

The practicability of the tax schedule has been questioned. The feeling has been expressed that a graduated tax, decreasing for each additional member of the family, would be more equitable than the present provision for a tax of \$5.00 for each member of the family up to a maximum of \$30.00. Provision has been made in recent amendments to the Act for the possible readjustment of the rate of taxation.

Initially, residents of the unorganized northern part of the province were not included under the Plan, as it was thought that paucity of hospital facilities and inadequate means of transportation, would make it too difficult for them to secure benefits in the event of illness. However, a great deal of interest has been manifested by residents of the north, and by an amendment they may be included on a voluntary basis until such time as administrative methods can be evolved for general coverage of the area.

The program may be viewed as a potentially significant social experiment,

in addition to its immediate values in meeting a need of the people of Saskatchewan. Through the system of records which have been established, important data concerning the need for hospital services, the cost of rendering such service, the quality of service and the further need for hospital facilities should be available. Such data will be of value for the Health Services Planning Commission as well as for other governmental units. Furthermore, the Saskatchewan experiment in providing hospitalization for the entire population of a province should forward a valuable source of information for agencies outside the province planning programs of health insurance.

Noteworthy has been the cooperation of the Saskatchewan Hospital Association, the College of Physicians and Surgeons as well as the associations of rural and urban municipalities in defining problems and recommending solutions which would assure efficient operation of this service to the community.

Health Services in Australia

By WILFRED PREST

Powers of the Commonwealth

IN the early years of the century Australia acquired a reputation as a land of advanced social legislation. The depression of the 1930's, however, revealed that Australia had fallen behind Britain and certain other European countries in the provision of social services, and she did not make good her deficiencies quite so rapidly as the sister dominion of New Zealand or even the United States. The reasons for this are partly political and partly constitutional, and it has taken the upheaval of the Second World War to provide both the opportunity and means whereby the gaps can be filled.

In the provision of health services the powers of the Commonwealth Government were until very recently limited under the Constitution to quarantine matters and the provision of invalid pensions. A system of invalid pensions for those suffering from permanent disabilities was instituted in 1910. Receipt of the pension is subject to a means test and the maximum rate of pension payable is at present 32/6 per week. The total number of invalid pensioners is about 58,000, or 0.78 per cent of the population. In 1912 the Commonwealth also introduced a maternity allowance of £5. Until 1931 the number of claimants was about 130,000 per annum, bu-

in that year a means test was imposed, the allowance was reduced to £4 and the number of claimants dropped to about 80,000 per annum.¹ In the more strictly medical sphere, the Commonwealth Health Department, in addition to administering quarantine regulations, has also maintained laboratories for the manufacture of serums and has sought to co-ordinate the work of State public health authorities and to stimulate research into medical problems through the medium of the National Health and Medical Research Council. The possibilities of Commonwealth action are, however, limited because sanitation, the administration of pure food and drugs acts, the control of infectious diseases, and the provision of mental asylums are all responsibilities of the States.

Functions of the States

Thus the States maintain practically all the tuberculosis and mental hospitals in Australia. In 1943 there were 72 such hospitals with 2,439 beds for tuberculosis, or just over one for every 3,000 persons, and 26,439 beds for mental diseases, or just over one for every 300 persons. The Parliamentary Joint Committee on Social Security estimated that there was a deficiency of nearly 3,000 tuberculosis beds and of nearly 7,000 mental diseases beds. With regard to tuberculosis, the Committee observed that this disease occasioned 2,500 deaths per annum and that there were probably 30,000 cases in the country. They commented that "facilities for the accommodation and treatment in hospitals and sanatoriums of tuberculous patients are tragically short of urgent requirements. Arrangements for the early detection of tuberculosis by systematic examination, and for the occupational rehabilitation of those who are past the infective stage, are hopelessly inadequate. There is also no proper provision for the financial

relief of the dependants of patients who, in the interests of the community, must be placed in hospitals and sanatoriums." Similarly, with regard to the provision for mental diseases, the Committee reported that "gross overcrowding is apparent everywhere. Generally, the treatment of mental diseases throughout Australia is in a most unsatisfactory state and urgently requires modernizing and improving."

