute for insurance so as to provide individual medical assistance in rural areas by means of collective organisation. They undoubtedly meet a permanent need, and it is always possible that they may be transformed into insurance schemes with their own resources, in which the parties concerned will be members of the organisations that provide benefits.

II. PART PLAYED BY SICKNESS INSURANCE IN RURAL MEDICO-SOCIAL POLICY

The contribution of sickness insurance to medico-social policy consists of three mutually complementary activities: individual curative and preventive assistance; participation in the campaign against social diseases; general measures to maintain the strength and increase the resistance to disease of the inhabitants of rural areas.

6. INDIVIDUAL CURATIVE AND PREVENTIVE ASSISTANCE

Individual assistance is the essential sphere of activity of sickness insurance and a sphere for which it is responsible whenever the legislation prescribes that sickness insurance must organise such medical care as the state of the patient requires.

In some countries, the responsibility of sickness insurance is in theory restricted to refunding the whole or part of the cost of medical and pharmaceutical assistance, but, every year, there is an increase in the number of insurance schemes which are called upon to organise individual assistance by providing insured persons with the services of general practitioners and specialists, with drugs, dental treatment and hospital treatment.

The insurance institution must be aware of the state of health of its members and their families so as to be able to take proper care of the sick and of those who are threatened by disease, as soon as the earliest symptoms appear. Every case brought to the notice of the medical service of the insurance fund is examined with a view to determining the curative and preventive methods that are essential so as to achieve permanent results.

An insured person who realises what are the duties of the insurance scheme and what his health means to himself will apply to the medical service of the insurance scheme of his own accord. One of the principal tasks of insurance is to bring within the reach of insured persons and their families the curative and preventive treatment which is necessary.

(a) *Detection of Disease.*

The insurance institution cannot rely entirely on the initiative of those concerned. If it hopes to intervene in time, it must take measures to detect the existence of disease in its very earliest stages. The detection and prevention of the diseases which may affect individual workers is a task for the medical

attendant or family doctor whom the insured person is entitled to consult as part of the benefits of the sickness insurance scheme.

The general prevention of diseases which are a danger to the public as a whole is usually a matter for the public health service, which tries to protect the population against epidemics from abroad, to neutralise the consequences of endemic diseases, to combat hereditary diseases, etc. The doctor who attends insured patients is in the best position for knowing what dangers threaten the individual or the family and those coming in contact with them ; he is also in a position to discover organic predisposition to disease and to take action in the case of chronic or acute diseases.

The detection of disease in its early stages and the early treatment of chronic affections have become easier now that medical science no longer considers only the development of the disease, but also studies the wide field that lies between health and disease, including the initial stages of various affections. It is in the best interests of sickness insurance to arrange for the systematic examination of all the insured persons, or at least of the social groups most threatened by disease, with a view to systematic detection and the application of early diagnosis.

(b) *Diagnosis.*

Diagnosis is the basis for preventive and curative measures. On it depends the decision taken with regard to the granting of benefits in cash or in kind. A study of all the diagnoses of the various medical attendants provides the insurance institutions with a knowledge of the diseases requiring special attentions. The insurance institutions therefore realise the importance of early diagnosis and try to provide the medical practitioners with various facilities in this direction.

If it is to provide precise information as to the curative and preventive measures to be recommended in any particular case, the diagnosis must be individualised and take account of the constitution of the patient and the strength of his organism. It must, at the same time, make allowance for his personality and for the social factors governing his life, such as his family position, the income of the household, his occupation, the nature of his dwelling, and other factors affecting his standard and mode of life. Such a diagnosis paves the way for medico-social treatment, for it not only considers the disease and the seat of the disease, but also provides social indications, and it is only by treating the social as well as the medical symptoms that success can be assured.

The doctor who deals with insured patients and tries to discover the early symptoms of disease is helping to develop the science of symptomatology and the better preparation of plans of treatment.

(c) Treatment and Care.

