Social Insurance in Venezuela

By Oscar M. Powell*

VENEZUELA'S system of social insurance against the risks of sickness, maternity, and occupational injuries, adopted in 1940, was put into effect by a series of decrees in 1944 and began operation in the Federal District on October 9, 1944. Some 80,000 insured workers and 160,000 dependents eligible for benefits have been enrolled under the program; this number represents about 60 percent of the entire population in the insurance zone. By February 1945 the new system was working sufficiently well for the Central Social Insurance Institute to recommend the creation, after further experience, of two new Regional Funds which would extend the insurance operations westward from the Federal District, in north central Venezuela, through the great oil region to the borders of Colombia.

In addition to cash benefits for insured workers, the system provides a wide variety of medical services, including general medical and clinical care; specialist services; hospitalization; home care; maternity, infant, and child care; school health services; dental services; glasses; and periodic health examinations of workers. For this range of services the circle of eligible dependents is wider and the qualifying requirements are more generous than anywhere else in the hemisphere. Demand for the services—heavy from the beginning—has called forth energetic and unremitting effort on the part of the insurance organization and its administrative, medical, dental, and social work personnel.

The new Venezuelan Government, the Revolutionary Junta which came into power in October 1945, voted a special credit of 4.6 million bolivars for social insurance on December 13, 1945. Most of the amount was allocated to health and maternity insurance, to cover a deficit and provide improved services through June 30, 1946. The decree made available to this program an estimated State contribution of 3.5 percent of covered wages from November 1, 1945, through June 30, 1946. Approximately 0.525 percent of wages was also allocated for administration of employment injuries. The decree provides that a permanent system providing larger Government contributions should go into effect by July 1 of this year.

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The Venezuelan Economy

Venezuela's general economic position in South America falls roughly between that of countries like Argentina, Brazil, and Chile, where industrialization has made its greatest advances on the continent, and that of the less industrially developed countries, which produce only a very few consumer goods. Oil production is especially important in the Venezuelan economy. Great deposits, developed by foreign concerns which use methods of high technological efficiency, have made Venezuela the greatest oil producer in Latin America and given it third rank in the world, after the United States and the Soviet Union.

Aside from the oil companies, however, the average firm has a limited capital investment and employs relatively few workers. Among the hindrances to industrial development cited by Professor Roberto Moll[1] are lack of skilled workers, inadequate transportation (although the highway system has some impressive achievements to its credit), and insufficient hydroelectric power. The standard of living of most of the population in turn limits the market for domestic goods. The objectives of improving consumption, nutrition, and production are all interconnected, and all—it is generally admitted—are difficult to achieve.

Nevertheless the Government, aided partly by the substantial revenues derived from its handling of the oil resources, has been pressing vigorously for a wide variety of social improvements ever since the death of Gómez, the former dictator, in December 1935. It has encouraged rural cooperatives, to aid in the slow but essential task of bringing about a structural change in agriculture. Some larger estates have been broken up into small holdings, to create a substantial *ranchero* class and so develop more efficient agricultural production. A 3-year plan, announced in 1938, has greatly expanded the public medical facilities and has brought about substantial progress in public health, education, and child welfare.

[1] "Lecciones de Economía Venezolana" *Revista de Fomento*, No. 55, 1944, p. 140.

Legislative History of Social Insurance

The power to legislate for social insurance was delegated to the Federal Government by the Constitution of 1936. The Labor Law of that year established certain employer responsibilities for death and disability resulting from employment, and also included brief directions for developing insurance for industrial injuries, sickness, maternity, old age, disability, and survivorship. In 1938, on the invitation of the Venezuelan Government, the International Labor Office sent a mission from Geneva to aid in drafting a social insurance measure. A bill providing for health and maternity benefits and industrial injury insurance for workers in industry and commerce was submitted to the National Congress in June 1938 but did not come to a vote. A more comprehensive measure, which included old-age and invalidity insurance, was introduced in 1939 but failed of adoption.