The States have also in varying degrees established or provided financial assistance for general hospitals. In 1943 there were in Australia 1,737 general hospitals with 58,000 beds, or one for every 140 persons. This total included 571 state-owned or subsidized hospitals with 43,000 beds, and 1,166 private hospitals with 15,000 beds. The average size of the latter was obviously much smaller than that of the former. Their efficiency was also generally lower although they included some well administered institutions run on a non-profit basis by religious denominations and other bodies. The patients in private hospitals, and in the private wards of public hospitals, were required to pay fees which might amount to the full cost of their treatment, but the patients in public wards were only required to pay according to their means. In 1941-42 patients' payments amounted to only 38 per cent of the maintenance cost of public hospitals, the remainder being met from government grants, from charitable donations, and, in some states, from public lotteries.

The Parliamentary Joint Committee on Social Security estimated that, of the 58,000 beds available in the general hospitals, the average number occupied each day was only 40,000. Nevertheless it was estimated that there was a shortage of nearly 7,000 beds. This shortage arose partly because some margin was essential in order to meet sudden epidemics and other fluctuations in the health of the community, and partly because the distribution of beds between different localities and different diseases was not

1. The number of claimants has now increased to about 160,000 per annum, since the means test was abolished and the allowance increased in 1943 (see below, page 3).

ideal. Thus there was a marked shortage of beds in the state capitals, while beds were often vacant in the small country hospitals. Similarly there was a marked shortage of beds for sub-acute, convalescent and chronic cases, with the result that many of these patients had to be accommodated in beds primarily provided for acute cases. The Parliamentary Joint Committee on Social Security reported that it was "struck in almost every hospital it visited by the large number of elderly people suffering from chronic disease accommodated in acute beds. We estimate that this accounts for probably 10 to 15 per cent of the total accommodation in acute hospitals, which could be released if other sub-acute and chronic facilities were made available."

Many of the public hospitals maintain out-patients' departments which are reported to be dealing with an ever-increasing number of patients. This growth in out-patient work is a serious drain on the resources of the hospitals and is in large part an infringement on the field of the general practitioner. In 1943 there were over 3,000 doctors in private practice in Australia and nearly 1,000 others were in salaried employment on the staff of hospitals or government departments. At that time there were also more than 2,000 doctors serving in the armed forces and a serious shortage of civilian doctors had developed, but before the war the number of practising doctors in the country as a whole had been more than sufficient to satisfy the accepted standard of one doctor for every 2,000 people. Nevertheless there tended to be too many doctors in the comparatively well-to-do residential suburbs of the large cities and too few in the poorer industrial suburbs and in rural areas. Apart from the growth of the hospitals' out-patient departments, there has been no serious encroachment on the field of private practice, but in Tasmania a Government Medical Service has been established in the country districts, and in Queensland the Govern-

ment employs full-time salaried medical officers in its larger hospitals.

Friendly Societies

There has never been any system of compulsory insurance against sickness in Australia, but voluntary insurance through friendly societies, sick clubs or sickness and accident policies is very widespread. So far as the friendly societies are concerned, the Commonwealth Year-Book states that "probably more than one-third of the total population of Australia comes either directly or indirectly under their influence. Their total membership is over 605,000, but as certain benefits, such as medical attendance and free medicines, and in many cases funeral expenses, are granted to members' families as well as to members themselves, this figure must, even when due allowance is made for young and unmarried members, be more than doubled to arrive at an estimate of the number of persons who receive some direct benefit from these societies." The latest friendly society statistics quoted in the Year-Book relate to 1941 and they reveal the existence of 188 registered societies with 5,864 branches. These societies had an annual revenue of nearly £1,000,000 from their invested funds and of more than £2,200,000 from members' fees and contributions. The average contribution per member was £3.13.0 per annum, or 1/5 per week. In return for this modest sum, members received medical attention valued at £902,000 per annum, sick pay amounting to £833,000 per annum, and funeral benefits amounting to £266,000 per annum. The number of members or members' dependents who received medical attention in the course of the year is not known, but the number who claimed sick pay was 152,000 (i.e. about one-quarter of the total membership), and the number of members who died was over 7,000. Thus the average annual value of the medical attention provided was about £1.10.0 per member; that of sick pay £1.7.6 per member, or £5.10.0 per claimant; and that of funeral benefit

9/- per member, or £36.9.0 in respect of each death. It is clear that the friendly societies play an important part in protecting their members against the expense and loss of earnings due to sickness. Nevertheless many of those who are most in need of such protection are too poor or too thriftless to seek it through membership of the friendly societies. For them the communal provision of medical services and of financial assistance in illness has long been an obvious necessity.