In some countries, insurance institutions may be required merely to cover the whole or part of the cost of medical assistance, whereas, in others, they must provide the insured persons with the services of duly qualified doctors and all the other services and material means necessary for the appropriate medical treatment.

The insured person is entitled to medical attention at the expense of the insurance fund. The granting of this right is of fundamental importance and is one of the typical features of sickness insurance: the necessary medical attention forms part of a social service at the disposal of the insured person, and he is free to claim the benefits of this service, except in so far as he may be required to meet a fraction of the cost of assistance.

When medical assistance is a right—and this is the case in the great majority of sickness insurance schemes for rural workers—it is of importance to know the standard of that assistance.

Two different methods exist. In the one, benefits include only the services of general practitioners, to the exclusion of any medical action requiring skill or experience that cannot reasonably be expected of a general practitioner. The other, which is both wider and more widespread, covers all curative and preventive measures that are possible in the district concerned: treatment by a general practitioner, all kinds of surgical operations, the services of specialists, laboratory services, dental treatment, treatment and care in hospitals and similar establishments, etc.

As this is a social service, the insured persons obviously cannot claim medical assistance implying expenditure for the insurance institution out of proportion to the nature and seriousness of the disease; they can only ask for the necessary treatment, but they can insist on its being adequate and appropriate.

Curative care and preventive treatment often involve not only the provision of medicaments and various hygienic and dietetic measures, but also special treatment, such as that by ultra-violet rays, diathermy, treatment by galvanic and faradic currents, etc. In such cases, only a system of collective organisation can provide a solution in rural districts.

When necessary, the insurance scheme must provide hospital treatment, which may be essential because of the nature of the disease, the attitude of the patient or his housing or family conditions. Unsatisfactory housing conditions, which are very common in rural districts, make hospital treatment more necessary and more frequent among agricultural insured persons than among other groups.

The nature and methods of individual assistance in rural areas may be summed up as follows. Such assistance calls for a medical service organised in such a way that it places at the disposal of the beneficiaries all possible means for the detection and treatment of disease in its earliest stages. The insurance scheme must give the beneficiary and the medical attendant all the necessary facilities for early diagnosis, in which account will be taken of social and occupational conditions. The methods of treatment must include all those accepted by current medicine; they must be scientific and applied in accordance with a definite plan in which account is taken of medical and social symptoms.

7. PARTICIPATION OF INSURANCE SCHEMES IN THE CAMPAIGN AGAINST SOCIAL DISEASES

Individual assistance is inadequate and ineffective for dealing with social diseases.

The outstanding feature of those diseases is the frequency of their occurrence; they are due largely to precarious social and economic conditions, and, in turn, they react on those conditions. The forms in which they appear are typical of social pathology. The diseases vary from country to country, from urban to rural areas, and in character and intensity at different times. In spite of the improvements achieved in most countries, these diseases still place a heavy burden on the community.

The diseases in question, which include tuberculosis, venereal diseases, rheumatic affections and cancer, cannot be fought or prevented by medical treatment alone. They call for extensive prophylactic action systematically applied and supplemented by measures for social and economic assistance. For many decades, the campaign against social diseases has been going on in every country, although the methods and technical measures may vary.

The essential purpose of this campaign is collective prevention, which aims at dealing, not merely with the individual who is ill or threatened by disease, but also with his family, his environment and, indeed, the whole of his social group.

There are two lines of action, the one direct, aiming specifically at the disease and the seat of the disease, and the other indirect, aiming at the protection of the family and other persons threatened, the improvement of conditions of housing and nutrition, and increasing resistance to disease.

It is the purpose of this dual action to detect those persons who are affected or threatened by disease, to see whether they require curative or preventive treatment and to apply that

treatment. The main phases in the campaign against social diseases may be said to be early detection and diagnosis, treatment and prophylaxis.

