1, 1972 all provinces and territories had entered the federal program. Under the Act federal government contributions to the provinces are based on half of the per capita cost of the insured services of the national program furnished under the plans of all provinces, excluding administration, multiplied by the number of insured persons in each province. The minimum criteria to be met are described in the following paragraphs.

Comprehensive coverage must be provided for all medically required services rendered by a physician or surgeon. There can be no dollar limit or exclusion except on the ground that the service was not medically required. The federal program includes not only those services that have been traditionally covered as benefits to a greater or lesser extent by the health insurance industry, but also those preventive and curative services that have been traditionally covered through the public sector in each province, such as medical care of patients in mental and tuberculosis hospitals and services of a preventive nature provided to individuals by physicians in public health agencies.

The plan must be universally available to all eligible residents on equal terms and conditions and cover at least 95% of the total eligible provincial population (in fact the plans cover over 99% of those eligible). This "uniform terms and conditions" clause is intended to ensure that all residents have access to coverage and to prevent discrimination in premiums on account of previous health, age, non-membership in a group, or other considerations. If a premium system of financing is selected, subsidization in whole or in part for low-income groups is permitted. It has been left to the individual province to determine whether its residents should be insured on a voluntary or compulsory basis. Utilization charges at the time of service are not precluded by the federal legislation if they do not impede, either by their amount or by the manner of their application, reasonable access to necessary medical care, particularly for low-income groups. The plan must provide portability of benefit coverage when the insured resident who has paid his premiums, if any, is temporarily absent from the province and when moving residence to another participating province. The provincial medical care insurance plan must be administered on a non-profit basis by a public authority that is accountable to the provincial government for its financial transactions. It is permissible for provinces to assign certain administrative functions to private agencies.

These criteria leave substantial flexibility with each province to determine its own administrative arrangements for the operation of its medical care insurance plan and to choose the way in which it will be financed, i.e. through premiums, sales tax, other provincial revenues, or by a combination of methods. Federal contributions to the provinces under this program totalled $678 million in the fiscal year 1973-74.

Provincial programs providing health care services (apart from those already insured under the Medical Care Act) for welfare recipients establishing eligibility on the basis of financial need are supported financially by the federal program known as the Canada Assistance Plan. This program provides for federal payment of half the cost of personal health care services, as well as welfare services. The provinces are free to make available a wide range of health care benefits.

**Hospital insurance.** Provincial hospital insurance programs, operating in all provinces and territories since 1961, cover 99% of the population of Canada. Under the Hospital Insurance and Diagnostic Services Act of 1957, the federal government shares with the provinces the cost of providing specified hospital services to patients insured by these programs. Specifically excluded are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, and institutions providing custodial care, such as nursing homes and homes for the aged. The methods of administering and financing the program in each province and the provision of services above the stipulated minimum required by the Act are left to the province.

Insured in-patient services must include accommodation, meals, necessary nursing service, diagnostic procedures, most pharmaceuticals, the use of operating rooms, case rooms, anaesthesia facilities, and radiotherapy and physiotherapy if available. Similar out-patient services may be included in provincial plans and authorized for contribution under the Act. All provinces include some out-patient services, and most cover a fairly comprehensive range. The Government of Canada contributes to each province out of the Consolidated Revenue Fund the sum of 25% of the per capita cost of in-patient services in Canada and 25% of the per capita cost of in-patient services in the province, multiplied by the average number of insured persons in that province. Thus, the total contribution is about 50% of the sharable cost for all