Trust fund expenditures	1950	1960	1970	1980
Total	18	34	35	43
Federal	17	54	55	58
State and local	19	15	11	18

General revenue expenditures are sometimes referred to as "discretionary" because they do not involve the kind of fixed obligation to contributors that is a feature of the social insurance trust funds. In 1976, 49.3 percent of all discretionary spending went for social welfare purposes. This percentage has declined slightly since then; by 1980, it had fallen to 45 percent.

Expenditures for Health and Medical Care

In fiscal year 1980, public and private expenditures for health and medical care rose to $239 billion, an increase of $31 billion over the previous year (table 6). The biggest percentage increases for both types of funding continued to be in health and medical services. But the 12.2-percent rise in public expenditures for research was over twice as large as the 5.4-percent increase in private funding for the same purpose.

Before the inception of the Medicare program in 1966, three-fourths of all health care spending came from private funds. Medicare increased the public spending portion dramatically. Since 1975, public funds have constituted approximately 42 percent of the total.[3]

Health care spending as a proportion of GNP doubled between 1950 and 1977, reaching 8.5 percent of GNP in the latter year. In 1980, that percentage increased to 9.1, indicating accelerating costs in health care expenditures at a time when the economy as a whole exhibited sluggish growth.

Home Visitation Effectiveness Study*

A recent project funded by the Social Security Administration determined that home visits did not reduce

[3] It should be noted that there is some duplication in the amounts designated for Medicare and Medicaid. The vendor medical payments listed under public aid include the premium payments by State public assistance agencies on behalf of Medicaid recipients for Supplementary Medical Insurance under Medicare. These premium payments—commonly called "buy-ins"—have not been offset in calculating expenditures under the Medicare program, but the actual amount of such payments is so small that this duplication makes virtually no difference in the total expenditures listed for either Medicare or Medicaid.

* Contract report titled, **Analysis of Local Welfare Office Administrative Procedures: The Effectiveness of Home Visitation**, Division of Family and Children Services, Georgia Department of Human Resources, June 1982.

Table 6.—Health and medical care: Private expenditures and expenditures under public programs, selected fiscal years, 1950–80

[Amounts in millions]

Source of expenditure	1950	1960	1965	1970	1975 [1]	1977	1978	1979	1980 [2]
Total	$12,027.3	$25,856.2	$38,892.3	$69,201.1	$124,716	$163,473	$184,287	$207,982	$238,654
Private funds	8,962.0	19,461.0	29,357.0	43,810.0	72,367	96,055	107,051	120,769	137,955
Health and medical services	8,710.0	18,816.0	28,028.0	41,329.0	69,092	92,546	103,547	117,077	133,877
Medical research	37.0	121.0	157.0	193.0	258	272	280	297	317
Medical facilities construction	215.0	524.0	1,172.0	2,288.0	3,016	3,237	3,224	3,394	3,761
Public funds	3,065.3	6,395.2	9,535.3	25,391.1	52,349	67,418	77,236	87,213	100,699
Health and medical	2,470.2	5,346.3	7,641.2	22,661.4	47,387	61,228	70,402	80,039	92,531
OASDHI (Medicare)	...	...	...	7,149.2	14,781	21,549	25,189	29,124	34,992
Temporary disability insurance [3]	2.2	40.2	50.9	62.6	73	76	78	76	50
Workers' compensation [3]	193.0	420.0	580.0	985.0	2,470	2,530	2,820	3,215	3,665
Public assistance medical payments	51.3	492.7	1,367.1	5,212.8	13,502	18,207	20,396	23,431	27,394
General hospital and medical care	886.1	1,973.2	2,515.5	3,553.8	6,406	6,022	7,209	7,623	8,143
Defense Department hospital and medical care (Armed Forces and dependents)	336.2	880.2	936.8	1,759.6	2,814	3,027	3,333	3,692	4,060
Maternal and child health programs	29.8	140.7	223.0	431.4	567	674	713	760	798
School health (education agencies)	30.6	101.0	142.2	246.6	350	414	485	520	569
Other public health activities	350.8	401.2	671.0	1,348.0	2,919	4,165	5,067	6,025	6,848
Veterans' hospital and medical care	582.8	879.4	1,114.8	1,651.4	3,287	4,321	4,856	5,308	5,750
Medical vocational rehabilitation	7.4	17.7	34.2	133.8	218	243	256	265	262
OEO health and medical care	...	...	5.6	127.3	...	...	...	...	...
Medical research	72.9	471.2	1,228.8	1,726.8	3,021	3,846	4,502	4,777	5,362
Medical facilities construction	522.3	577.7	665.3	1,003.0	1,941	2,344	2,332	2,397	2,806
Defense Department	1.1	40.0	31.1	52.5	94	301	227	215	31
Veterans' Administration	161.5	59.6	77.0	70.9	137	245	270	276	323
Other	359.8	478.1	557.2	879.6	1,710	1,798	1,835	1,906	2,452
Total, as percent of gross national product	4.2	5.1	5.6	7.0	8.0	8.5	8.5	8.6	9.1
Public, as percent of total expenditures	25.5	24.7	24.5	36.7	42.0	41.2	41.9	41.9	42.2

