Hospital Insurance in Canada

by
Sylva M. GELBER

The passage of the Hospital Insurance and Diagnostic Services Act in 1957 marked a significant advance in the development of social security in Canada. But it was also the culmination of a long series of efforts to overcome the difficulties raised by the constitutional division of authority between the federal and provincial governments. In the following pages Miss Gelber, of the Department of National Health and Welfare of Canada, devotes particular attention to these obstacles to the introduction of a co-ordinated social security system in a federal State. In so doing she first gives a succinct history of Canadian social security in general, and of health insurance in particular, and then analyses the provisions of the 1957 Act in such a way as to show how they have been devised to improve and extend insured hospital care throughout the country, while at the same time respecting the constitutional prerogatives of the provinces.

ON 1 July 1958, the ninety-first birthday of Canadian confederation, a new programme of federal-provincial co-operation was inaugurated. This was the hospital insurance and diagnostic services programme, designed to provide new strength for the Canadian social security system. The programme reflects developments in social security legislation in Canada within the traditions and the limitations prescribed by the Canadian constitution. The British North America Act, passed in 1867, divided legislative jurisdiction between the Dominion and the provincial governments in terms which were adequate at the time the legislation was enacted. Concepts of public health and public welfare as we understand them today, however, could not be foreseen some ninety years ago. Consequently, in dividing the powers of the two levels of government, no subdivision was made in the fields of health and welfare, with certain minor exceptions.

Among the fields of jurisdiction allocated to the Dominion Government in the British North America Act is the raising of money by any mode or system of taxation; another field is quarantine and the establishment and maintenance of marine hospitals. The fields of jurisdiction assigned to the provinces, on the other

hand, include direct taxation within the province for the raising of revenue for provincial purposes; in addition, the provinces were given jurisdiction for the establishment, maintenance and management of hospitals, asylums, charities, and eleemosynary institutions, in and for the province, other than marine hospitals. Other precise matters listed as coming within the jurisdiction of the provincial legislatures, and which have some bearing on matters pertaining to health and welfare, are civil rights in the province and all matters of a merely local or private nature.

The constitutional problem which has had to be faced over the years in devising social security legislation, has been to ensure that such legislation fits into the constitutional allocation of responsibilities as between the federal and the provincial governments.

Generally speaking, the following three distinct types of social security legislation have evolved in Canada over the years:

(1) Non-contributory social assistance programmes based on the principle of a means test. Four of them are provincially administered and are supported by federal financial contributions; one is provincial and one, with respect to veterans, is federal. These programmes include—

(a) old-age assistance, joint federal-provincial;

(b) blind persons' allowances, joint federal-provincial;

(c) disabled persons' allowances, joint federal-provincial;

(d) unemployment assistance, joint federal-provincial;

(e) mothers' allowances, provincial only;

(f) war veterans' allowances, federal only.

(2) Welfare programmes financed and administered by the federal Government and including—

(a) old-age security, which was made possible by an amendment of the British North America Act; and

(b) family allowances.

(3) Insurance programmes, in the main contributory, including one federal programme, exclusively provincial programmes and joint federal-provincial programmes. The major programmes under this heading are—

(a) workmen's compensation, provincial, administered provincially under provincial law;

(b) unemployment insurance, federal, administered under federal legislation, made possible by an amendment of the British North America Act;

(c) hospital insurance, joint federal-provincial, administered by the provinces under provincial law and in accordance with agreements pursuant to federal legislation.

In so far as the hospital insurance programme is concerned, it should be noted that the pattern which has been adopted resembles the pattern established in connection with the assistance programmes rather than the other insurance programmes. By following this method, it was possible to initiate federally supported insurance programmes, administered by provincial governments, without recourse to an amendment of the British North America Act.

Milestones on the Road to the Present Structure of Social Security Legislation

The first programme bearing any resemblance to social security, inaugurated by the federal Government, was the programme of government annuities introduced in 1908. While this programme was wholly federal in concept, it was voluntary in character, and hence involved no constitutional problem.

In 1914 the provinces, starting with Ontario, began to enter the field of workmen's compensation. The programmes introduced provided collective liability insurance for workers employed in specified types of employment. They were, and still are, financed by employer contributions, and their constitutional validity has never been questioned.

Manitoba (in 1916) was the first of the provinces to enact mothers' allowance legislation. The programmes introduced by this legislation provide allowances designed to assist needy mothers and dependent children; they are wholly provincial and non-contributory and at no time was any constitutional problem involved.

In 1927 the federal Government passed the Old Age Pension Act, under which payments were made to the provinces for programmes administered by them. These payments, made out of general revenue, initially represented 50 per cent. and subsequently 75 per cent. of the cost of such pensions.

In their report, some years later, the Royal Commission on Dominion-Provincial Relations, commented—

> Thus, without acquiring additional jurisdiction, the Dominion assumed heavy financial responsibilities for a costly function regarded by the Dominion and the provinces alike as a provincial responsibility.[1]

[1] Royal Commission on Dominion-Provincial Relations : *Report*, Book II : *Recommendations* (Ottawa, 1940), p. 17.

From the constitutional point of view, this Old Age Pension Act was of particular significance. It set the pattern into which many subsequent federal-provincial social security programmes were fitted. It was this statute which established the device of operating joint programmes by means of agreements entered into between the federal and provincial governments. Basically, it was the same pattern which was utilised thirty years later in the hospital insurance programme.

The depression of the 1930s provided the circumstance for the first major test of the British North America Act as it relates to social security legislation. In 1930, and during the subsequent seven years, the federal Government was obliged to come to the assistance of the hard-pressed municipalities to provide relief in connection with the widespread unemployment of the day. Both the federal and provincial governments had viewed this to be a constitutional obligation of the municipalities. However, the federal Government started making short-term grants-in-aid to the municipalities, under agreements concluded with the provinces, for purposes of relief. The responsibility for the administration of relief, including the cost of administration, was left with the municipalities. The federal Government was not able to exercise any measure of control over the funds provided to the municipalities, since the municipalities were constitutionally answerable to the province, in spite of the fact that the municipalities themselves only raised less than one-sixth of the total amount spent during those years on relief. This was obviously a most unsatisfactory programme from the federal Government's point of view.