The mechanism for dealing with tuberculosis, rheumatism, venereal diseases, cancer, etc., has nowhere been instituted as a complete system, but has gradually been built up in successive stages. Sickness insurance cannot and should not be solely responsible for all the measures necessary for combating social diseases, but it is an integral part of the machinery for that purpose. The extent of its participation varies from country to country and from district to district, according to the development of the public health services and the degree of perfection of the sanitary equipment. It may make a very great contribution in rural districts in connection with diagnosis, treatment and prophylaxis if it collaborates systematically and harmoniously with the public health service and the medical profession:

8. GENERAL MEDICO-SOCIAL MEASURES

The action of sickness insurance is not restricted to individual assistance or even to the treatment and prophylaxis of social diseases. In order to facilitate the organisation of individual assistance and collective preventive measures, the insurance scheme plays a part in more general measures for improving the conditions under which the campaign for raising the standard of health in rural areas is carried on.

These measures are called general, because they are taken in the interests of the collectivity as a whole without aiming at any special individuals or social groups. They are general both in their variety and in their extent, being directed sometimes towards a limited social group and sometimes towards all that section of the population whose resources are inadequate and whose conditions of life and housing are unsatisfactory. The main forms of this action are the development of sanitary equipment, investments for such development and education in hygiene.

(a) *Development of Sanitary Equipment.*

Sickness (or sickness and invalidity) insurance schemes contribute indirectly but substantially to the development of sanitary equipment by facilitating the admission of insured persons, and possibly also of members of their families, to establishments for treatment and cure. This contribution is particularly important in rural areas where conditions of housing and the inability to obtain proper care at home make hospital treatment necessary for the sake of the patient and those around him.

In connection with hospital treatment, as in its other fields of activity, the insurance scheme must try to obtain the best possible results with the least possible expenditure. The health authorities in many countries assist the insurance scheme in this direction by particularly favourable conditions for the admission of insured persons to public hospitals—reserving a certain proportion of beds for insured persons, reducing the cost of maintenance in hospital, guaranteeing a special rate of charges, etc. As the insurance institutions represent a very numerous group of persons who may require the services of the hospitals, they have every right to claim such privileged treatment, for they provide the hospitals with clients whose ability to pay is beyond doubt.

But the sanitary equipment (for purposes of diagnosis, treatment and prophylaxis) established by the public health services, by local authorities, by social welfare organisations or by private initiative is not always adequate or appropriate to the requirements of insurance. In such case, the insurance scheme may find it necessary to help in the development of the existing equipment by adding beds or even new wards to existing public hospitals, by granting loans or subsidies for the improvement or extension of the existing equipment, etc. It is, of course, essential that the equipment which is thus supplemented and improved should be of undoubted technical quality, and that the assistance of the insurance scheme means a definite improvement in and extension of the services available for insured persons.

Such collaboration in the development of the general sanitary equipment cannot be considered satisfactory unless that equipment as a whole meets the legitimate requirements of insurance institutions. In view of the gaps in, and the inadequacy of, this equipment in the rural districts of most countries (inadequacy as regards quantity or quality, non-existence or shortage of certain types of institutions, prohibitive rates for agricultural insured persons in certain specialised establishments, etc.), social insurance schemes have been led to develop their own equipment. This solution does not relieve the public authorities of their responsibility for the creation and maintenance of general equipment, but it has the advantage of hastening the rate of progress.

In rural areas, as in urban centres, the greatest caution must be observed in planning sanitary equipment so as to make certain of filling the existing gaps and yet avoiding overlapping. The sickness insurance schemes in rural districts first of all make use of the existing establishments, and it is only when these prove inadequate as regards quantity or quality that they proceed, in agreement with the supervisory authorities and the

public health services, to establish supplementary equipment which is indispensable for the fulfilment of their task.

(b) *Investments for the Development of Equipment.*

Compulsory insurance is an institution of a social nature which is intended to strengthen the social fabric for the benefit of the insured groups of the population, who must be protected even before they have a claim to insurance benefits.