This administrative planning and legislative discussion, however, paved the way for the current law, the Compulsory Social Insurance Act of June 14, 1940, which was promulgated on July 24 of the same year. The act directed that the programs for health and maternity insurance and insurance against industrial injuries should be adopted first and that methods of providing protection against other risks—old age, invalidity, death, and involuntary unemployment—should be studied. It also specified that the programs should be introduced gradually, by decrees of the Federal Execu-

tive, who is to determine both the type of firms to be included and the geographic areas in which the programs are to be put in operation. Coverage in terms of the labor market was specified, with certain temporary exceptions (agriculture, domestic employment, home work, and temporary employment) and a few outright exclusions (family workers and those performing casual services outside the scope of the employer's regular business).

The benefits, in cash and kind, were prescribed in sufficient detail to provide a general guide for the later regulations.

The act also directed that the administrative expenses of the social insurance program were to be met from the National Treasury. The Central Social Insurance Institute, under direction of the "competent Minister," was charged with the general supervision of all social insurance programs, while regional administration of health and maternity insurance was delegated to Regional Funds.

Several important points were left to later decisions, to be made by Executive decree. These decisions, which were more than 3 years in the making, included the fixing of wage classes and contributions, methods of paying contributions, details regarding benefits and the rights and duties of beneficiaries, registration of workers in the system, and the rules for the central and regional bodies.

The operating method, in short, had to be worked out. This was accomplished chiefly through the General Regulation of February 19, 1944, in the preparation of which the writer had the privilege of participating. The General Regulation, supplemented by later decrees, provides the working rules for the Venezuelan social insurance system. It deals in detail with the scope, administration, financial resources, and benefits of the programs and also governs disputes, penalties, questions of medical service, and transitional matters.

Scope of the Programs

Save for the exemptions and exclusions to be noted, all individuals working for private firms and companies are covered by virtue of an express or implied contract of employment. Persons who work in public corporations and establishments are also covered if their positions are considered to be employment under the Labor Law and its regulations. Anyone who earns more than 9,600 bolivars [2] a year is not covered for health and maternity insurance, but there is no salary limit for insurance against occupational accidents and diseases.

Some groups are temporarily excluded pending a determination of the best method of coverage; others are declared not subject to insurance. Temporarily exempted are workers in agriculture and stock raising, home workers whose working conditions are not similar to those of ordinary employees, and domestic and temporary workers. Persons who are "not subject," and so outside the scope of the insurance programs, are those performing occasional services not within the regular course of the employer's trade or business, and members of the employer's family who work exclusively for him and live under his roof.

Administration

The administrative bodies are the Central Social Insurance Institute and the Regional Funds. The first, and to date the only, Regional Fund to be established is that for the Federal District, which also serves the municipalities of Chacao and Petare. Both the Institute and the Funds are declared to be autonomous public corporations, having their property separate from and independent of the National Treasury. Their autonomy, which is in accord with the 1936 and 1939 recommendations of the Conferences of American States which are members of the International Labor Organization, is qualified by the Compulsory Insurance Act and the General Regulations. Thus it will be noted that the Institute works in cooperation with certain regular departments of the Government and that it retains substantial control over the Regional Fund or Funds.

The Institute is under the general supervision of the Ministry of Labor and Communications and has close liaison with the Ministry of Health and Social Assistance. In turn, the Institute has supervision over the Regional Funds, which administer the sickness and maternity program. It directs the administration of insurance against occupational accidents and diseases. It is also responsible for conducting research and making studies of old-age, invalidity, survivor, and unemployment insurance.

Through its supervisory powers over the Regional Funds, the Institute can assure uniformity of administration as social insurance is extended to additional areas. It may, for special reasons, modify the wage classes, risk classes, and contributions detailed in the General Regulation, but its decisions on these matters are subject to approval by the Ministries of Labor and Communications and of Health and Social Assistance. Though its authority over administration is virtually complete, it can make no fundamental changes in the rights and obligations of the insured workers without the consent of the Ministers mentioned.