In an effort to set up an orderly programme to cope with the problem of unemployment, including the establishment of an employment service and the provision of unemployment benefits, the federal Government enacted in 1935 the Employment and Social Insurance Act. This legislation envisaged a federally administered programme which included the imposition of premium payments. At the time of its passage through the House, there was an expression of doubt as to the validity of the Act in the light of the terms of the Canadian constitution. The following year, as a result of a change of government, the Act was submitted to the Supreme Court of Canada for a ruling as to its validity. The Supreme Court ruled that the Act was *ultra vires*. In explaining the Supreme Court ruling, Justice J. Rinfret stated—

> Insurance of all sorts, including insurance against unemployment and health insurances, have always been recognised as being exclusively provincial matters under the head " Property and Civil Rights " or under the head " Matters of a merely local or private nature in the Province ".

In answering the claim that this insurance Act was, in fact, a measure for raising taxes, a matter which came within the jurisdiction of the federal Government, Justice Rinfret stated—

> . . . the Dominion Parliament may not, under pretext of the exercise of the power to deal with its property, or to raise money by taxation, indirectly accomplish the ends sought for in this legislation. If it were otherwise, the Dominion Parliament, under colour of the taxation power, would be permitted to invade almost any of the fields exclusively reserved by the constitution to the legislatures in each province. . . .

A similar decision regarding the constitutional basis of the Act was made the following year by the judicial committee of the Privy Council.

Following these decisions the Government established by Order in Council a Royal Commission on Dominion-Provincial Relations on 14 August 1937. The Commission was charged with the task of re-examining the economic and financial basis of Confederation and the distribution of legislative powers in the light of economic and social developments since 1867. It was asked to express an opinion, after examination and investigation, as to what would best effect a balanced relationship between the financial powers and obligations and functions of each governing body, subject to the retention of the distribution of legislative powers essential to a proper carrying-out of the federal system in harmony with national needs and the promotion of national unity.

The Commission's report, which was not presented to the Prime Minister until 3 May 1940 [1], gave considerable attention to the problems of social security legislation in the light of the terms of the constitution. In making recommendations for a clear division of responsibility between governments in this field, the Commission stated that it was guided by the principle that existing constitutional arrangements should not be disturbed except for compelling reasons. Such compelling reasons, the Commission concluded, existed in the field of relief for unemployed employables, as distinct from unemployables, and in the field of a compulsory system of contributory old-age pensions. In the field of health, the Commission predicted that—

> . . . the health activities of governments are indeed only beginning and that expenditures in this field are likely to increase rapidly in Canada, especially in the field of preventive medicine, and medical aid for the lower income groups (either in the form of state medicine and hospitalisation, or health insurance, or both).

[1] In the meantime, in 1937, the Old Age Pension Act had been amended to make provision for the payment of allowances to eligible blind persons, but the constitutional basis of the legislation remained unchanged.

But the Commission concluded that there was no insuperable obstacle to the establishment of health insurance by a province, and stated that—

> In recommending provincial jurisdiction over health insurance we are aware of the possibility incidental to any social insurance scheme put into effect province by province that it may result in inequalities of taxes on industry as between provinces. We think, however, that regional differences in Canada militate against an acceptable national scheme.

In summing up its proposals with regard to jurisdiction in social insurance, the Commission stated that although it was of the opinion that unemployment insurance and contributory old-age pensions are inherently of a national character, while health insurance could be financed and efficiently administered by the provinces, it also suggested that rigidity in the matter of jurisdiction should be avoided. It proposed that some measure of elasticity in jurisdiction over social insurance should be maintained in the event that changing conditions might warrant a change in jurisdiction. At the same time the Commission emphasised the possibility of federal assistance by grants-in-aid for specialised health services programmes administered by the provinces.

An immediate result of the report of the Royal Commission was the introduction of an amendment to the British North America Act in 1940, to enable the federal Government to enter the field of unemployment insurance, a field in which the Commission recommended that the federal Government " is the only government which can meet, in an equitable and efficient manner, the large fluctuating expenditures due to unemployment ".

In the same year the Unemployment Insurance Act was passed. This Act makes provision for a federally administered employment service and for the payment of unemployment insurance benefits, financed out of an unemployment insurance fund composed of contributions made by employees, employers and the federal Government, in specific types of employment.

In 1944, with the passing of the Family Allowances Act, the federal Government inaugurated a new federally administered programme without having to have recourse to constitutional amendment. The programme is a non-contributory one, financed from consolidated revenue. It is designed to assist in providing equal opportunity for Canadian children through the provision of monthly cash payments. No means test is involved.

With the passing of the Department of National Health and Welfare Act in 1944, the federal Government transferred from the department, which had succeeded the original Department of Health, the functions relating to health matters, and for the first time allocated to a Minister of the Crown duties, powers and func-

tions in matters relating to social security and social welfare " over which the Parliament of Canada has jurisdiction ".

In April 1945, with the war all but over, the Government placed before Parliament a White Paper on Employment and Income.[1] In describing this document recently, one of Canada's foremost political historians and commentators stated—

> . . . that neglected document was second in importance, I believe, only to the pact of Confederation itself, for it codified the new society long agrowing, it raised expectations that no Canadian government could possibly deliver singlehanded, it ratified a new social state of mind, it confronted all future governments with vast and completely new responsibilities.[2]

He further stated that the White Paper outlined the Government's policy of maintaining full employment and " generally to fix everything by the methods of Lord Keynes ". The object of government policy was described in the White Paper as the " maintenance of levels of employment and income greatly above those ruling before the war . . . and higher standards of living ". In discussing expenditures, the White Paper noted that—

> The Government has given support to the development of additional social security measures, and has indicated willingness to institute contributory old-age pensions and health insurance, as soon as financial and administrative arrangements with the provinces can be agreed upon.

On the basis of the policy enunciated in the White Paper, the federal Government convened a Federal-Provincial Post-War Conference on Reconstruction. Included in the proposals presented to the Conference was a federal offer to the provinces with regard to a comprehensive health insurance programme on a nation-wide basis. These proposals are discussed more fully below. Suffice it to say that the Conference failed to achieve agreement on the broader issues involved, and the health insurance proposals were consequently shelved.

In 1950 the Government set up a joint parliamentary committee of the House of Commons and the Senate to study the question of old-age security. The committee's recommendations were subsequently accepted by the federal Government and adopted by Parliament. These recommendations paralleled those of the Royal Commission a decade earlier, in so far as they pertained to the role of the federal Government in this field.

In 1951 an amendment was made to the British North America Act to permit the federal Government to legislate in the field of old-age pensions concurrently with the provincial govern-

[1] *Employment and Income. Statement of Policy, Presented to Parliament by the Minister of Reconstruction, April 1945* (Ottawa, 1945).