[1] Beginning 1975, revisions in source data preclude decimal fractions.
[2] Preliminary estimates.
[3] Includes medical benefits paid under public law by private insurance carriers and self-insurers.

Source: Health Care Financing Administration, Office of Research, Demonstrations, and Statistics, Division of National Cost Estimates.

the error rates of cases in the Aid to Families with Dependent Children (AFDC) program.

The Division of Family and Children Services (DFCS) of the Georgia Department of Human Resources conducted the project. It was initiated to test the proposition that visiting the homes of AFDC clients would clarify understanding of reporting responsibilities and thus retard case errors. Site of the experiment was the Chatham County DFCS in Savannah, Georgia.

Incoming AFDC cases were randomly assigned to one of three groups: In the first group, the members were not visited at all during the 6 months of the study. This "never-visited," group served as the control group. Members of the second, or "once-visited," group were seen in their homes by an intake worker while their applications for AFDC were in the review process before approval. They differed from the third, or "twice-visited," group in that the latter received both the intake visit and another visit. The second visit was conducted by the permanent caseworker—the redetermination worker—in the fourth month of the study and was designed to provide specific information on reporting changes in AFDC eligibility, penalties for nonreporting, and other rights and responsibilities of AFDC recipients.

The effectiveness of home visits was evaluated 6 months after initial case approval by measuring payment errors in two ways. First, redetermination workers performed desk reviews on all cases in the study to determine presence, type, and amount of payment errors. Table 1 summarizes the differences in error rates for the three groups. Less than 20 percent of the cases were in error; and the most common error was underpayment. But how many times clients were visited did not directly relate to the number of case errors. The once-visited group showed both a lower error rate and a smaller average amount paid in error for overpayments and underpayments than did either of the other groups (table 2).

Second, after payment errors were measured by the redetermination worker, one-fourth of the cases were randomly selected for a field review that used quality control procedures. Here also the once-visited group showed the lowest case error rate (15 percent), compared with both the never-visited group (22 percent) and the twice-visited group (24 percent).

Other data from the study show that—

- In the full field review, 33 percent of the 187 cases examined were in error. Over half the errors originated with the client, and almost all of these client errors involved incorrect reports of income.
- Although both the desk review and field review found the once-visited group to be least error prone, the errors discovered during the two reviews were not always in the same cases (table 3).
- A client satisfaction survey administered to a subsample of recipients showed there was a gain over the 6-month period in clients' ability to correctly answer questions about AFDC. The rate was nearly the same for all three groups—about 40 percent.
- Records of a sample of cases showed there was no clear relationship between case error rate and the number of contacts with the client outside the home, such as drop-by visits and telephone calls to the office.

The researchers concluded that the findings do not support a required extra home visit as an effective way of reducing AFDC payment errors.

Table 1.—Number and percent of cases at redetermination, by research group and error status of case

Research group	Total	Redetermination status			
		Correct	Over-payment	Under-payment	Ineligible
Number of cases	720	586	45	71	18
Never visited	218	173	13	27	5
Once visited	323	271	20	21	11
Twice visited	179	142	12	23	2
Percent	100	81	6	10	2
Never visited	100	79	6	12	2
Once visited	100	84	6	6	3
Twice visited	100	79	7	13	1

Source: **Analysis of Local Welfare Office Administrative Procedures: The Effectiveness of Home Visitation**, Division of Family and Children Services, Georgia Department of Human Resources, figure 17, June 1982.

Table 2.—Number of valid cases and average amount paid in error at redetermination, by research group

Research group	Valid cases [1]	Average amount paid
Underpayments, total	66	$42.29
Never visited	23	39.43
Once visited	20	34.65
Twice visited	23	51.78
Overpayments, total	44	66.02
Never visited	13	70.15
Once visited	19	54.58
Twice visited	12	79.69

[1] Valid cases are those which clearly show amount paid in error.

Source: **Analysis of Local Welfare Office Administrative Procedures: The Effectiveness of Home Visitation**, Division of Family and Children Services, Georgia Department of Human Resources, figures 20 and 21, June 1982.