The administrative body of the Institute is an Executive Council (*Consejo Directivo*) made up of six principal and six alternate members; the Government, employers, and insured workers are equally represented among the membership. The members are appointed by the President, through the Minister of Labor and Communications, for 2-year terms; they serve without pay but receive traveling expenses and fees for attendance at Council meetings.

A Director General, also appointed by the President, is the Council's executive officer, charged with assuring compliance with its regulations, preparing its budget, reviewing the budgets of the Regional Funds, and organizing, allocating, and naming the personnel of the Institute.

The Regional Funds, under the supervision of the Central Institute, administer health and maternity insurance in their jurisdictions, collecting contributions and providing benefits. In matters relating to insurance for occupational accidents and diseases, the Funds act as executive agents for the Central Institute. Each Regional Fund is administered by an Executive Board (*Junta Directiva*), constituted and appointed in the same way as the Institute's Executive Council except that its members must have their residence within the jurisdiction served by the Fund. A Director, chosen by

[2] The current exchange value of the bolivar is about 30 cents.

Table 1.—*Weekly contributions for health and maternity insurance, by wage classes*

[In bolivars]

Wage class	Salary range						Basic daily wage	Weekly contribution
	Daily		Weekly		Monthly			
	From	To	From	To	From	To		
I	0	3.99	0	23.99	0	99.99	2.70	1.00
II	4.00	7.99	24.00	47.99	100.00	199.99	6.00	2.10
III	8.00	11.99	48.00	71.99	200.00	299.99	10.00	3.50
IV	12.00	15.99	72.00	95.99	300.00	399.99	14.00	4.90
V	16.00		96.00		400.00		18.00	6.30

Table 2.—*Weekly contributions for occupational accidents and diseases, January 1946*

[In bolivars]

Wage class	Risk class					
	A	B	C	D	E	F
I	0.05	0.10	0.20	0.40	0.55	0.65
II	.10	.20	.45	.90	1.25	1.45
III	.20	.35	.75	1.50	2.10	2.40
IV	.25	.50	1.05	2.10	2.95	3.35
V	.30	.65	1.35	2.70	3.80	4.30

the President, performs functions parallel to those of the Director General of the Institute. Subject to the approval of the Institute, the Funds formulate their own rules.

As a step toward building a governmental career service, the General Regulation specifies that the personnel of both the Central Institute and the Regional Funds are to be selected on the basis of capacity and merit. For the Regional Funds, selection of employees must also conform to standards fixed by the Central Institute.

The Regional Funds, in consultation with the medical colleges, determine most professional matters, including the question of physicians' fees. Conflicts between physicians and the Regional Funds are referred to a special commission made up of representatives of the Ministry of Health and Social Assistance, Ministry of Labor and Communications, and the Central Institute. Disputes of a general character are handled by the labor courts, but appeals from fines assessed against either employers or insured persons are made to the Director General of the Central Institute, whose decision is final.

Contributions

The collection and recording of contributions have been made as simple as possible. The Central Social Insurance Institute is responsible for the details of the collection method, which is based on the stamp system. A stamp book, or workbook, is distributed to each covered worker by the Regional Funds, which also sell the stamps to employers at least once each month. Workers deposit their books with the employer when beginning their jobs, and he must keep them in a safe place, accessible to inspection by either the worker or authorized social insurance officers. To claim benefits the worker must obtain and present his book at the insurance office. When the book has expired, it is turned in to the insurance office, which issues a new book showing the cumulative value of stamps to the worker's credit.

The workbook is evidence of the worker's eligibility for benefits, and the social insurance institutions do not maintain a record of the worker's earnings. Each employer's requisition for stamps is made on a ruled form on which he must enter the name of each worker, the number of the workbook, the worker's wage and wage class, and the stamps bought on the worker's account, as well as the number of weeks for which the stamps are purchased. The worker also fills out, for the Fund, an individual schedule of descriptive information.

For health and maternity insurance, contributions are based on a schedule of five wage classes and are divided equally between employer and employee, each paying, on the average, somewhat less than 3 percent of wages. The employer withholds the worker's share of the contribution from his wages. Table 1 shows the wage classes and contributions as fixed by the General Regulation.