[2] Bruce HUTCHISON, in *Maclean's Magazine* (Toronto), 2 Aug. 1958, p. 46.

ments, and in the following year the Old Age Security Act was passed. This Act provides federal pensions for all persons 70 years of age or over who have been residents of Canada for a prescribed number of years. Initially, a 20-year residence requirement was prescribed but this was reduced to ten years in 1955. No means test is involved. The payments are financed through *(a)* a 2 per cent. sales tax, *(b)* a 2 per cent. tax on net corporation income, and *(c)* 2 per cent. on individual net taxable income, subject to a maximum of $60.

The moneys raised through these means are deposited in a fund earmarked for old-age payments. This fund has been experiencing deficits annually which have, so far, been met by loans that are paid off by grants from general revenue.

At the same time a new Old-Age Assistance Act and Blind Persons' Allowances Act were passed, repealing the 1927 Old-Age Pensions Act and subsequent amendments. Unlike the old-age security programme, which is wholly federal, this legislation makes provision for a federal-provincial programme similar to that which preceded it, in that the administration is provincial and the device of federal-provincial agreements is continued. Here too, the echoes of the recommendations of the Royal Commission on Dominion-Provincial Relations are audible.[1]

The Old-Age Assistance Act is designed to provide assistance for persons in the 65-year to 69-year age group, on the basis of a means test. The federal Government reimburses the provinces for 50 per cent. of the cost of assistance payments.

In 1954 the Disabled Persons Act was passed, patterned on the earlier Old-Age Assistance and Blind Persons' Allowances Act. It is a federal-provincial programme operated through agreements, based on a means test, for permanently and totally disabled persons.

In 1956 the federal Government inaugurated another grant-in-aid programme, the unemployment assistance programme, which, though similar in some ways to the previous assistance programmes, differs in that the federal Act makes no specifications with regard to the means test. The responsibility for determining the scale of benefits and the conditions of payment for unemployment assistance rests with the provincial authority.

Another feature of the unemployment assistance programme, which distinguishes it from earlier assistance programmes, is that no line of demarcation is drawn between so-called " employable " and " unemployable " persons. This feature is particularly

[1] The Commission had stated : " We see no strong objections to the continuance of provincial administration of non-contributory pensions, even if a contributory system were established by the Dominion."

interesting in view of the proposals made by the Royal Commission on Dominion-Provincial Relations only a decade before, namely: " . . . Our proposal is that a clear line should be drawn between employables and unemployables and that the Dominion should assume responsibility for employables only."

In this connection, however, it should be recalled that the Royal Commission also recommended the need for flexibility in staking areas of jurisdictional responsibility in the social security field.

By the time serious consideration was being given to the details of the present federal hospital insurance programme, the patterns for social security legislation in Canada were more or less fixed. The experience gained through the years by trial and error and the findings of judicial bodies and commissions had all played their part in designing the form of legislation which was most compatible with the Canadian constitution and Canadian tradition. If hospital insurance legislation were to be introduced by the federal Government without having recourse to an amendment of the British North America Act, it could only be achieved by establishing a programme of grants-in-aid to support provincially administered programmes.

Milestones on the Road to Public Health Insurance Programmes

Under the constitution the federal Government had been made responsible for a number of health matters in connection with several of the jurisdictional functions allocated to it. These included responsibilities in connection with militia and defence; immigration; navigation and shipping; trade and commerce; railways, steamships and public works, in so far as these came within federal jurisdiction. In addition, the federal Government was responsible for the administration of certain public health enactments such as those pertaining to food and drugs, quarantine and a number of others. These responsibilities were administered by a number of departments.

Generally, however, public health matters were administered by the provinces. Until the appointment of the first full-time Minister of Health in New Brunswick in 1918, the provinces carried out their responsibilities through boards of health.

In order to centralise the federal responsibilities and, in addition, to co-ordinate the federal Government's role with the activities of provincial governments in the field of public health, a federal Department of Health was established in 1919. At the same time provision was made for the establishment of a Dominion Council

of Health, on which was represented each of the provincial health authorities. This council has been functioning regularly ever since its initial formation.

The first federal grant-in-aid to the provinces (for the control of venereal disease) was made in 1919 and was renewed annually until 1932, when it was discontinued during the depression.[1]

It was also in 1919 that Saskatchewan enacted legislation for a municipal doctor plan, enabling rural municipalities and, to a limited extent, the towns and villages, to provide medical care for their residents. The following year Manitoba initiated a similar programme. The first municipal hospital plan to be introduced in Canada was a municipal hospital plan set up in Alberta in the same year. In its initial stage this plan was based on a single hospital. The subject of national health insurance also made its first appearance in the political arena in the same year, when one of the major political parties included the subject in its national platform.

In the early 1920s the concept of group insurance coverage had not yet emerged, but commercial companies were already selling sickness and accident insurance on a cash indemnity basis to individuals.

Newfoundland, which only became a province of Canada in 1949, introduced the first government-sponsored medical hospital plan in North America in 1934. This cottage hospital programme, in addition to a subsequent health programme for children, continued to serve a large portion of Newfoundland residents through the years preceding the inauguration of the federal-provincial hospital insurance programme, commenced in Newfoundland on 1 July 1958.

In 1935, as a result of reports on health insurance prepared by committees appointed in Alberta in 1928 and 1932, a Health Insurance Act was passed in Alberta but was never put into operation. British Columbia also passed a Health Insurance Act in 1936 which shared the same fate.[2]

Although these early attempts in Alberta and British Columbia to enact health insurance legislation were not fruitful, the introduction of the legislation had the effect of stimulating public interest in the subject of health insurance generally.

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[1] This grant will be discussed more fully below in connection with the national health grants programme.

[2] A Royal Commission had been appointed in British Columbia in 1919 and another in 1929 to study the problem of health insurance in the province. The obstacle to the implementation of the British Columbia legislation at that time appears to have stemmed from the refusal of the medical profession to participate in the scheme.

Between 1935 and 1940 some early experiments were made with voluntary insurance. Voluntary programmes providing a variety of benefits under different arrangements and at different costs began to appear. These took the following forms:

(a) Medical association programmes: these programmes, based on voluntary prepayment and sponsored by medical societies, provided medical and surgical services.

(b) Commercial insurance company programmes: commercial firms began to offer health insurance coverage on a group basis.

(c) Life insurance company programmes: the successful switch of emphasis of the commercial agencies from the indemnity type of coverage for sickness and accidents on an individual basis, to group coverage, encouraged the life insurance companies to compete by providing group coverage.

(d) Hospital association programmes: in order to establish some method of avoiding heavy financial deficits, hospital associations began to enter the field of hospital insurance through such organisations as the Blue Cross.

(e) Industrial programmes: a number of industrial firms, utilising the newly developing programmes, began to provide group coverage for employees and families in the hospital and medical care field.