Table 3.—Correspondence between redetermination and field review findings, by error status of case

Field review status	Redetermination status			
	Over-payment	Under-payment	Ineligible	Correct
Overpayment	1	2	1	12
Underpayment	0	8	0	1
Ineligible	3	1	1	6
Correct	9	8	1	127

Source: **Analysis of Local Welfare Office Administrative Procedures: The Effectiveness of Home Visitation**, Division of Family and Children Services, Georgia Department of Human Resources, figure 24, June 1982.

Requests for additional information about the 176-page report should be directed to the **Publications Staff, Office of Research, Statistics, and International Policy, Social Security Administration, Room 1120, Universal North Building, 1875 Connecticut Ave., N.W., Washington, D.C. 20009.**

Highlights From Canadian Government Green Paper: Better Pensions for Canadians

The Canadian Government recently proposed for public debate a series of possible changes to its social security and private retirement systems. The proposals were contained in a Green Paper entitled, **Better Pensions for Canadians**. Released in December 1982, the paper addresses the means of improving coverage and retirement income, the financial stability of the system, the correct mix of national retirement programs—the universal Old Age Security and Guaranteed Income Supplement with the earnings-related programs (Canada Pension Plan and Quebec Pension Plan)—and the relative roles of public programs, private pensions, and private savings.

The issuance of the Green Paper is the first step in the pension reform process. A Parliamentary Special Committee is holding public hearings throughout Canada during 1983 to obtain public reaction to the specific proposals. The committee is to report to Parliament by the end of 1983 with detailed recommendations for action. If Parliament legislates any changes in the Canada Pension Plan, the governments of the various provinces must consent for the changes to become law.

Highlights from the Green Paper are reproduced below, verbatim. Footnotes have been added to clarify some sections. Further information is available from Daniel Wartonick, Comparative Studies Staff, Office of Research, Statistics, and International Policy, Social Security Administration.

* * *

Introduction

Many Canadians have expressed concern over the adequacy and fairness of the retirement income system. In response to these concerns, the Government of Canada is putting forward for discussion and debate a number of proposals for reform. These proposals will be referred to a Parliamentary Committee through which all interested parties and the public at large will have the opportunity to express their views.

The government invites all Canadians to study and discuss these suggested initatives, and to recommend ways in which they might be improved. It is only through the co-operative efforts of all Canadians that the full diversity of circumstances can be taken into account and the desirability of the proposals properly judged.

The government's overriding priority is to restore the health of the Canadian economy to its full vigour. Some have argued that discussion of pension reform should be postponed until economic recovery is well under way. Their concern is that confidence in the economy would deteriorate if the uncertainty of increased pension costs were added to the current problems in the economy.

It does not need to be stressed, given the "6 & 5" program,[1] that the Government of Canada is acutely aware of the seriousness of the current economic situation and of the need to contain costs. However, pension reform will be a lengthy process because of the time required for consultation, negotiation, legislation and implementation. Thus, costs arising from pension reform will not be felt in the immediate future and will not interfere with the current program of economic recovery.

The Government of Canada believes that discussion of pension reform, pursued in a spirit of openness and co-operation, should now focus on the proposals that are presented in *Better Pensions for Canadians.*

The Existing Retirement Income System

The federal **Old Age Security** pension (OAS) is the foundation of retirement income in Canada. All residents of Canada over age 65 receive an indexed flat rate benefit, based on years of residence in Canada; the indexing of OAS, however, will be capped over the next two years at 6% and 5% respectively in the context of the "6 & 5" program. The OAS benefit was $2,842 a year in 1982. OAS payments represented about 25% of all income received by the elderly in 1979, the most recent year for which full data are available.

The compulsory **Canada Pension Plan** (CPP) and the parallel **Quebec Pension Plan** (QPP) provide a second source of retirement income.[2] The maximum benefit under these plans was $3,692 in 1982. In 1979, these plans provided some 8% of the income of the elderly, since only those who retired after 1976 were eligible for full pensions. However, this percentage is growing rapidly as these plans mature.

Old Age Security pensions, and the Canada and the Quebec Pension Plans were designed to leave consider-

[1] The "6 & 5" program refers to the Canadian Government's plan to reduce inflation to 6 percent in 1983 and 5 percent by the end of 1984 through limited increases in government spending and voluntary compliance to wage guidelines in the private sector.

[2] At the inception of the CPP, all provinces had the option to set up their own public pension programs. Quebec was the only province to opt out of the Canadian program by establishing the QPP. However, the QPP has provisions that are almost identical to the CPP and earnings credits are portable between the two plans.