The system of occupational accident and injury insurance rests on a different contribution base (table 2), with the full charge on the employer. Rates were reduced in October 1945, effective January 7, 1946. There are six risk classes, ranging from firms with fewer than four workers and with no machinery (class A)—schools are also included in this group—to certain transportation firms, mines, and other undertakings with the highest risk (class F). The average employer contribution has been estimated at 2.31 percent of wages.[3]

Contributions for both programs are due on the first working day of each week, or on the first day of employment in the case of laborers who begin work later in the week. If different employers hire a worker during the same week, only the first employer pays the contribution. Payments are suspended when the worker is receiving cash benefits.

The contribution of the National Treasury is important. It includes all costs of administering the programs, and the initial cost of setting them up and of providing and maintaining the health and medical equipment. Though not originally fixed in percentage terms, the Government contribution as determined by Decree No. 89 of December 13, 1945, is now approximately 4.025 percent of wages.

There is provision for a technical reserve and a reinsurance fund for the system of industrial accidents and diseases. In health and maternity insurance, any surplus must be used entirely to set up and maintain a reinsurance fund for the Regional Funds. So long as there is only one such Fund, the surplus constitutes its reserves. The Central Institute manages all reserves.

Benefits

Benefits under health insurance include both cash payments and medical care for the worker and medical care for his family. This care extends to the wife (legal or common law); to legitimate, natural, or adopted children up to age 18; to other minors living with and dependent on the worker; and to his mother if she lives with him and is supported by him.

[3] *Seguridad Social*, August 1945.

After a waiting period of 3 days, the insured worker is entitled to cash benefits equal to two-thirds of the base wage. No qualifying period is necessary to obtain these benefits.

For maternity insurance, whether for the woman insured by her own employment or dependents of the insured worker, contributions must have been paid for at least 13 weeks in the year before confinement—4 of the 13 in the first quarter of the year. This requirement was modified during the first year of the program's operation. The insured woman who has met the contribution requirement is entitled to medical benefit and a cash payment, equal to two-thirds of her basic wage, during the 6 weeks before and after delivery. Gainful employment must be discontinued for the time the cash benefit is paid. The medical benefit, available also to members of the insured worker's family, includes prenatal care and obstetrical aid as well as necessary postpartum attention.

All health insurance benefits are limited to a maximum of 26 weeks. When such benefits are exhausted, the insured worker must contribute for 26 weeks to qualify for further benefits, except in the case of a new illness, for which only 8 new weekly contributions are necessary. As the rights of the family derive from the rights of the insured worker, the loss of the latter's right to sickness benefit entails a corresponding loss for members of his family, except for those who are under treatment at the time. On the other hand, when a family member loses his right to benefits by reason of 26 weeks of treatment, the rights of the other members and of the insured worker to the same benefits are not affected. If the insured worker exhausts his right to benefits, payment of a single weekly contribution will restore the right to medical care for the eligible members of his family who have not exhausted their own rights to such treatment.

If the worker leaves covered employment, his and his dependents' rights to medical attention continue for 6 weeks after the last contribution week. The 6 weeks' provision also operates when the insured worker receives a pension under the work injury program and stops working.

Medical care is provided in medical centers of various types, through home visits, and in hospitals. It includes general and specialist services, medicines, dentistry, school health work, and examinations of insured persons. In less populous areas the medical centers are financed in collaboration with other public bodies, national and local. Others are financed entirely by the insurance system, which has also invested some of its reserves (accumulated under the occupational injuries program) in local government loans for hospital construction.

Hospital care is available in cases of contagious illness, when control or observation is essential, in surgical and similar cases, and when family care is not available. As the insurance system does not as yet own any hospital properties, it has made contracts with eight institutions whereby a definite number of beds are paid for. If the insured wishes to enter another hospital, his expenses are defrayed on the basis of what the cost would have been in one of the hospitals under contract. Thus 9 bolivars daily is set for general illness or maternity care and 10 bolivars for surgical cases, plus payment of the doctor's fees in accordance with schedules approved by the College of Physicians of the Federal District. When the insured worker is hospitalized, his cash benefit stops but the family receives a weekly payment equal to half the amount of his benefit.