Although very few Canadians had any form of health insurance at that time, the large-scale development of voluntary insurance began in about 1942, the year in which the federal Government set up an Advisory Committee on Health Insurance. In March of the following year, the Advisory Committee presented a report to the House of Commons Special Committee on Social Security including a draft Bill for the establishment of a health insurance programme on a nation-wide basis. This Bill had been reviewed by the General Council of the Canadian Medical Association, which went on record as favouring the principle of health insurance.

The provinces, too, appeared to support the principle of health insurance legislation, but were of the opinion that a health programme should be implemented in stages and should be sufficiently flexible to permit the provinces to build gradually on the various existing services.

During 1943 and 1944 both the Advisory Committee on Health Insurance and the Special Committee on Social Security continued to study the subject and in July 1944 a further report, including an amended Bill, was presented to Parliament. It was recommended that the subject should be referred to a federal-provincial conference.

In 1945 the federal Government presented the first concrete proposals for a comprehensive, nation-wide health insurance programme to the Federal-Provincial Post-War Conference on Reconstruction, to which reference was made earlier, to be introduced gradually as an integral part of a broader proposal for federal-provincial co-operation.

The proposals included *(a)* general practitioner services and public ward care in hospitals, as a first stage ; and *(b)* other services, including specialist services, laboratory and radiological services, nursing services out of hospital, drugs, etc., at successive later stages. They also included an offer to make available to the provinces a number of health grants to enable them to strengthen and expand their health services.

The conference failed to reach agreement on the broader fiscal proposals made by the federal Government and, with the shelving of the broader proposals, the health proposals were also shelved.

Meanwhile, certain developments were taking place in the provinces. In 1944 Alberta added a maternity hospitalisation programme to its existing municipal hospital plan, which had been growing since its inception in 1919. Although the new programme, like its predecessor, cannot be described as an insurance programme, it was a state-financed hospital plan providing free hospital maternity care subject to an eligibility requirement of one year's residence in the province.

In 1945 Manitoba introduced a health plan designed to provide urgently needed services in the rural areas, particular stress being placed on the preventive aspects of medicine. It was described as an extension of the municipal doctor plan inaugurated 25 years earlier, widening the methods whereby municipalities could pay in advance for medical care and introducing the principle of provincial grants. Municipal funds to finance the medical care service, as well as the municipal share of the health unit and diagnostic service cost, could be raised by a personal health levy or an annual property tax. Under the plan diagnostic facilities were made available on a province-wide basis so that all medical practitioners could have the advantage of adequate X-ray and laboratory service.

The following year Alberta again introduced health insurance legislation, resembling the federal proposals of the previous year. The Act, passed in March, was not proclaimed and was ultimately repealed in 1953.

In 1947 Saskatchewan introduced a comprehensive hospital insurance programme, financed through a combination of individual premiums and provincial general revenue and based on a compulsory principle. To a considerable extent, this programme

provided the basis for the federal programme which reached the statute books a decade later.

In 1948 the Government salvaged from the proposals which had been presented to the Post-War Conference on Reconstruction, the proposals relating to health grants and announced the establishment of grants for the following purposes: *(a)* health surveys; *(b)* hospital construction; *(c)* professional training; *(d)* public health research; *(e)* general public health; *(f)* mental health; *(g)* tuberculosis control; *(h)* cancer control; *(i)* crippled children; *(j)* venereal disease control.[1] Subsequently grants for the following three purposes were added: *(a)* child and maternal health; *(b)* laboratory and radiological services; and *(c)* medical rehabilitation.

In introducing this programme in the House of Commons, the Prime Minister described the grants as "being fundamental prerequisites of a nation-wide system of health insurance".

The national health grants programme has made federal funds available to the provinces in increasing amounts every year since the inauguration of the programme. In the case of some of the grants the share of each province is calculated on the basis of a flat rate minimum plus an additional amount per head related to population and, in some instances, to provincial public health needs. In other cases the federal Government grants a sum equal to that made available by the province concerned for the same purpose.

In the following year (1949) British Columbia introduced a province-wide hospital insurance programme. Initially, this programme was based on a premium system which proved to be less successful than that in Saskatchewan. The premium system was later abandoned, therefore, and the British Columbia programme was subsequently financed from general revenues and from part of the income derived from a provincial sales tax. Another feature of the British Columbia programme which differed from that in Saskatchewan was the levy of a "co-insurance charge" of $1 a day for hospital care.

The year 1950 saw the inauguration of a medical-dental care programme in the Swift Current area of Saskatchewan, providing a complete range of medical care services in home, office and hospital, as well as dental care for children. This programme was financed through compulsory premium and property tax. In addition, a small annual provincial grant was made available.

In the same year Alberta introduced a programme of provincial grants for hospitalisation in municipal hospitals. This programme

[1] The original grant, which had been discontinued in 1932, was partially reinstated in 1938, when the federal Government started making a small grant available to the provinces for drugs, and was further expanded for venereal disease control in 1943.

was an extension of the original municipal hospital plan inaugurated in the province some thirty years earlier. It was not an insurance programme in the same sense as the programmes introduced in Saskatchewan and British Columbia, although the principle of the co-insurance charge was comparable to that in British Columbia. The Alberta programme was further extended, in 1953, by the introduction of a special services programme and of a state-financed hospital programme for victims of poliomyelitis.

The over-all situation in Canada in the mid 1950s, therefore, was that public hospital insurance programmes or state-financed hospitalisation was available to residents in four provinces. In addition, large-scale developments in the voluntary insurance field, which had been a characteristic feature of the preceding decade, made coverage available to many Canadians. Prior to the participation of the federal Government in the hospital insurance field, over 40 per cent. of the Canadian population was already covered by voluntary hospital insurance. In addition, something more than a third of the Canadian population were covered with respect to surgical and medical benefits.

Despite these developments, however, the limitations of voluntary or private insurance plans had become obvious. For the most part persons not eligible for group coverage over a given age, or suffering from pre-existing conditions, were still without benefit. Arbitrary limitations on the length of hospitalisation were inevitably written into insurance policies. In spite of state support, which varied from province to province and from municipality to municipality, the hospitals were still being left with the major financial responsibility for the care of indigents. With the ever-increasing costs of hospital care, hospital deficits were becoming unbearable. It was in these circumstances that the provinces requested in 1955 that the subject of health insurance should be placed on the agenda of a federal-provincial conference which was held in October.

At this conference the Prime Minister expressed the willingness of the federal Government to provide federal financial support to provincially administered hospital insurance programmes, and federal proposals were placed before the provinces as a concrete offer three months later.

