improve their standard of living. Participants learned to prepare a family budget, to compare values, prices, and credit when shopping, and to use group effort to combat financial ills. Use of the credit union as the alternative source of credit was stressed.

These programs, which were conducted in 1967, were sponsored by the University of South Dakota. The Project Moneywise task force presented an 8-day consumer education program at Standing Rock, North Dakota, in May 1968, and it is hoped that in the future more universities will sponsor similar training for residents of reservations in their areas.

Social Security Abroad

EXPANSION OF CANADA'S MEDICARE*

On April 1, 1969, Newfoundland, Nova Scotia, and Manitoba joined Canada's national program for health insurance, bringing the total number of Provinces now participating to five. When the program first went into effect last July, only Saskatchewan and British Columbia had established medical insurance plans that qualified. Although some of the other Provinces also had comprehensive medical care programs, they were not structured to satisfy all of the Federal Government's requirements. To qualify for Federal funds, a Provincial plan essentially had to be universal, comprehensive, portable, and publicly administered. "Portability" referred to measures for safeguarding continuous protection for persons moving between Provinces or temporarily absent from their own Provinces. A Province's plan was considered to be universal if it furnished insured services to 90 percent of its insurable residents initially and 95 percent subsequently.

Two other Provinces, New Brunswick and Alberta, have recently expressed their intention to participate in the national medical insurance program during this calendar year. The three remaining Provinces are Prince Edward Island and the two most populous, Quebec and Ontario (together these two account for more than half the national population). Quebec is now preparing to launch a program that will probably meet Federal requirements and may become operative by mid-1970. Ontario already has a voluntary health insurance scheme, but it does not yet satisfy the Federal criteria for universality.

Although the Federal Government contributes about half the participating Provinces' medical insurance costs, the exact level is established by a formula designed to give relatively more assistance to economically disadvantaged Provinces. A national per capita cost is first determined by averaging medical insurance expenses of all participating Provinces. The individual Province then receives half this amount for each resident who benefits from the program. The effect of the formula is to reimburse a province with low medical costs for more than 50 percent of its expenditures for medical insurance.

The method of financing each participating Province's share of the cost varies widely. Manitoba has a compulsory premium set at a level designed to cover the entire Provincial share of the cost. Saskatchewan also depends to a certain degree on compulsory premiums, but they are set at a much lower level. Since April 1968, Saskatchewan has also been collecting utilization fees to discourage overuse of medical facilities. British Columbia has a voluntary premium plan, and Newfoundland and Nova Scotia rely on general revenue financing.

In December, Canada's Minister of Finance stated that expansion of the national medical insurance program would help to curb the rising rate of medical costs. He noted that, in Saskatchewan (which has had a universal medical insurance scheme since 1962) administrative costs represent about 6 percent of total medical costs; at the same time, according to the Hall Royal Commission,[1] private insurance groups generally collected, on a national basis, $1.37 for every $1.00 expended in benefits. Furthermore, physicians' fees in Saskatchewan rose only 4.5 percent per year between 1963 and 1967, in contrast to a rise of 8 percent a year in the rest of the country.

The Minister of Finance also suggested that

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*Prepared by Joseph Simanis, International Staff, Office of Research and Statistics.

[1] The Hall Commission was appointed in 1961 to study medical needs in Canada. It submitted its final reports in 1964 and 1965.

TABLE M-27.—Gross national product and personal income, by type, 1940–69

[Amounts in billions. Before 1960, data are for the 48 States and the District of Columbia, except where otherwise noted. Beginning 1960, includes Alaska and Hawaii]