Act of 1938

The first attempt to improve on the above state of affairs was the passing of the National Health and Pensions Insurance Act in 1938. This Act was intended to establish a system of contributory pensions and sickness insurance administered through approved societies on the English model, but was not to come into operation until a date to be fixed by resolution of both Houses of Parliament. In fact, the necessary resolution has never been passed. The immediate cause of the failure to proclaim the Act was the opposition of the farmers within the Country Party to compulsory contributions from employers, although the Country Party was one of the two parties in the government coalition at the time and had not opposed the bill in its passage through Parliament. In Parliament, however, the bill had been opposed by the Labour Party because it imposed a compulsory levy on the workers. The bill was also strongly opposed by the medical profession, who objected to the introduction of the panel system. Apart from the opposition of interested parties, it is nevertheless true that the Act did not provide anything in the nature of a comprehensive health service and that it imposed two inherently bad taxes—a poll tax on employees and a wages tax on employers. Almost the only result of this episode was the establishment of a Commonwealth Department of Social Services, which in 1941 took over from the Treasury the administration of invalid and old age pensions and

which has provided a ready-made instrument for the administration of the social services that have been recently introduced.

In 1941 a select Committee of both Houses of Parliament on Social Security was appointed. The appointment of this Committee, which is still in session, was evidence that the social conscience of Parliament had been aroused and the reports of the Committee, which have been freely drawn upon above, have done much to determine the character of subsequent legislation. With the advent of a Labour Government in September, 1941, it was clear that a new approach would be made to the problem of social security in general, and of health services in particular, as soon as the war situation permitted. Contributory insurance was dead.

National Welfare Fund

Early in 1943 the Government announced the establishment of a National Welfare Fund to be financed by appropriating each year a sum equal to one-quarter of the total collections of income tax from individuals, up to a maximum of £30,000,000. The Government declared its intention of ultimately providing sickness and unemployment benefits out of the Fund, but for the time being the only services chargeable against the Fund were maternity allowances, which were to be granted in future without a means test and on a more liberal scale than in the past; a new maternity benefit of 25/- per week for eight weeks; and a new system of funeral benefits for old age pensioners.

In September, 1945, the Treasurer announced in his budget speech that it had been decided to charge all health and social service expenditure to the National Welfare Fund, including child endowment and invalid, old age and widows' pensions. To meet these additional charges the income of the Fund had to be increased. This was done by paying into the Fund the proceeds of the pay-roll tax which had been levied since

1941 as the principal means of financing child endowment, and by dividing the existing income tax into two parts, one of which was to be called the Social Services Contribution and was to be paid exclusively into the National Welfare Fund in place of the former appropriations from income tax. The basic rate of the Social Services Contribution is $\frac{1}{6}$ in the £1, but incomes below a certain level are exempted and the rate of the contribution is reduced on a further range of incomes. The exemption limit, and that below which reduced rates of contribution apply, varies with the number of the taxpayer's dependents, but in the case of a taxpayer without dependents the exemption limit is £104 per annum, and that below which reduced rates of contribution apply is at present £220 per annum. These low incomes have also been exempted from income tax, but other incomes, of course, remain liable to income tax, although at reduced rates to allow for the payment of the Social Services Contribution. The taxpayer makes one return of income on which both taxes are assessed, and both are collected together in one payment.

In the present financial year the Social Services Contribution is expected to yield £51,000,000 and the payroll tax £13,000,000, so that the total income of the National Welfare Fund will be £64,000,000. Of these receipts, however, about £50,000,000 is likely to be absorbed by old age pensions, widows' pensions, child endowment and unemployment benefits, leaving only some £14,000,000 for health services. In addition to invalid pensions and maternity allowances, two important new health services have been introduced. Sickness benefits became available in July, 1945, and hospital benefits in January, 1946. The Government also intended to introduce pharmaceutical benefits on the latter date but its constitutional power to do so was successfully challenged in the High Court and the further development of its health programme was therefore held

up pending an amendment of the Constitution.

Sickness Benefits

The Sickness Benefits Scheme is intended to provide for the maintenance of the temporarily incapacitated and their dependants, as distinct from the permanently incapacitated who have long been provided for by invalid pensions. The rate of benefit per week is £15.50 for a man, plus £1 for a wife and 5/- for one dependent child. No payment is made for additional children since child endowment is available for them. Lower rates are payable to single persons between the ages of 16 and 21, but single women over 21 are entitled to the same rate of benefit as men. Men over 65 and women over 60 are not entitled to benefit, although they do not become eligible for old age pensions at these ages unless they cease working, and some anomalies have arisen on this account.