In January 1956, when the details of the federal proposal were made known, the Prime Minister stated that it was the view of the federal Government, with which the provinces appeared to agree, that " priority of attention should be given to the development of plans to cover diagnostic (laboratory and radiological) services and hospital care, and that only after the establishment of some form of hospital insurance should further consideration be given to what additional steps should be taken ".

The main features of the federal proposals were that the federal Government was prepared to assist with technical support and financial assistance any province wishing to embark upon agreed phases of provincially administered health insurance programmes, involving no constitutional change or interference in provincial affairs, as soon as a majority of the provincial governments, representing a majority of the Canadian people, were ready to proceed. The Government was prepared to recommend to Parliament legislation to provide grants to cover a share of the cost of hospital insurance programmes.

The federal proposals were based on the acceptance by the provinces of certain basic principles. In order to participate in the programme a province would be required to undertake to make insured services uniformly available to all residents of the province. In addition to insured hospital services, the province would be required to include specified diagnostic services. In order to ensure that no excessive financial burden was placed on insured patients in respect of hospital costs the province would be required to limit any co-insurance or deterrent charges which, under provincial legislation, it might propose to levy.

In determining the costs which would be deemed to be sharable, the federal Government proposed that these should be based on normal operating and maintenance costs in so far as they related to standard ward care. But the Government made it clear that it did not propose to share in capital costs or in the administrative costs relating to the provincial insurance programme.

The proposals also made clear the Government's intention of excluding from the hospital insurance programme the costs of caring for patients in tuberculosis and mental hospitals. In explaining this exclusion, the Government pointed out that the costs of care in these instances were already being met almost exclusively from public funds.

The federal Government proposed to contribute to provincial hospital insurance programmes an amount based on a formula that would have the effect of providing a larger percentage of provincial costs to provinces in which the costs were lower. In making these proposals, the federal Government emphasised its readiness to provide technical assistance, in addition to financial support, in the development of provincial programmes.

In March of the following year, legislation based substantially upon the terms of the proposals made to the provinces was introduced in the House of Commons. The relevant resolution reads as follows :

> That it is expedient to introduce a measure to authorise contributions to be paid out of the consolidated revenue fund to provinces in respect of

costs incurred by them in providing insured hospital and diagnostic services pursuant to provincial law and to agreements made in accordance with the said measure, to commence when at least six provinces, containing at least half the population of Canada, have entered into such agreements and qualified for the receipt of such contributions.

During the debate on the Bill criticism was expressed of a number of provisions, one of which was the subject of a subsequent amendment to the Act a year after its enactment. This pertained to the provision, appearing in the original resolution and subsequently repeated both in the Bill and the Act, to the effect that federal contributions would only commence when at least six provinces, containing at least half of the population of Canada, had entered into agreements with the federal Government and had provincial laws in force.

It had been contended that, since considerable financial outlays by the federal Government would be involved, federal contributions should not be made for the benefit of a minority of the population, when all the population would be contributing to federal funds through national income tax payments. However, in the following year the limiting provision with regard to federal contributions was deleted so that five provinces who were prepared to begin could participate in the joint programme.

The Hospital Insurance and Diagnostic Services Act became law in April 1957 and was proclaimed as coming into force on 1 May 1957.

The deletion of the limiting provision with regard to federal contributions, which was passed by an amendment in June 1958, permitted the federal Government to commence participating in the hospital insurance programme from 1 July 1958.

By that time six provinces had signed agreements with the federal Government, five of which proposed to inaugurate the joint federal-provincial programmes immediately. The first agreement had been signed with the province of Ontario in March 1958. Owing to the enormous task involved in administrative preparations in that province, however, Ontario fixed the commencement date of its programme for 1 January 1959. The provinces of Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia commenced their programmes on 1 July 1958. Nova Scotia signed an agreement with the federal Government in October 1958 and envisaged inaugurating its programme on 1 January 1959.

The Hospital Insurance and Diagnostic Services Act

The Hospital Insurance and Diagnostic Services Act, described in its preamble as " an Act to authorise contributions by Canada in respect of programmes administered by the provinces providing

hospital insurance and laboratory and other services in aid of diagnosis ", is a relatively short one, consisting of only ten sections, seven of which contain the essential elements of the programme. Within these few sections, provision is made for one of the largest social security programmes in Canada and undoubtedly the most significant advance in the health field in the history of the Dominion.

The Act does not make provision for a state hospital plan, in that the nationalisation of hospitals is not envisaged. In fact, it has been devised in such a way as to leave undisturbed the traditional patterns of the hospital structure across the country. No provision is made for change in the ownership of hospitals nor is any change envisaged in the form of the actual administration of hospitals, other than the requirement that the province be responsible to ensure that adequate standards are maintained.

The advantages of the new programme over voluntary or private prepayment hospital insurance programmes are to be found in the requirement that the insurance benefits must be made available to all bona fide residents of the province on uniform terms and conditions. In effect, this eradicates such exclusions as those commonly applied to persons suffering from pre-existing conditions. The factor of age may no longer exclude many individuals for whom, heretofore, hospital insurance coverage was not available. No limit is placed on length of stay in hospital, other than that dictated by medical necessity. In addition, the Act places no ceiling on federal contributions except that these may only be made in accordance with its financial provisions.

In short, the Act has been devised so as to provide an orderly prepayment method for meeting the ever-increasing costs of hospital care for all residents of the country, without embarking on a programme differing in any degree from that which is compatible with Canadian traditions and without injecting any form of federal interference in a provincial field of jurisdiction.

The federal Government has stressed the fact that it views this programme primarily as one designed to further the health services in the provinces. Although considerable financial outlays are involved, emphasis has been placed on the fact that this is not essentially a fiscal programme. In the administration of the Act it is planned to give considerable attention to the quality of care provided. Education and research, in so far as these are important elements, will continue to be supported. The federal Government has also intimated that consultant services will be available and that technical assistance will be provided in connection with the health grants to ensure a high quality of administration.

While the federal Government will not share the provincial administration costs, the costs of training competent technical staff and establishing technical services in the provinces will be covered through the national health grants programme.

Exclusions

Although the Act is broad in scope, there are several important exclusions. For example capital costs, including capital depreciation and interest on debt, are excluded from the definition of operating costs. It should be noted, however, that this exclusion relates only to the value of land, buildings or physical plant; items such as movable and non-movable technical equipment required by a hospital will be regarded as a sharable cost.

Moreover, the exclusion of capital costs from the calculation of sharable costs under the hospital insurance programme does not affect the role of the federal Government in assisting the provinces in this field. In fact, the amount of the grants provided for hospital construction through the national health grants programme were substantially increased just prior to the commencement of the hospital insurance programme.