Sickness insurance schemes do not as a rule have actuarial reserves, because their benefits are payable for short periods and do not depend on the length of time spent in insurance. Long-term insurance schemes dealing with the risks of old age, invalidity and death devote a considerable fraction of their actuarial reserves to investments of social utility which help to improve the conditions of hygiene of the insured population. As healthy dwellings are of fundamental importance in the campaign against social diseases, the building of cheap houses is one of the most important types of investment in this connection. It would be desirable to develop this type of investment more extensively in rural areas, provided always that the conditions of safety and yield which naturally govern any investment policy can be observed.

Among the many other investments which may be used to improve the hygienic conditions under which the insured persons live, those which interest the agricultural insured population include public baths, water supplies, sewage systems and the draining of land.

(c) *Education in Hygiene.*

Education in hygiene is intended to induce the population to practise the rules of health. People must be given some general ideas of physiology and pathology, more particularly as regards social diseases, and taught to adopt a mode of life and habits that are compatible with the requirements of hygiene. Such education touches every phase of individual, family and collective life. It is necessary in rural districts as a means of overcoming ignorance and negligence : lack of cleanliness, avoidable contact with germs, unscientific nutrition, badly ventilated and dirty dwellings, inadequate bodily cleanliness and the abuse of alcohol.

Insurance institutions are in contact with the insured persons and are in a better position than other organisations for taking action in this educational field. As the insured persons are associated in the management of the insurance scheme and contribute to its resources, they become collaborators in safeguarding the health of the population, and they collaborate

with a realisation of the value of health and earning capacity. The special strength of sickness insurance in this field lies in the direct share that the interested parties take in its preventive and educational work.

* * *

The International Labour Conference urged the States Members of the International Labour Organisation to institute compulsory sickness insurance for agricultural workers by adopting the Sickness Insurance (Agriculture) Convention (No. 25).

The purpose of this Convention is to guarantee to insured persons, in exchange for a deduction from their wages, a subsistence allowance in the event of a loss of earnings as a result of illness, and also the right to medical and pharmaceutical assistance for the first twenty-six weeks of illness at least. This assistance includes treatment by a duly qualified doctor, and the supply of drugs and other therapeutic requirements of good quality and in sufficient quantity. The Convention leaves it to the legislation of each State to authorise or prescribe, under such conditions as may seem desirable, the extension of medical assistance as thus defined to the members of the insured person's family.

The International Labour Conference also laid down in the form of a Recommendation (No. 29) a certain number of general principles which had been found most suited for ensuring effective medical assistance. These principles not only define in wide terms the factors that make up individual assistance and the purpose and extent of benefits in kind, but also encourage sickness insurance schemes to participate in the campaign against social diseases and in general preventive measures.

The conclusions given below summarise the contribution which sickness insurance can make, when it covers large sections of the rural population, to the provision of effective rural medical assistance.¹

¹ These conclusions form part of Chap. IV of "General Survey of Medico-Social Policy in Rural Areas (C.60/M.22.1939. Conf. E. V. R. 13).

CONCLUSIONS

Collective Organisation of Medical Care.

A system providing efficient medical care for rural populations calls for measures of collective organisation making available all the facilities of modern medical science for the maintenance of health and the detection and treatment of disease in its earliest stages.

Compared with other methods of collective organisation (such, for instance, as the system under which individuals pay subscriptions for medical attendance, and that of individual medical assistance entrusted to practitioners appointed by public or autonomous authorities, whether or not accompanied by financial participation by the patients), social sickness insurance has the two-fold advantage of associating those concerned more closely with the preservation of their own health both in a financial sense and generally by making them conscious of its importance, whilst at the same time making them appreciate more fully the importance of a rational health and welfare organisation. A sickness insurance scheme—whether compulsory, or voluntary but recognised and subsidised by public authority—which is planned to cover all agricultural labourers and their families and, as far as possible, the independent farmer, will help powerfully to provide efficient individual medical care.

Medical Care as the Chief Function of the Sickness Insurance Medical Services.

The difficulties of organisation which formerly arose owing to the wide dispersion of agricultural populations now no longer impede the extension of sickness insurance to rural areas. It is desirable that agricultural workers should have the benefit of all the medical care afforded by sickness insurance schemes, in so far as this is not already provided by some public medical service open to the whole rural community. The same facilities should also be extended to the members of the insured person's family, and, especially, to the wife or husband and to children until they reach adult life.

