

Disability and Medical Care Insurance: An Excerpt From the Board's Ninth Annual Report

THE UNITED STATES is unique among the major industrial countries of the world in that it has no systematic general provision for offsetting loss of earnings when a worker is sick or disabled or for assuring that adequate medical care is available to persons who require it, regardless of their ability to pay for such care at the time they need it. Throughout the war years, as in all times except periods of widespread unemployment, the losses and costs attributable to sickness and disability have been the greatest single cause of poverty and dependency in the United States. If employers again make more restrictive and rigorous requirements in hiring workers, and if women and children find it harder than at present to get paid jobs, the volume of dependency attributable to disability and premature death will tend, of course, to be much greater than it has been in recent years.

Disability Insurance

The burden of substandard health in the United States is dramatized by the finding that about 2 out of 5 of the men called up have been found physically or mentally unfit for military service at the Selective Service examination, and many others have been discharged for medical reasons while in training. On the basis of examinations made through May 1944, the Director of the System reports that "of the men between 18 and 37, more than 5 million are not physically fit to assume their responsibilities as citizens in war." The great majority of these, moreover, are "not only unfit for military service but because of their defects less useful to the community in any other capacity."

These figures, of course, relate only to men, and to men in the prime of life. In the whole population a far larger number of persons are handicapped by substandard physical or mental health. Rates of sickness and disability are higher among women than among men, and are much higher among persons aged 40 and over than in the age groups called for military service. Costs and losses from temporary or permanent disability are heavy,

often intolerable, drains on family income. They likewise constitute needlessly heavy burdens on public resources in the form of wasted expenditures for education, costs of dependency and delinquency, and direct public expenditures for medical care. Industry pays its share of the price in terms of absenteeism and lowered efficiency of persons who are on the job but working at less than their potential capacity.

The Social Security Board continues to be of the opinion which it has expressed on earlier occasions that lack of social insurance to meet the economic risks of sickness and disability is the most serious gap in organized provisions for social security in the United States. These risks have two major aspects—the loss of earnings by workers who are sick or become permanently disabled, and the barrier of cost which deters or prevents families at nearly all income levels from obtaining needed medical care. Cash disability benefits to offset wage loss are discussed in this section; ways to enable families to pay for medical care, in the pages following.

Volume of Disability

On an average day, at least 7 million persons in the United States are so disabled by sickness or injury that they cannot go about their ordinary business—school, work at home or on the job, or whatever it would normally be. Nearly half of these would be in paid jobs, or looking for such jobs, except for their incapacity. The other half includes children, students, housewives, old people, and others who are not in the labor force.

Of the 7 million disabled on the average day, about half have been incapacitated for less than 6 months; the remainder, for 6 months or more. For social insurance purposes, total disability is ordinarily rated as "permanent" when it has continued for more than 6 months; shorter periods are considered temporary. On an average day, the whole group of persons incapacitated from following their normal pursuits is about the size of the entire population of New York City; those who have been disabled for 6 months or more are a group

about as large as the population of Chicago. Over the course of a year, about one in every three or four wage earners in the United States is incapacitated by temporary sickness or disability; in years of epidemics the rate is even higher. As Selective Service examinations and many special surveys have shown, additional millions of persons who are up and about are suffering from physical and mental conditions which limit their ability to do their full share at home, at work, and in the life of their community and the Nation.

Wage Loss From Disability

Disability usually throws a double burden on family resources. Apart from the unexpected and largely uncontrollable expenses which sickness brings, disability of the breadwinner almost always cuts down or stops family income. Loss of earnings from temporary and permanent disability runs to some \$3-4 billion in ordinary years in the United States; loss of working time, to perhaps some 1.5-3.3 million man-years. In its effect on family security, permanent disability is like old age, except that it involves additional medical costs and often comes unexpectedly, at a time when a worker's family responsibilities are greatest and when he has had little opportunity to accumulate savings. Loss of earnings during temporary disability is likely to cause greater hardship than losses during unemployment, because of the additional expenses which sickness commonly brings.

