Full orphans receive a pension equal to 30 percent of this amount. There is also a funeral grant equal to two monthly "living wages" of the Department of Santiago.

HEALTH INSURANCE FOR SALARIED EMPLOYEES

A law creating government-sponsored health insurance for public and private salaried employees and their dependents was signed on March 26, 1968. Originally, the bill was introduced in the congress in September 1964. The new program and the Medical Assistance Fund created under the law will be administered by a new entity to be known as the Employees National Medical Service *(Servicio Medico Nacional de Empleados* or SERMENA).

Background

Salaried employees in Chile have heretofore received no cash benefits under the sickness insurance program of the social security system. Except for tuberculosis, syphilis, heart disease, and cancer, medical benefits were limited to preventive and curative services under the Preventive Medicine Law of 1937. Those suffering from a nonstatutory disease were, however, referred to a personal physician for the necessary care but received no social security benefit if hospitalization was required.

Under the 1952 law establishing the National Health Service, the President was given authority to incorporate additional beneficiary groups into the National Health Service program by executive decree. No such action has been taken, however, mainly because of objections from affected groups. The salaried employees have resisted any health insurance plan that would bring them into a program with the blue-collar workers, and the medical profession has also posed objections. The new law represents a compromise to satisfy these objections.

Financing and Benefits

The Medical Assistance Fund established under the law will be financed from four sources: (1) contributions from employees equal to 1 percent of their salaries; (2) matching contributions from employers; (3) contributions from retired persons equal to 1 percent of their pensions; (4) contributions from the pension fund equal to 2 percent of retirement benefits paid each year, and (5) interest, dividends, rents, etc. produced by investments of the fund. Additional users' charges may also be levied on beneficiaries to cover any differences between receipts and expenditures of the fund.

Only those physicians with 6 hours of daily salaried employment in a public sector institution (excluding the Employees National Medical Service) can provide medical services to the beneficiaries. In effect, then, only doctors working for the National Health Service will be able to provide medical services under the law. Reimbursement of fees will be based on minimum fee schudules established by each professional association.

Salaried employees earning less than two monthly "living wages" will be reimbursed for 70 percent of their medical costs; those earning more than two monthly "living wages" will be reimbursed for 50 percent. To help beneficiaries meet their share of the cost of medical benefits received they may apply to the fund for loans up to 1 year at no interest. The Employees National Medical Service will pay a beneficiary a subsidy of up to 85 percent of his average taxable salary for the past 6 months while he is on sick leave for a curable illness not covered under the law. Sick pay is normally paid for a maximum of 12 months but may be extended for an additional 6 months.

Canadian Medical Care Insurance Inaugurated

The national program for medical care insurance that went into effect in Canada on July 1, 1968, will apply initially to Saskatchewan and British Columbia, thus covering about 15 percent of the country's 20 million inhabitants. Of the 10 Provinces, only these two had on-going programs that met the conditions for participation in the Federal-Provincial plan, originally passed by Parliament in December 1966.

Under the new program the Federal Government will contribute approximately half the cost

of Provincial medical care insurance programs that meet Federal standards. Within the next few years, other Provinces are expected to develop programs to meet the conditions for Federal assistance. Alberta and Ontario currently have medical care insurance programs, but they do not cover enough of the population or for other reasons do not meet the conditions for Federal participation. Saskatchewan's program is the only one with compulsory coverage applying to all residents.

The Federal Government has stated that the program, when fully implemented, would require an increase of 12 percent in personal income taxes if this method of financing is used. The average net cost to the individual taxpayer would be considerably lower than that figure, since the Government plan would in many cases replace private medical insurance coverage. The full financial burden will be assumed only gradually as more Provinces decide to participate. Government spokesmen estimate that, for the remainder of the year, only $50 million from general revenues will be necessary to fund medical care in the two Provinces where the program has been put into effect.

Health insurance legislation is primarily a Provincial responsibility under the Canadian constitution, but the Federal Government does set certain criteria that Provinces must meet to qualify for Federal funds. The programs must:

—be enacted by Provincial legislatures
—provide for coverage of at least 90 percent of all residents during the first year and 95 percent after the second year
—limit the waiting period required for new Provincial residents to qualify for benefits to 3 months
—pay for services to its own residents who are temporarily absent and to former residents who have not completed the waiting period in another participating province
—cover, under uniform conditions for all insurable residents, all medically required services rendered by medical practitioners (except those provided for under other Federal laws or Provincial workmen's compensation), as well as paramedical services designated by the Federal Government and provided for in the plan
—give "reasonable compensation" to medical practitioners
—operate the plan on a nonprofit basis by a public authority appointed by the Provincial Government.

The Federal contribution to each Provinical program equals 50 percent of the per capita cost of the medical insurance programs in all participating Provinces multiplied by the average number of insured persons resident in the Province during the year. Thus, if the actual per capita costs of the program are somewhat higher in one Province than in another, the former would receive somewhat less than 50 percent of the cost from Federal funds and the latter would receive somewhat more.

The new medical care insurance program is not the first instance of Federal-Provincial sharing of medical costs. A Federal-Provincial hospital insurance program begun in 1958 has included all the Provinces since January 1961. The Federal contribution of approximately one-half the total cost currently amounts to $400 million annually.