Receipt of the benefit is subject to a personal means test. The claimant is permitted to receive sick pay of up to £1 per week from a registered friendly society or sick club, and a further income of up to £1 per week from other sources. Any income in excess of these amounts is deducted from the benefit payable. Thus a married man with a family who is in receipt of £1 sick pay and £1 from other sources is entitled to the maximum benefit of £2.10.0 per week but, if his sick pay and other income together amount to £4.10.0 per week, he ceases to be entitled to any sickness benefit. The exemption of the first £1 per week of sick pay from friendly societies was designed to avoid penalizing those who insured themselves voluntarily against sickness, and seems not only to have been successful in this respect but also to have actually encouraged the further growth of the friendly societies. This may be because no similar concession is made in respect of income from sickness and accident policies taken out with insurance companies.

The act which authorized the payment of sickness benefits also authorized the payment of unemployment benefits on a similar scale and the Social Service Department administers the two benefits in close conjunction with each other. Claims for sickness benefit have to be lodged with a District Officer of the Commonwealth Employment Service or with a District Agent. Applicants must complete a formidable questionnaire and they are required to make a declaration before a prescribed functionary that their answers to 29 separate questions, some comprising several parts, are correct, and that they are temporarily incapacitated and have suffered a loss of wages thereby. In addition, they are required to submit their birth certificate, marriage certificate, birth certificates of children and a medical certificate. It is intended shortly to introduce a briefer questionnaire, but this elaborate procedure cannot be greatly simplified in the absence of a social security document for each person. Payment is made by crossed not-negotiable cheque posted to the claimant each week.

When the Sickness Benefit Scheme was introduced, it was estimated that it would cost £2,000,000 per annum for each 1 per cent of sickness and that on the average there was 4 per cent of sickness in the community. In the first year of operation, however, the average number of persons in receipt of benefit at the end of each week was only 6,000 and the total value of benefits paid was only £526,000 for the whole year. This low rate of claims may have been partly due to ignorance of the benefits available, but it was also partly due to the introduction of a "waiting period" of seven days from the lodgment of the claim before benefits became payable. This eliminated many claims in respect of short term sickness. Furthermore the formalities necessary to establish a claim no doubt deterred many of those who, after several years of full employment,

had accumulated sufficient savings to tide them over periods of temporary illness.

Hospital Benefits

The Hospital Benefits scheme is intended to provide hospital accommodation in public wards free of charge regardless of the patient's means, and to ensure a corresponding reduction of fees for the more exclusive classes of hospital accommodation. Since the maintenance of hospitals is not a Commonwealth responsibility, there were only two ways in which the Commonwealth Government could implement its policy. One was to reimburse patients for the cost of hospital treatment up to a prescribed maximum, but this was obviously open to abuse and would have been awkward to administer. The other way was to offer the States a Commonwealth grant for distribution to the hospitals on condition that they ceased charging fees for patients in public wards and reduced the fees for other patients. This was the method adopted.

In the current financial-year the Commonwealth grant to the States for this purpose is estimated at £4,700,000. The grant is calculated on the basis of the daily average number of occupied beds and is at the rate of 6/- per bed per day, or £109.10.0 per bed per annum. Actually the fees paid by patients in public hospitals averaged one or two shillings per day less than this in all states except New South Wales and Western Australia. In order to prevent the other states reducing their own contributions to public hospitals, they are required to pay into a trust fund the amount by which the 6/- per occupied bed that they receive from the Commonwealth exceeds the average daily amount per bed formerly paid by patients. The trust fund is to be used for new hospital construction. So far as patients in private wards or in private hospitals are concerned, the Commonwealth grant is to be used to

reduce their fees by the full amount of 6/- per day.

Since this scheme only came into operation in January, 1946, it is still too early to assess its full effects. It has relieved the public hospitals of the invidious and burdensome task of assessing their patients' means and collecting small accounts. On the other hand, the private hospitals find themselves faced with the task of collecting their income from two sources instead of one. A falling-off in charitable donations to public hospitals has occurred, but the Commonwealth has undertaken to make good this deficiency, and the falling-off may be only temporary on account of a mistaken notion that the Commonwealth has taken over the full maintenance of public hospitals. From the patient's point of view the chief anomaly is that, while he receives free treatment as an in-patient in a public hospital, he still finds himself assessed according to his means when he becomes an out-patient. The removal of this anomaly is bound up with the Commonwealth's plans for providing pharmaceutical benefits and a free medical service.