Existing Insurance Provisions

Few American workers have or can get insurance against permanent loss of their capacity to earn, except for work-connected injuries or disease covered by workmen's compensation laws. These causes account for less than one-tenth (perhaps nearer one-twentieth) of all disabling illnesses among persons in the labor force. Our country stands almost alone among the great nations of the world in failing to protect the great majority of wage earners against incapacity of nonoccupational origin. Thirty-one countries have compulsory social insurance for wage earners against permanent disability; the United States is the only Nation which insures workers against old age without also insuring them against permanent or chronic disability. Thirty-two coun-

tries have insurance against wage loss in temporary disability, and the United States is one of only three which insure temporary loss of earnings from unemployment without also insuring the loss from temporary sickness.

Limited protection against total and permanent disability is made for workers covered by the Railroad Retirement Act, by retirement systems for Federal employees, and certain other public or private retirement plans. One State—Rhode Island—provides cash disability benefits during temporary sickness for industrial and commercial workers covered by the State unemployment compensation law. Veterans of the armed forces receive benefits during total temporary disability for a period following their discharge. They also receive benefits for total or partial permanent disability when disability is service-connected, and in certain circumstances have this protection against non-service-connected disability. Voluntary insurance against permanent disability is very expensive on an individual basis, since the persons most likely to buy it are those who have reason to believe themselves poor risks; most commercial insurance companies have ceased to write policies of this type. Commercial insurance against loss of earnings during temporary disability has been increasing in recent years but is unlikely to help those most in need of such protection. The costs of such insurance are high for the protection it offers, and relatively few workers can and will purchase it.

Averaging Wage Losses From Disability

Costs of disability benefits represent a redistribution of existing financial burdens so that workers themselves, or workers and their employers, and government, can meet risks which now bear heavily on private and public resources. The vast total wage loss from disability in any given year falls on only a small minority of all workers' families, though all are subject to risk of loss. In a given year a relatively small group of families suffer the catastrophe of prolonged or permanent disabling illness, and their misfortunes cause heavy drains on public funds; a larger group suffer serious losses but are not reduced to dependency. Disability insurance, like life insurance or fire insurance,

is a way of distributing the losses of the relatively few over the many who are subject to the risk, and of spreading the cost to the individual over a period of time. It thus reduces the individual's share to an amount he can carry, while giving every individual the desired protection.

The field organization, wage records, administrative experience, and other characteristics of the Federal old-age and survivors insurance system provide a ready framework for administering benefits for permanent total disability. Cash benefits would be provided for the wage earner whose permanent disability forces him to retire prematurely, and for his dependents, just as benefits are already being paid to retired wage earners who have reached the age of 65. The cost of permanent disability benefits would be relatively small at the beginning, as under all long-term insurance programs, and would rise as additional beneficiaries were added to the rolls. Costs would vary according to the scale of benefits established and other benefit conditions; with reasonably adequate provisions, the cost might be expected to level out at about 1 or 2 percent of covered pay rolls after provisions had been in effect for 15 or 20 years. Much of this cost would represent a transfer to contributory financing of costs now met from public funds in the form of relief or institutional care.

Substantial provision against wage loss from temporary disability and the early period of a disability which might later prove permanent could be made by setting aside an amount equivalent to about 1 percent of covered pay rolls. Obviously, provisions for the two types of benefits should be coordinated if there are separate systems for temporary and for permanent disability insurance. Coordination is essential to prevent overlapping or gaps for workers whose incapacity continues, and to ensure that benefit amounts will represent an appropriate proportion of wage loss during the initial weeks or months of disability and a somewhat lower proportion over prolonged periods, when the family presumably can make some adjustment to the loss of earnings. As against separate systems, however, there would be many obvious advantages in unifying administration of both types of disability benefits, and such a plan deserves careful consideration.