The medical services attached to the insurance system should offer patients, and make available to their doctors, every facility for effecting an early and complete diagnosis in the light of the social and occupational circumstances of each individual.

Insured persons and members of their families should be entitled, free of charge, to the services of a duly qualified general practitioner; to drugs and other therapeutic requisites of adequate quality in sufficient quantities; to any necessary surgical procedures and the services of specialists; to attendance in

childbirth; to preventive and remedial dental treatment; and to treatment and maintenance as in-patients in a suitable institution, where the type of ailment, or the family or living conditions of the patient, make this necessary.

While taking every care, in view of the limited resources at its disposal, to practise reasonable economy, and while avoiding in all cases useless or superfluous prescription or treatment, the sickness insurance medical service should collaborate in establishing an efficient organisation for medical care in rural areas. It should provide facilities for the better geographical distribution of doctors; for the transport of insured persons or, where required, of the practitioners and auxiliary staff; for diagnosis and the treatment provided under the insurance scheme; and for up-to-date hospital treatment through the participation of the insurance funds in defraying the expenses incurred and through suitable contributions towards the development and improvement of hospital equipment and health equipment generally.

Participation of Insurance Funds in Social Disease Control.

In the interests of the group of persons in its care, the insurance system should help in the campaign against social diseases; for these, while specially prevalent in rural areas, cannot be controlled or prevented by medical treatment alone, but call for systematic preventive measures coupled with cheap but efficient medical treatment and social action.

Action by the insurance funds in the campaign against social disease is the more necessary the less developed the other agencies engaged in this work. It should be such as to secure for the beneficiaries of the insurance system an improvement and extension of preventive and curative treatment, unless such treatment is already available to all concerned through the operation of a public medical service.

Success will depend in the first place upon systematic efforts to detect cases of disease and upon early diagnosis. The task devolving upon insurance funds is to help on the work of detection and to facilitate the precautionary examination of persons exposed to or suspected of infection, and the periodical examination of any sections of the community which are specially exposed to risk. The insured person's right to consult a doctor at any moment will conduce to early diagnosis.

Insurance funds should also co-operate in organising therapeutic measures, consisting of treatment and general or special medical care supplemented by economic and social assistance and after-care and supervision. Benefits in cash are also a considerable factor in the struggle against social diseases, when they enable the standard of nutrition and of housing to be maintained

or improved. Other benefits, particularly those provided by the social assistance service, may prove essential to successful treatment—*e.g.*, supervision of the due observance of the attending physician's instructions, education of the patient and those living in association with him, and such forms of occupational assistance as special facilities in cases of change of occupation and re-adaptation to social life and work.

Co-operation between insurance funds and other agencies or institutions engaged in combating social disease, as also with the medical profession, must necessarily proceed on the basis of a pre-arranged joint programme designed to co-ordinate the work of all participants, fill any gaps and eliminate duplication. Such a scheme can be based either on a system of sharing out the work among the various agencies, or on team work by all concerned; in the latter case, its execution can be entrusted either to a body created *ad hoc* or to some existing agency which is particularly qualified to carry out one particular part of it.

Participation of Insurance Funds in the General Preventive Action.

Insurance funds can make a substantial, though indirect, contribution to the development of preventive and curative institutions by providing facilities enabling such establishments to be patronised by insured persons. They may even participate directly in the improvement and extension of these institutions, provided they are assured that their standard of efficiency is adequate and that they really will be thrown open to the members of the funds.

Insurance funds should assist in spreading hygienic habits among insured persons and their families (personal hygiene, diet, etc.).

Finally, insurance institutions can contribute to the local improvement of public health by encouraging the construction of healthy dwellings through the grant of mortgage loans and building advances. Further, by investing capital in undertakings of social and economic value, they can strengthen rural economy and promote rural sanitation (extension of means of communication, water supplies, etc).