Other important exclusions from the Act concern the types of institutions which may be considered as participating hospitals. Broadly speaking there are three types of institutions which are specifically placed outside the programme. These are tuberculosis hospitals or sanatoria; hospitals or institutions for the mentally ill; and nursing homes for the aged or other institutions for providing custodial care.

With regard to mental and tuberculosis hospitals, these receive financial support from the provinces, substantially assisted by federal funds provided through grants for mental health and tuberculosis control, and care in these institutions is therefore provided virtually without cost to the residents of the province. Since the purpose of the hospital insurance programme was stated to be the provision of an orderly method of prepaying hospital costs, on the one hand, and since residents of the province are not financially deterred from acquiring necessary hospital care in tuberculosis sanatoria and mental hospitals, on the other hand, it was considered that the need in these particular areas for insured services did not apply. Furthermore, the federal Government is continuing to assist the provinces in the support of these institutions through the existing grants.

With regard to nursing homes, it was generally recognised that in present circumstances the controls of expenditures and utilisation which are possible in hospitals would not be possible

in nursing homes. In addition, the nursing homes were not, for the most part, in a position to provide the basic in-patient services which, under the Act, must be made available to insured persons. Moreover, so far as institutions for custodial care are concerned it was considered that, broadly speaking, these could more properly be described as welfare institutions rather than institutions providing health care.

Hospitals Covered by the Act

The Act does not contain any precise definition of a hospital. For an institution to qualify as a participating hospital, however, it is required to be licensed, approved or designated by the province in accordance with the relevant law of the province. Whether a hospital meets the other requirements of the Act depends on whether it is in a position to provide the in-patient services that must be provided as insured services and, in addition, maintains an admission policy which removes the possibility of any element of custodial care.

No line of demarcation is drawn between general hospitals, chronic hospitals or convalescent hospitals.

The Act also includes in the definition of "hospital" what is described as another " facility ", by which is meant an institution providing certain specialised types of diagnostic services, such as laboratories and radiological centres.

The relevant provincial law must provide that hospitals will offer insured services upon uniform terms and conditions to residents of the province, in accordance with the conditions specified in the federal legislation. The provincial law is also required to provide for the payment of amounts to hospitals in respect of the cost of insured services, to specify the manner in which payments will be made for insured services for eligible residents of the province in hospitals situated outside the province, and to provide for payments to be made to hospitals owned by the federal Government. It is also a requirement of the federal Act that the provincial law must authorise the province to enter into an agreement.

Agreements with the Provinces

Agreements are the instruments through which the contractual arrangements are made with the provinces. The federal Act empowers the Minister of National Health and Welfare to enter into an agreement for the payment of federal contributions, and specifying the matters with respect to which each of the parties is required to agree and covenant. In so far as the federal Govern-

ment is concerned, an undertaking must be included to pay the province the amounts of money which the Act authorises. The federal Government is also required to supply to the province reports and records of the calculation of the costs. The reason for this requirement will become more obvious when the methods for the calculation of the federal contribution are examined.

The provincial undertakings include those matters for which the province is required to make provision in its law. In addition, the province must make such arrangements as are necessary to ensure that adequate standards are maintained in the hospitals and to maintain adequate records and accounts.

Since the federal Government does not propose to interfere in any way with the administration of the provincial hospital insurance programmes, it must be assured that the arrangements in the province are adequate to provide the necessary controls both with regard to the quality of care and utilisation and with regard to the financial aspects of the programme. For this reason each province is required to attach to the agreement a detailed scheme for administration.

Broadly speaking the scheme for administration must describe in detail the provisions of the provincial programme, including the arrangements by which residents of the province become insured persons ; the arrangements by which the insured services are made available to insured persons ; the methods of financing the provincial share of costs ; the arrangements for the payment of amounts for insured services ; and, in fact, all of the methods the province proposes to utilise for the fulfilment of its undertakings in relation to the agreement and federal legislation.

A particularly important section of the scheme for administration is that pertaining to the provincial methods for maintaining adequate standards, including the effective utilisation of in-patient and out-patient services. Before entering into an agreement with a province the federal Government must be satisfied that the methods described in the scheme for administration are adequate to protect the interests of the federal Government, as well as the provincial government, in providing the essential quality and quantity controls.

Provisions regarding Residence

In defining residents of the province the federal Act stipulates that no specified period of residence may be required as a condition precedent to the establishment of residence. In so far as federal legislation is concerned, " residents of the province " means persons legally entitled to remain in Canada, who make their home and are

ordinarily present in the province, but does not include tourists, transients or visitors. It should be noted that Canadian citizenship is not a requirement for eligibility.

At the request of the provinces the law officers of the Crown were requested to give an interpretation of this section. Their interpretation was to the effect that a qualifying period for benefits would not be inconsistent with the requirement that no period could be stipulated in connection with residence. In consequence some provinces proposed to incorporate such provisions in their legislation. In order to ensure that residents of a participating province who change their place of residence to another participating province should not suffer any break in insurance coverage, federal regulations were enacted. These regulations provide that an insured person who moves to another province may be deemed to continue to be a resident of the original province for a period of time not exceeding three months. The decision as to whether or not a person is, in fact, a bona fide resident of the province, rests with the provincial authority.

As mentioned earlier, the provinces are also required under the Act to make provision for insurance coverage with respect to residents who are away from their home province. The federal law makes no specifications as to the nature of these provisions and they may therefore differ from province to province. However, the participating provinces are working out reciprocal arrangements with regard to out-of-province benefits for insured residents.

Recovery of Costs from Insured Persons Otherwise Covered

The federal Act places certain limitations on the insured services which may be provided to insured persons in certain circumstances. These relate to insured persons who are eligible for and entitled to the same type of services under the terms of other legislation. For example, insured persons eligible for and entitled to receive in-patient services under the terms of a provincial workmen's compensation law would not be entitled to insured services under the provincial hospital insurance legislation. In this way, the benefits provided under existing legislation are maintained, while duplication of coverage is eliminated.

The Act also requires provinces to make arrangements for the recovery of the cost of insured services furnished to an insured person who is legally entitled to recover the cost from some other person. These are third party liability cases, in which the insured person has a legal right to the payment of certain costs. The legislation does not prescribe the methods by which the provinces must make these provisions, other than stating that all proper and

reasonable steps to effect such recoveries should be made by subrogation or otherwise. A variety of methods may be used by the provinces in this regard.