The Social Security Board believes that social insurance against permanent and temporary disability is needed in the United States and is feasible at this time from the standpoint of both administration and costs. The economic impact of permanent disability is so severe for the families concerned and so costly to the public that the Board believes it important to establish permanent disability insurance if provision of both types of disability benefits cannot be undertaken immediately.

Medical Care Insurance

Health among a people depends on many factors other than medical care—among them, the amount and distribution of national income, the level of education and of sanitary safeguards, and climate and other environmental factors. Because the United States is the richest of the nations and is known throughout the world for its natural advantages and its progress in education, sanitary controls, and scientific achievement, it is often declared that Americans, as a people, stand first in health. It is argued that our present arrangements for making medical services available to individuals are fully justified by our health record.

Security of Life

Available statistics do not bear out the claim that the United States is the healthiest nation. Probably the best single basis for international comparison is the death rate among babies in their first year of life. In the years preceding the war in Europe, according to statistics of the League of Nations, 7 countries had lower infant mortality rates than the United States. From 7 to 11 countries—the number differing for various age groups—had lower death rates among children and adolescents, and 20 or more countries had lower rates among persons aged 35-64.¹ Death rates among the Negro population in the United States are typically higher than those of white persons. Even if international comparison is restricted to the white population, however, our death rate is by no means the lowest. In the ex-

¹ From tables in *Statistical Year Book of the League of Nations, 1941/42*, pp. 40-41, 62-67; and League of Nations, *Annual Epidemiological Report for the Year 1938*, pp. 65-67.

pectation of life for white boys at birth, the United States ranked fifth among the pre-war nations; for white men at age 20, it ranked ninth; at age 40, twelfth; and at age 60, thirteenth.

Despite past progress in preventing sickness and prolonging life, the United States has not yet achieved for all its people—and in particular for those in the working ages—the level of security of life which has been attained in some other nations with much smaller economic resources.

Progress in Public Health

Much of the spectacular progress in lowering the general death rate in this country has been in preventing deaths from the communicable diseases of childhood and from typhoid fever, tuberculosis, and pneumonia and influenza. Between 1900 and 1940 typhoid fever and diphtheria were all but wiped out, and death rates for other communicable diseases in this group were cut down by from 60 to 90 percent. For all other causes of death taken together, the decline was only 16 percent. The decline in the general death rate in recent decades has been due chiefly to the decline in certain infectious diseases which have been controlled largely through public measures for sanitation and various other activities of public health departments.

This progress is still spotty. If all States had had as low an infant mortality rate as one State had in 1942, some 35,000 babies could have been saved. If, in 1941, all States had had the tuberculosis rate of the lowest State, some 42,000 deaths could have been prevented, mostly deaths of men and women in the productive ages. This was about the number of the Nation's war fatalities at the end of nearly 2½ years of fighting.

It is not an accident that deaths which could have been prevented through accepted public health measures and sanitary controls are relatively the most numerous in States which lack adequate facilities for controlling such diseases and spend inadequate amounts for public health. Hundreds of thousands of lives could be saved each year, and additional hundreds of thousands of families saved needless suffering and expense, if the time-tested public health measures now actually in effect in some

parts of the country were in full use everywhere.

Present Burdens of Sickness

A much larger part of the existing burden of ill health, disability, and postponable death now comes from illnesses which cannot be prevented or controlled by methods which automatically protect the whole community. Full use of the resources of modern medicine to reduce suffering, prevent disability, and prolong vigor and life demands increasingly the services which doctors must give patients individually, one by one. Such care also demands increasing use of necessarily costly facilities and techniques.

With progress in saving lives of babies and children, a growing proportion of the population lives to middle age and old age, when the most important causes of disability and death are diseases of the heart and arteries, cancer, and other chronic ailments. Most of these kill slowly, after a long period of illness and gradually increasing disability. Many of them attack in the years of life when responsibilities for family support are heavy. Disability insurance, as well as medical care insurance, would be of particular importance in encouraging workers to seek medical advice at an early stage, when adequate care might prolong their usefulness and their lives. They would know that, if the diagnosis was what they feared, some support would be at hand for them and their families. Most people will not go to doctors until they have to if they know that loss of earnings will mean catastrophe to the family or fear that they will not be able to pay for the care they need.