Home care is specified when the sick person cannot attend the clinic but is not hospitalized. A physician from the curative center to which the insured belongs attends the patient, and a visiting nurse calls daily to ensure compliance with the doctor's orders, give injections, maintain the chart for the attending physician, and perform similar services.

Table 3.—*Receipts and benefit expenditures, Venezuelan social insurance programs, October 1944–July 1945* [1]

[In bolivars]

Month	Receipts	Value of medical benefits	Value of temporary cash benefits and funeral grants				
			Total	Ambulatory patients	Hospitalized patients	Maternity cases	Funeral grants
	Health and maternity insurance						
Total	7,018,351	4,381,926	1,235,458	1,065,721	68,120	54,615	47,003
1944							
October	802,776	193,735	11,058	8,074	511	170	1,403
November	696,455	223,089	52,882	44,553	3,851	1,478	3,000
December	781,657	336,890	91,637	75,737	7,103	4,293	4,500
1945							
January	690,721	414,640	122,645	103,081	7,496	6,068	5,100
February	610,205	430,906	143,837	122,264	8,483	6,490	6,600
March	776,423	633,152	174,726	151,007	10,490	8,329	4,900
April	758,632	675,148	209,068	181,300	11,155	9,713	6,900
May	818,505	720,350	209,786	183,747	10,157	8,482	7,400
June	819,138	745,010	219,819	195,058	8,869	8,692	7,200
July	854,839	(2)	(2)	(2)	(2)	(2)	(2)
	Insurance for occupational accidents and diseases						
Total	3,425,061	426,024	205,500	197,450	3,912	.....	8,100
1944							
October	334,472	43,649	4,662	4,042	20	.....	600
November	292,306	58,013	13,584	13,153	131	.....	300
December	344,395	62,307	24,723	23,450	373	.....	900
1945							
January	301,387	63,772	24,911	23,303	438	.....	1,200
February	287,455	69,672	24,704	23,241	1,215	.....	3,300
March	343,384	22,402	30,082	29,473	609	.....	.....
April	340,703	36,435	27,685	25,952	533	.....	1,200
May	392,746	31,794	24,747	24,051	396	.....	300
June	376,421	37,020	31,282	30,785	197	.....	300
July	411,792	(2)	(2)	(2)	(2)	.....	(2)

[1] Does not include permanent disability and survivors' pensions or lump-sum disability payments under insurance for occupational accidents and diseases.

[2] Not available.

Source: *Seguridad Social*, Caracas, April–September 1945.

Benefits for occupational accidents and diseases are interlocked with the general program. For the first 26 weeks the injured person receives medical care and any necessary orthopedic and prosthetic appliances through the regular health insurance facilities, with hospitalization as required. If he is not able to work, his cash benefits are the same as for health insurance—namely, two-thirds of wages, payable from the fourth day for a maximum of 26 weeks. The Regional Fund administers these services under the direction of the Central Social Insurance Institute.

After 26 weeks, or sooner if permanent incapacity is determined, a pension graded to the degree of disability becomes payable for life or for the duration of the disability. For total disability the monthly pension is two-thirds of the basic salary, plus a sum to pay for an attendant if one is needed. For partial disability of 10 percent or more, the monthly pension equals two-thirds of the amount by which the injury has reduced his wages. If the incapacity is between 5 percent and 10 percent, he receives a lump-sum payment equal to three times the annual value of the pension that would have been computed for such incapacity. The degree of disability is determined for specified accidents and diseases in accordance with an official schedule.[4]

If the injury causes the worker's death, a monthly pension is payable to his survivors as long as they meet the eligibility requirements. The pension, which varies according to the size of the family and the physical condition of the beneficiary, is determined by the following scale of payments:

Beneficiary	Percent of basic wage of insured person	Duration
Widow, able to work	25	Life or until remarriage.
Widow, disabled or aged 65.	30	Life or until remarriage.
Widower, disabled and previously dependent on wife.	30	Life.
Half orphan	15	To age 15; later if disabled.
Whole orphan	25	To age 15; later if disabled.