Federal Contributions

The amount of the federal contribution, or grant, is calculated on a formula laid down in the Act. This formula has been designed so as to make the percentage of the federal contribution higher in provinces where costs are lower than the national costs. In order to achieve this end, the annual federal contribution is based on a figure obtained by calculating the aggregate, in the relevant year, of 25 per cent. of the cost per head of in-patient services in the whole country, and 25 per cent. of the cost per head of in-patient services in the province (from which is deducted the amount of authorised charges per head), multiplied by the average of the number of persons in the province who were eligible for and entitled to insured services at the end of each month in the given year.

It will be noted that one of the essential ingredients of this formula is the average for the year of the number of persons in the province who are eligible for and entitled to insured services. The methods by which this average may be obtained will depend upon the methods used in the province for insuring residents. In a province where no premium method applies and where coverage is universal, the average can be based upon the population of the province. A definition of population has been set out in the regulations.

In provinces in which the premium method applies, the average number of persons will again depend on the administrative methods of registration. In most provinces the premiums are related to single persons and family groups only ; no actual head count is made. In these circumstances methods have had to be devised to calculate the size of the average family in the population.

Another ingredient in the formula is the so-called authorised charge. This refers to deterrent charges or co-insurance charges which the provinces are free to impose, provided the amounts are specified in the agreement to ensure that they are reasonable. These must, of course, apply to all residents of the province.

The cost per head of in-patient services referred to in the formula are, of course, only sharable costs. It will be recalled that in discussing certain exclusions from the Act, mention was made of the exclusion of certain capital costs with regard to land, buildings or physical plant.

Obviously, in order to calculate both the national and the provincial cost per head of in-patient services, it is essential to

obtain precise cost reports, including precise breakdowns of the financial data contained in each.

The methods for calculating federal payments to the provinces will be uniform, and will be based on uniform reports of expenditures; in certain cases additional data will be required, in the light of individual provincial differences.

The provincial authority in all the provinces will, in the first instance, be responsible for the examination of individual hospital budgets. At the end of each year the provincial authority will examine the expenditures of each hospital in relation to the budget, and will approve or disapprove of certain expenditures. Obviously, the federal Government will not share in expenditures which have not been approved by the province. In order to facilitate the co-operative effort of the two governments, federal auditors located in the provinces will work closely with the provincial authority in the examination of the costs involved. Under the terms of the Act the provinces are required to maintain adequate records and accounts respecting the cost of in-patient and out-patient services and to permit the federal Government to have access to these and to audit them.

The Act also permits the federal Government to make advances to the provinces in order to enable them to maintain payments for insured services, without waiting until the final calculation of the federal contribution is made, after the end of the year.

In-patient Services Provided by the Act

The insured services for which provision is made in the Act are described as in-patient and out-patient services, diagnostic services being included in both. In fact, both lists of services are identical, the difference being in the requirement that, in order to participate, a province is required to provide in-patient services; out-patient services are wholly optional.

Accommodation and Meals.

The first of the in-patient services which must be made available is, of course, accommodation and meals. The insurance programme is limited to coverage for standard or public ward accommodation only. In so far as private or semi-private accommodation is concerned, insured persons will themselves be responsible for that part of the charge which exceeds the standard rate in the particular hospital concerned. It is anticipated that, in some provinces, voluntary insurance will still be available for persons wishing to take out insurance for preferred accommodation. In all circumstances the hospital insurance programme will not include this type of care.

Necessary Nursing Service.

The second in-patient service is necessary nursing. Insured services must include routine nursing service but not private nursing service in the usual sense. However, where additional nursing service is medically necessary because of the condition of the patient, special nursing services will be deemed to be insured if properly prescribed and approved, as considered necessary by the province.

Diagnostic Procedures.

The third in-patient service which must be available relates to diagnostic procedures. It includes laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis or treatment of any injury, illness or disability. It should be noted that diagnostic services are specifically mentioned in the title of the Act itself. It is generally considered that basic diagnostic procedures form an essential part of good hospital care. Since emphasis has been placed on the quality of service in this programme, it was considered essential to include in the Act the stipulation that these basic diagnostic procedures should form an integral part of insured services.

In including diagnostic procedures, however, it was not intended to deviate from the basic principle that the Act does not encompass services that would be considered to be more appropriate to a medical care programme. Consequently, clinical procedures related to diagnosis will not be considered as insured benefits. It is essential, therefore, to differentiate between the laboratory, radiological and other diagnostic procedures provided to the attending physician by the hospital, and the clinical procedures carried out by the physician himself in order to establish a diagnosis. Although payment to physicians for carrying out clinical procedures will not be covered, the hospital facilities required for these procedures, the examination of any specimens obtained by these procedures, and any necessary reports on specimens, will be insured benefits.

At the same time it has been considered that the value of certain diagnostic procedures may depend on the qualified interpretations given to them. For this reason the actual interpretations of the procedures are considered to be insured services, when these are necessary.

No fixed method is laid down in the Act by which the arrangements for the interpretations of diagnostic procedures should be made. The requirements of the Act are satisfied, however, as long

as insured persons have made available to them the diagnostic procedures and necessary interpretations to which reference is made in this part of the legislation.

While the provinces must provide as an insured service the basic diagnostic procedures commonly made available in hospitals, they are also free to include additional diagnostic procedures.

Pharmaceutical Services.

The fourth in-patient service includes drugs, biologicals and related preparations as provided in an agreement, when administered in a hospital. The drugs which a province proposes to provide as an insured service may vary from province to province. Flexibility in this regard is permitted by the Act.

The drugs may not be provided for patients to take home with them. In addition to the primary consideration that the insurance programme is intended to cover hospital care only, it was also considered that while the cost of drugs administered in the hospital would be amenable to adequate financial controls, the cost of drugs provided to patients for care following discharge from hospital could not adequately be controlled in the present programme.

Operating Room, etc.

The fifth insured in-patient service which must be made available is the use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies. Generally hospitals are accustomed to making a charge for the use of these facilities, quite apart from the charge made to the patient with respect to the fees of the surgeon or the anaesthetist. Here again, it must be recalled that this programme is geared to provide hospital care as opposed to medical care and, consequently, the costs of the facilities, including the equipment and supplies, are insured services, while the fees of the surgeon and the anaesthetist do not come within the compass of the Act.

In addition to the supplies required to be provided in connection with the use of the facilities mentioned above, routine surgical supplies which may be required following an operation or in other circumstances in the course of hospital care are included as insured services.

Radiotherapy and Physiotherapy.

The Act also requires that where available, radiotherapy and physiotherapy facilities must be included. The words " where available " have been used advisedly in the Act, since these facilities are not available in all hospitals. However, in those hospitals in

which radiotherapy and physiotherapy facilities exist, they must be included as insured services.