General morbidity rates and death rates are averages, made up of the experience of groups who have been able to benefit from all advances in scientific knowledge and skill, and of those who have had scant share in this progress. Sickness comes oftener and lasts longer, and death comes earlier, in the homes of the poor than of the well-to-do.

Reasons for Lack of Care

To some extent, the inadequacy of the medical care received by the American people as a whole is due to the fact that some places, especially rural areas, lack adequate medical and hospital facilities. These are

areas where average income is low. Present resources for medical care are unevenly distributed, because hospitals tend to cluster in cities where large numbers of persons seek their services and financial resources are ample, and doctors also locate in cities and towns where they find hospitals and laboratories and a better chance to earn a living. Even when medical facilities are ample, however, a considerable part of the capacity of hospitals and the time of skilled practitioners goes unused in ordinary years, though in the same places there are sick people badly in need of services. Ignorance and inertia have some part in the failure of people to get medical services they need, especially early in illness when services are most valuable. By far the most important reason, however, for the lack of needed care and for the volume of "charity" required of doctors, hospitals, and the public is the present method of paying for medical care—when sickness is at hand and family income is likely to have been cut down or stopped.

Methods of Paying Medical Costs

In an ordinary year the American people pay about \$4 billion for all civilian health and medical services, including costs of hospital construction. Of this total, about four-fifths comes from private funds and one-fifth from public funds. The total expenditure, governmental and private, for all health and medical services is equivalent to about \$30 a person a year. But in any year some families pay little or nothing to doctors and hospitals, while others pay hundreds or even thousands of dollars. The difficulty with medical costs is that no family can know how much or how costly medical care they will need or can limit their needs for care to what they can afford. If costs could be averaged for the types of medical services which are ordinarily bought individually, most self-supporting families could pay for adequate medical care without hardship.

Tax-supported care.—For certain major forms of medical care or care of certain groups in the population, much or all of the cost has been "averaged" through payment from the tax funds to which the whole community contributes, not merely the sick person or his family. In 1943, for example, 97 percent of all beds in hospitals for mental and nervous dis-

eases were in publicly owned and operated hospitals, and 85 percent of all beds for tuberculous patients were in tax-supported hospitals. These types of long-continued care obviously are too costly for any but the richest families to bear individually. These diseases, moreover, have long been recognized as endangering public health and safety and leading to public costs for broken and dependent families.

The Federal Government, again for obvious reasons, has always been responsible for medical care of the armed forces. In addition to care of service-connected injuries and illnesses, moreover, by the end of the war some 16 million veterans will be able to receive publicly supported medical care for non-service-connected conditions through veterans' facilities.

From colonial times, care of the sick poor has been considered a public responsibility, though often provided very inadequately if at all. It is estimated that total public expenditures for medical care of the indigent and low income groups—including expenditures of the Federal Government, the States, and their localities—are at least \$150 million a year.

Most of the care given under the arrangements outlined above is "state medicine" in the sense that it is financed from public funds, is given through publicly owned facilities, and is given for the most part by physicians or others paid directly by government agencies. It represents not only a method of financing costs but also a way of organizing medical and institutional practice. Since "state medicine" has ordinarily been used as a term of opprobrium, it should be pointed out that some of these areas of medical service, notably care of mental illness and prevention and care of tuberculosis and other communicable diseases, are those in which progress has been outstanding and for which the United States is known favorably throughout the world.

Insurance methods.—A n o t h e r group of arrangements has been developed in the United States through which costs of medical care are distributed among employers or the individuals directly concerned, or both, without recourse to tax funds.

Costs of medical care for work-connected injuries, and in some States also of occupational disease, are in-

sured under State or Federal workmen's compensation laws; only one State lacks such legislation. These laws make costs of industrial accident and disease a part of the cost of production.