Tuberculosis Benefits

The Sickness and Nospital Benefits schemes have been supplemented by a special scheme to deal with tuberculosis. In addition to the sickness benefit to which a sufferer may be entitled, he or his dependents may be granted a special allowance from a fund of £250,000 made available to the States by the Commonwealth with the object encouraging sufferers to cease work and seek treatment. Moreover, in addition to the grant of 6/- per day for existing tuberculosis beds payable under the Hospital Benefits scheme, the Commonwealth has undertaken to pay the States a subsidy at the same rate for new tuberculosis beds with the object of encouraging them to expand their accommodation for tuberculosis cases. Furthermore, the Commonwealth has undertaken to subsidize the establishment by the States of diagnostic

and after-care facilities on a £1 for £1 basis up to a maximum of £50,000 per annum for each type of facility.

Free Medicine and Medical Attention

For several years the Commonwealth Government has been investigating the possibility of the establishment of a free medical service. In 1943 the Parliamentary Joint Committee on Social Security reported in favour of the establishment of a net-work of medical centres and clinics in cities and country towns. These centres were to provide free diagnosis and treatment and were to be staffed on a part-time salaried basis by medical officers who would have the right of private practice. In addition, the Committee recommended the establishment of a voluntary full-time salaried medical service in the remote areas. This plan was adopted in principle by the Government and discussions were held with the States and the British Medical Association, but efforts to obtain the support of the latter failed. In the meantime, the Government went ahead with a plan to provide free medicines. Under the Pharmaceutical Benefits Act of 1944 every resident of Australia was to be entitled to receive, free of charge, any medicine listed in an official formulary on the presentation of a properly signed prescription to a chemist registered under the Act. The chemist would then be paid out of the National Welfare Fund at rates to be fixed by the Commonwealth.

In October, 1945, however, the constitutional validity of this Act was challenged in the High Court of Australia by the Attorney-General of Victoria on the relation of the Victorian Medical Society. In its judgment, delivered on the 19th November, 1945, the Court declared that the Act was *ultra vires*.¹ This decision cast doubt on the validity of other Commonwealth acts providing social services and also on its proposed free medical service.

1. A-G. ex-rel. Dale v The Commonwealth, A.L.R., 1945, page 435.

Further progress was clearly impossible without an amendment of the Constitution, which could only be secured by a referendum. It was decided to hold a referendum at the same time as the General Election of the 28th September, 1946. The result was the approval by the necessary majority of electors, in a majority of the States and in the Commonwealth as a whole, of an amendment to extend the Commonwealth's powers to cover "the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances."

The result of the referendum has removed the danger of any legal challenge to the Commonwealth's social security legislation, and has removed any doubt about the Commonwealth's powers to proceed with the establishment of a National Medical Service. The free medicine scheme will undoubtedly be re-introduced, but it will now become part of a more comprehensive plan. The Commonwealth Government is proceed-

ing with its plan to establish free medical centres, and it is reported that it may re-open negotiations with the British Medical Association. The Government hopes, however, that a sufficient number of doctors will be available to staff its centres even if no agreement can be reached with the British Medical Association, and it has announced its intention of proceeding with an ambitious long-range plan of training its own doctors.

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It will be seen from the foregoing that the health and social services introduced in the last few years or planned for the immediate future are sufficiently extensive to revolutionize the existing social set-up in Australia. It is doubtful whether anyone, even in Australia, yet realizes the full implications of these changes, for they have hitherto been overshadowed by events in the international sphere. Should a depression occur, however, the value of these new social services will immediately become apparent, provided that the administrative and financial machinery that has been evolved, proves adequate to stand such a strain.

Dentistry's Role in Public Health

By JOHN OPPIE McCALL, DDS

IT is generally accepted that a relationship exists between dental health and general health,—that dental disease may adversely affect general health. If this is so the prevention and treatment of dental disease assumes a place in the public health program along with measures for the control of other diseases.

Extent of Dental Disease

The first point of inquiry, then, is about the extent and severity of dental

disease in the population. The only comprehensive surveys made have been limited to children. These have a broad application, however, since dental disease starting in childhood tends to continue into adult years and with increasing damage to the dental structures. A country-wide survey in 1933, initiated by the U.S. Public Health Service, a city-wide survey in St. Louis some years later and numerous smaller surveys in other communities all agree in placing the percentage of children in the United States affected by dental decay at more than 90 per cent. At the Guggenheim

EDITOR'S NOTE: Dr. McCall was for many years connected with the dental clinics for children of Greater New York set up by the Guggenheim Foundation.