Period	Gross national product	Personal income							
		Total	Wage and salary disbursements[1]	Social insurance and related payments[2]		Public assistance payments[3]		Other income[4]	Less: personal contributions for social insurance[5]
				Amount	Percent of personal income	Amount	Percent of personal income		
1940	$99.7	$78.3	$48.2	$1.7	2.1	$2.7	3.4	$26.4	$0.7
1945	211.9	171.1	117.5	2.9	1.7	1.0	.6	52.1	2.3
1950	284.8	227.6	146.7	6.7	3.0	2.3	1.0	74.7	2.9
1955	398.0	310.9	211.3	12.7	4.1	2.5	.8	89.7	5.2
1960	503.7	401.0	270.8	23.3	5.8	3.2	.8	112.9	9.3
1961	520.1	416.8	278.1	26.8	6.4	3.4	.8	118.2	9.6
1962	560.3	442.6	296.1	27.8	6.3	3.5	.8	125.5	10.3
1963	590.5	465.5	311.1	29.4	6.3	3.6	.8	133.2	11.8
1964	632.4	497.5	333.7	30.5	6.1	3.8	.8	142.0	12.5
1965	684.9	538.9	358.9	33.1	6.1	4.0	.7	156.3	13.4
1966	747.6	586.8	394.6	36.3	6.2	4.3	.7	169.4	17.8
1967	789.7	628.8	423.4	42.9	6.8	4.9	.8	177.9	20.4
1968	860.8	685.8	463.5	48.8	7.1	5.6	.8	190.9	22.9
1968									
April		672.6	453.2	48.6	7.2	5.4	.8	188.0	22.6
May		678.2	457.5	48.7	7.2	5.5	.8	189.3	22.8
June	852.9	683.7	462.2	49.0	7.2	5.5	.8	180.9	22.9
July		689.2	465.4	49.2	7.1	5.6	.8	192.1	23.1
August		694.1	468.7	49.8	7.2	5.7	.8	193.1	23.2
September	871.0	699.7	472.8	49.9	7.1	5.8	.8	194.5	23.3
October		703.2	474.9	50.3	7.2	5.9	.8	195.5	23.4
November		708.0	478.9	50.5	7.1	6.0	.8	196.1	23.5
December	887.4	713.5	483.3	60.0	8.4	5.9	.8	187.8	23.5
1969									
January		716.1	486.5	51.5	7.2	5.9	.8	197.6	25.4
February		721.4	490.9	52.0	7.2	6.0	.8	198.3	25.5
March	903.4	727.7	495.7	52.2	7.2	6.1	.8	199.3	25.6
April		730.5	497.4	52.6	7.2	6.2	.8	200.0	25.7

[1] Includes payments in kind; includes pay of Federal civilian and military personnel in all areas. Excludes earnings under work-relief programs in effect during 1935–43.

[2] Includes government transfer payments to beneficiaries under OASDHI, railroad retirement, public employee retirement, unemployment insurance, and veterans' pensions and compensation programs; cash and medical payments under workmen's compensation and temporary disability insurance; and court-awarded benefits for work injuries sustained by railroad, maritime, and other workers under Federal employer liability acts.

[3] Includes government transfer payments to recipients of direct relief under programs of old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and general assistance; includes, during 1935–43, earnings under work-relief programs and the value of surplus food stamps. Excludes payments made in behalf of recipients to suppliers of medical care (vendor payments).

[4] Includes proprietors' income, dividends, personal interest, and rental income; other transfer payments not enumerated in footnotes 2 and 3 (such as Government life insurance payments, World War bonus payments, mustering-out pay and terminal-leave benefits to discharged servicemen, subsistence allowances to veterans at school); and employer contributions to private pension and welfare funds and other labor income (except compensation for injuries).

[5] Includes life insurance premium payments for veterans.

Source: Department of Commerce, Office of Business Economics. Data regrouped to highlight items of special interest to the social security program.

SOCIAL SECURITY ABROAD

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efforts to hold down medical costs would be facilitated if changes in the method of financing hospitalization insurance were adopted. Canada's hospital insurance—in existence since 1958—is presently administered on a Federal-Provincial cost-sharing basis similar to that for medical insurance. Under the new proposals it would be turned over completely to the Provinces. They would then be compensated for the increased financial burden by receiving a share of the Federal Government's general tax revenue. The Minister of Finance suggested that the change would permit closer supervision of hospitals by the provinces and would thus result in greater economies. Further action in this direction is unlikely, however, until current Federal-Provincial discussions resolve the general question of revenue-sharing and the broader, but related, issue of constitutional reform.