In recent years a large number of middle-class families have been able to average some of their medical costs through membership in voluntary prepayment plans. The membership of Blue Cross plans, which cover certain hospital bills, includes about 15 million persons, or about 11 percent of the population. Voluntary prepayment plans for medical care, established by industry, medical societies, and community and other groups, probably cover about 4 or 5 million persons, about half of whom are counted in the number covered by Blue Cross plans. These families pay a regular fixed amount each month and know that, within limits fixed by the contract, their hospital or other medical bills will be paid if they become sick. Contracts are commonly restricted to surgical expenses or fix extra fees for some services. In addition, commercial insurance companies sell policies—usually to indemnify hospital or surgical expenses or both—on an individual and group basis. The scope of the protection is always limited and often is restricted to care of accidental injuries. All in all, possibly from 30 to 35 million persons have some protection against hospital and medical costs under the Blue Cross and other voluntary prepayment plans and commercial insurance. Comprehensive protection against medical and hospital costs is limited to a few million.

Workmen's compensation and the other arrangements mentioned above are forms of insurance. They are ways of distributing and paying costs, not forms of medical practice. In one way and another, they help to cut through the barrier of costs by distributing medical care expenses over the whole group of insured persons, the well and the sick, and by distributing the costs over periods of time—the years of earning as well as the weeks or months of sickness. In the usual voluntary prepayment plan, a patient picks his doctor or hospital from all participating in the plan; doctors and hospitals decide whether or not they wish to join such plans. These plans cause no change in the personal relationship between a doc-

tor and his patient, except to wipe out misgivings of both about the bill and to lessen the other important failing in that relationship—that so many people have no relationship with any doctor.

All the voluntary forms of medical care insurance mentioned above are fulfilling valuable functions in their limited sphere. They are necessarily more costly than the arrangements which could be evolved with wider sharing of sickness risks and with the administrative economies feasible for larger units. Their great shortcoming is that they reach so small a part of the population and fail to reach those who have the greatest need of medical care insurance. From the standpoint of both the public and the families concerned, the great majority of the population must have some better way to pay medical costs if American families are to achieve the level of health and economic independence which our national resources should assure.

Compulsory social insurance.—Neither the course of present developments in this country nor experience in other countries which have tried voluntary health insurance gives any indication that comprehensive and adequate arrangements to insure medical costs can be made in any way except through a compulsory insurance system. In this aspect of health security the United States faces a situation not unlike that in old-age security a decade ago. At that time, many employers had established sound retirement systems for their workers; some persons had banded together to provide for themselves as a group or had made adequate individual provisions through annuities or other forms of commercial insurance. It was clear then, however, as it is clear now for medical care insurance, that these voluntary arrangements could not be expected to extend to even a majority of the population in need of insurance or to the groups whose needs were greatest.

Medical care insurance would enable self-supporting families to pay for and get needed medical services without any important alteration because of the insurance system in present forms or organization of medical practice. Moreover, families dependent on public funds could be covered through payment of contributions on their behalf by the agencies admin-

istering assistance. They thus would receive care in the same way in which others receive it; the stigma and, typically, the inadequacy of "poor-law medicine" could be wiped out.

Contributions equivalent to about 3 percent of annual earnings would pay for adequate basic medical and hospital services for both workers and their dependents. A more comprehensive system would cost the equivalent of about 4 percent. These costs would be no more than now is spent by families on the average. They are less than the average expenditure by families in the low income groups, since, contrary to the general impression, low-income families spend, on the average, a larger proportion of their incomes for medical care than families in better circumstances, though—because of their more frequent and severe illness—they receive much less in relation to what they need.

Public discussion has centered around three alternative methods of providing medical care insurance. It

has been suggested that it could be established on a State-by-State basis, without participation by the Federal Government. It could follow the pattern of unemployment compensation, in which Federal legislation gave inducement to States to enact laws and establish insurance systems. Or, following the analogy of old-age and survivors insurance, it could be established as a Federal system.