Radiotherapy facilities include equipment and facilities for superficial and deep X-ray therapy, radium, cobalt bomb and other radioactive material. Physiotherapy facilities include all types of facilities required for sound care. The services provided to patients by physiotherapists employed by the hospital are included, along with the services of other hospital personnel.

Services of Hospital Personnel.

With regard to the services of hospital personnel, it has been essential to ensure that the traditional services provided in a hospital by physicians, in other words medical care services, should be separated from the services provided by other personnel. Services rendered to patients in the hospital by physicians are not deemed to be insured services since these are medical care services. Although insured services may include the services rendered by persons who receive remuneration from the hospital, the fact that a physician may receive such remuneration for the purpose of rendering medical care is not considered to alter the consideration that these services are not hospital services. Thus, the services rendered to patients by general practitioners, surgeons and specialists, including anaesthetists, are not insured services under the Act.

On the other hand, in the provision of hospital care there are a number of duties which are carried out by physicians such as those of hospital administration and the medical direction of such hospital programmes as rehabilitation, geriatric or cancer programmes. To the extent that a physician is appointed and remunerated by the hospital in connection with such duties his services are insured services. The services provided by interns and residents are considered to be integral parts of hospital care; their remuneration may therefore be included in calculating the operating hospital costs of providing insured services.

Physicians may also be reimbursed through the insurance programme for the interpretation of diagnostic procedures.

With the exceptions relating to certain services of physicians, the services of other hospital personnel are included in the insurance programme. These would include such personnel as physiotherapists, occupational therapists, radiotherapy technicians and social workers.

Other Services.

In defining in-patient services, the federal Act allows further flexibility for the inclusion of other services which a province may

wish to include as insured. Rehabilitation or cancer programmes are examples of the type of services which might be included. The main limitation in this regard is that the service must be made uniformly available to all residents of the province.

In summing up the provisions of the Act in so far as they relate to in-patient services, it will be noted that these will be substantially the same in all provinces for the most part. It may be anticipated, however, that other services will be added in some provinces and, to this extent only, variations may be found from one province to another.

The Act is more flexible in the area of out-patient services. The provinces have the option of initiating out-patient services at any rate which they deem to be satisfactory to meet their own needs. The list of out-patient services with respect to which the federal Government may contribute is the same as that described above in connection with in-patient services. Of these the province may choose one; it may choose two, it may choose all or it may choose none. The principle underlying the provision of out-patient services in the Act is to enable the provinces more adequately to control the utilisation of in-patient services by offering the alternative of out-patient services and to provide a broader health programme.

It is obvious that, in the initial stages at least, considerable varieties will be found in the extent of out-patient services in provincial insurance programmes.

Emerging Patterns in Provincial Hospital Insurance Programmes

It has already been noted that by 1 July 1958, when the federal Government commenced making contributions under the Hospital Insurance and Diagnostic Services Act, six provinces had concluded agreements with the federal Government. Three additional provinces, Nova Scotia, New Brunswick and Prince Edward Island, had also indicated their intention to conclude similar agreements, so as to inaugurate programmes in those provinces during 1959. As already mentioned Nova Scotia subsequently signed an agreement with the federal Government on 16 October 1958. The following discussion relates only to the seven provinces which have already concluded agreements.

It will be clear from the discussion of the requirements of the federal Act that, in a number of areas, all the provincial programmes contain certain common features. These relate to the minimum requirements of the federal Act generally and to the requirement

that insured services must be available to all residents of the provinces on uniform terms and conditions. It will also be clear, however, that in matters where the federal Act leaves to the provinces freedom of choice (e.g. methods of financing the provincial share of costs, scope of the programme above the basic minimum required by the federal law, out-of-province benefits, and methods of provincial administration) varying patterns of developments are bound to emerge.

The provinces have designated a variety of authorities to administer the provincial programmes. In some instances, the Department of Health has been named ; in others a separate body has been established for the purpose. In all instances, however, the Minister of Health reports to the provincial legislature.

In Newfoundland and Saskatchewan the authority is vested in the Department of Health with the Deputy Ministers as the responsible officers. In Alberta a director has been given the responsibility within the Department of Health for the programme, and he reports directly to the Minister. In British Columbia a commission within the Department administers the programme. In Manitoba a commissioner is vested with the responsibility of administration, and in Ontario and Nova Scotia a separate commission has been established, unrelated to the Department of Health.

The methods which the provinces have chosen for financing hospital insurance may best be described as a combination of individual premiums, augmented by general revenues ; a combination of a sales tax or property tax, combined with general revenue ; or general revenue only.

In British Columbia a sales tax is imposed and in Alberta the programme is financed through imposition of a property tax. In Newfoundland the programme is financed out of consolidated revenue.

In Manitoba and in Ontario the individual premium method is used, while in Saskatchewan the hospitalisation tax, similar to the premium, is supplemented by general revenue. Nova Scotia levies a special hospital tax.

In five provinces a qualifying period for benefits has been adopted. In British Columbia, Saskatchewan, Ontario and Nova Scotia this period is three months, while in Manitoba it is one month.

The provisions of the federal Act permitting the levy of authorised charges have been used only in the provinces of British Columbia and Alberta.

In so far as out-of-province benefits are concerned, all provinces make these available on an emergency basis. In Ontario emergency

hospitalisation is the only out-of-province benefit. However, the other provinces have included additional circumstances in which these benefits are payable for residents of the province.

With regard to the scope of services, all of the provinces, of course, provide the basic in-patient services. The Ontario provincial programme also includes mental and tuberculosis hospitals, which are excluded from the federal-provincial programme.

The out-patient services for which provision is made by the provinces include emergency services within a prescribed period following an accident in British Columbia, Saskatchewan, Manitoba, Ontario and Nova Scotia. In Saskatchewan, however, additional out-patient services are provided for the pathological examination of tissue, and in Nova Scotia specified laboratory and radiological examinations, and radiotherapy and physiotherapy services are also provided, where available. In Newfoundland a broad programme of selected diagnostic procedures is included.

* * *

While it is too early to estimate the impact of the hospital insurance programmes in Canada, there can be no doubt that they will have a great effect on the quality of hospital care throughout the country; they will remove from individual hospitals the overwhelming burden of operating deficits; they will remove from residents of the provinces all financial obstacles to hospital care and will ensure that no Canadian resident need face economic disaster resulting from unforeseen and ever-increasing hospital costs. Every element in the community stands to benefit including municipal governments, hospitals, the medical profession and consumers, to mention only a few. The road ahead may not be free of difficulty but there is little doubt that the direction is firmly set.