[4] *Gaceta Oficial*, October 5, 1944.

A widow who remarries receives a final payment of a lump sum equal to three times the amount of her annual pension. The aggregate of all survivor benefits for a family may not exceed the amount payable for total disability; when this limitation applies, each benefit is reduced proportionately. If this amount is not exhausted by payment to the survivors noted above, however, other dependents become eligible for pensions.

On the death of a worker insured under any of the programs, a lump-sum payment of 300 bolivars is made.

Operation of the Program

The exact coverage of the Venezuela system, in terms of persons currently protected, is a matter of estimate. In April 1945, when 75,000 workbooks had been issued and 5,540 employers registered by the Regional Fund of the Federal District, it was estimated that about 10,000 of the individuals enrolled were not active in the covered labor market. The 65,000 workers thus eligible for benefit, plus their dependents, made up a potential beneficiary group of some 206,000 persons. Medical personnel serving the insured population and affiliated with the Regional Fund numbered 586 persons, including 183 physicians, 25 dentists, and 97 nurses. The Fund had an administrative staff of 94, while the personnel of the Central Institute stood at 35.

The health and maternity insurance budget for the first operating year, based on estimated income of 9.0 million bolivars, allocated funds as follows:

	Percent
Total	100.00
Medical and surgical care	42.55
Pharmaceutical care	4.39
Hospitalization	19.00
Dental care	6.28
Cash benefits	27.59
Reinsurance fund	.19

For occupational accidents and diseases, the similar budget allocation, based on estimated income of 3.4 million bolivars, was:

	Percent
Total	100.00
Medical and surgical care	18.53
Temporary cash compensation	15.32
Pensions and capital payments	30.16
Industrial safety and hygiene	1.75
Unexpected costs and general reserves	34.24

The over-all summary of receipts and expenditures (table 3) shows that growth over the first 10 months of experience was substantial, especially for health and maternity insurance, in which both medical and cash benefits rose steadily month after month.

Table 4.—*Volume of medical services, May–July 1945*

Type of service	May	June	July
Services in medical centers (including clinical, pediatric, dental, and home care)	85,154	84,631	85,785
Services in specialist center (including laboratory services, ophthalmology, urology, otolaryngology, dermatology, etc.)	19,710	20,747	20,735
Services in traumatological center (work accidents, general accidents, etc.)	5,499	5,801	5,317

Relatively few pensions for disability or to survivors have as yet been paid under the occupational injuries program. Eighteen pensions for permanent partial disability had been awarded, up to August 8, 1945, none for permanent total disability, and 16 lump-sum payments had been made for disabilities of 5 to 10 percent. In 18 cases of compensable fatal accidents, pensions were awarded in connection with 16 cases; of these, pensions went to 12 wives or common-law wives, 5 mothers, 11 children, and 6 other dependents.

The average annual value of the partial disability pension has been about 715 bolivars. The value of the survivor pensions per case (with roughly 2 pensioners for each insured worker) has been approximately 1,070 bolivars yearly. Lump-sum payments averaged about 370 bolivars.

The volume of medical services for May–July 1945, a period typical of operations once the programs were well under way, appears in table 4.

Future Growth

The population in the territory where the social insurance programs now operate includes about one-tenth of Venezuela's 4 million inhabitants. Further extension of coverage, both within the present zone and beyond it, was considered in the report and recommendations of the Executive Council of the Central Social Insurance Institute as early as February 15, 1945. The Council studied the inclusion of

government employees and discussed the question of extending the system to additional territory. The Council suggested that the short operating history of social insurance and the consequent lack of reliable experience make it desirable to defer immediate coverage of the public workers.

Inclusion of additional territory under the insurance programs was recommended, but only after further development and observation of the operations in the Federal District. The present Government has issued a decree (No. 90, December 13, 1945) calling for preparatory studies in order that the system may be established in the States of Zulia, Carabobo, and Aragua.