For reasons outlined in the following section of this report, the Board believes that it would be simplest, most economical, and most effective to establish comprehensive protection through Federal legislation, while providing authority to utilize State agencies and other facilities. In any event, administration of benefits should be so decentralized that all necessary arrangements with doctors, hospitals, and others would be worked out on a local basis. The general pattern of arrangements with hospitals and doctors should be developed with the collaboration of professional organizations and with careful regard for re-

gional, State, and local circumstances. In each area of administration—local, State, and Federal—policies and operations should also be guided by advisory bodies representing those who pay the insurance contributions and those who provide the services.

The much-advertised fears of "socialized medicine," "regimentation" of doctors, hospitals, or patients, loss of the patient's freedom to choose his doctor, and deterioration of quality of care can be made wholly groundless. A system of medical care insurance can and should be so designed as to avoid these disadvantages. By making services readily available to those who need them, without fear of the costs, the quality and effectiveness of service may be improved, and the incomes of doctors and hospitals may be made better and more secure. If, at the same time, professional education, research, and the construction of needed facilities are financially aided, progress in medicine and improvement in national health can be greatly accelerated.

Why Beneficiaries Retire

By Edna C. Wentworth*

ONLY ABOUT 5 PERCENT of 2,380 men receiving old-age benefits, who were visited in 1941-42 by representatives of the Bureau of Old-Age and Survivors Insurance, said they retired and filed for benefits because they wished to do so and while they were in good health. More than half of the men, on the other hand, reported that they were laid off by their employers, and about a third stated that they had quit working because of illness or failing health.

These 2,380 men were part of a group of beneficiary families in 7 cities who were surveyed by the Bureau between May 1941 and July 1942 in a study to determine the extent to which the insurance benefits provide basic protection against want. The survey covered 750 beneficiary families in Philadelphia and Baltimore combined, 804 in St. Louis, 828 in the Southern cities of Birmingham, Memphis, and Atlanta combined, and 1,147 in Los Angeles. Earlier articles have discussed information obtained in

these surveys from the primary beneficiaries and widows with entitled children concerning their income, the assets they possessed, their living arrangements, and the family composition of the household.¹

This article deals specifically with the replies of the male primary beneficiaries to the question, "Why did you quit working in covered employment before you filed for benefits?" It should be borne in mind that this discussion relates to a relatively small group of insurance beneficiaries and to the situation found in a specific period of time. Application of the conclusions to all primary beneficiaries must be made with caution, and it must be remembered that the

answers to this question were made with reference to employment conditions in 1938-40.

Months Elapsing Between Covered Employment and Entitlement

Nearly one-half to two-thirds of the men in the four surveys² reported that they had worked up to the time of entitlement or to within a month of it (table 1), although the data do not indicate how steady this employment had been during the years prior to entitlement. At the opposite extreme, the relative number of beneficiaries who terminated their covered employment 13 to 25 months before they became entitled to benefits ranged from 6 to 13 percent among the four surveys.

The wide range in the number of months was attributable in part to the 1939 amendments to the Social Security Act under which any person who had already reached age 65 or would attain age 65 during the first half of 1940 would need only 6 quarters of coverage to acquire insured status.

*Wentworth, Edna C., "Economic and Social Status of Beneficiaries of Old-Age and Survivors Insurance," *Social Security Bulletin*, Vol. 6, No. 7 (July 1943), pp. 3-20; and Malitsky, Marie C., "Resources of Old-Age and Survivors Insurance Beneficiaries in Three Southern Cities," Vol. 6, No. 9 (September 1943), pp. 3-17. These articles should be consulted for discussion of the purpose of the surveys, methods of selecting the sample, definitions, concepts, and general analyses.

¹Data from the Philadelphia and Baltimore surveys were combined—as were those for Atlanta, Birmingham, and Memphis—to give samples allowing more significant analyses.