The initial successes of the Venezuelan social security enterprise augur well for the future. The years of discussion between the Labor Law proposals of 1936 and the start of effective operations in 1944 helped to give the public a better understanding of social insurance, while the time taken to set up a sound and simple system appears to have been well spent. Insurance against occupational accident and disease, an integral part of the social insurance program, provides the basis for distinct improvements in protection against work injuries. Through inspection services, the publication of safety standards, and the use of a variety of educational methods, the social insurance system has dedicated itself actively to industrial safety. Because operations began during a period of high employment, collections of contributions have substantially exceeded the original estimates. Tentative plans for extension of services have followed promptly upon establishment of the first Regional Fund. These are signs of healthy growth.

Legislative Changes in Public Assistance, 1945

By Jules Berman and Haskell Jacobs*

DURING 1945, legislative sessions were held in all States except Mississippi. Louisiana and Virginia had special sessions restricted to subjects other than public assistance. The remaining States (including the District of Columbia, Hawaii, and Alaska) enacted in all about 500 laws which were pertinent to the programs of old-age assistance, aid to the blind, and aid to dependent children.

There was a marked trend toward extending the programs to additional groups of needy persons, through elimination or liberalization of conditions of eligibility, and toward increasing the amount of assistance payments, through abolishing or raising the statutory maximums on payments. Some States extended their programs beyond the coverage or potential levels of assistance payments for which Federal matching would be available.

Two new programs were established which were accepted by the Social Security Board during 1945. Delaware's plan for aid to the blind was approved October 26, and Alaska instituted a plan for aid to dependent children, approved July 31. Alaska's program, which is administered by the agency administering old-age assistance, extends aid to children under 16 years of age. There are no residence requirements. In addition to the relatives listed in the Social Security Act in the definition of a "dependent child," the Alaska law specifies "any person standing in loco parentis." The maximum payment is $25 a month for the first child and $15 for each additional child.

Delaware's new law, administered by the Commission for the Blind, makes aid available to any needy blind person 21 years of age or over who is not an inmate of a public institution or not publicly soliciting alms, who was a resident of the State at the time he lost his sight, or who has resided in the State 5 out of the last 9 years prior to application, the last year continuously. A $40 monthly maximum on assistance is set.

The following summary includes the significant legislative changes relating to levels of assistance payments, eligibility requirements, medical care, institutional residence, fair hearings, agency personnel, and State and local administrative organization.

Standards and Practices

Level of Assistance Payments

Considerable legislative activity was directed toward increasing the amount of assistance payments. Some States removed the maximum limitation on payments, and various others made changes in the maximums set in their laws. Oregon and Hawaii eliminated the maximum for old-age assistance; Nebraska, Colorado, and Maryland for aid to dependent children; and Iowa and Hawaii for aid to the blind. South Carolina removed from its constitution the provisions concerning maximums for all programs but retained the maximums written into the public assistance law.

Washington established a minimum base of $50 a month (less income and resources) for old-age assistance in place of its previous $40 maximum. Maximums for old-age assistance were raised from $45 to $60 in Alaska; from $40 to $50 in Wyoming;[1] from $40 to $45 in Illinois; from $30 to $40 in Vermont, South Dakota, and North Carolina; and from $25 to $30 in Delaware. Conecticut and Minnesota retained the $40 maximum but amended their laws to permit higher payments to meet the cost of medical care; Michigan raised the maximum from $40 to $60 to cover the costs of hospital and nursing-home care. California made permanent an increase from $40 to $50 which had been previously enacted but was due to expire. Aged recipients in Utah became entitled to payments of $40, less income and resources, rather than $30, less income and resources; as before, that amount may be increased by payments for medical expenses.

In aid to dependent children, South Dakota raised its maximum from $18 to $30 for the first child but kept the $12 maximum for each additional child. Minnesota raised its maximums of $23 for the first and $15 for

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[1] The maximum for recipient and spouse is $80.