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 and cover at least 95% of the total eligible provincial population (in fact the plans cover over 99%). A uniform terms and conditions clause is intended to ensure that all residents have access to coverage and to prevent discrimination in premiums because 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 applications, reasonable access to necessary medical care, particularly for low-income groups. The plan must provide portability of benefit coverage when the insured resident 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 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, that is, through premiums, sales tax, other provincial revenues, or by combination of methods.

Federal financial contributions to the provinces prior to April 1977 were based on half of the national per capita cost of the insured services of the national program, excluding administration, multiplied by the number of insured persons in each province. A 1976 amendment to the act established a ceiling of 113% on the per capita increase of the federal contribution for the fiscal year 1976-77.

Hospital insurance. The Hospital Insurance and Diagnostic Services Act which took effect on July 1, 1958, was designed to make available to all eligible residents a wide range of hospital and diagnostic services, subject to medical necessity, at little or no direct cost to the patient, thereby removing financial barriers to adequate care which existed for many residents prior to the introduction of the program.

Under the act, contributions by the federal government are authorized for programs administered by the provinces providing hospital insurance and laboratory and other services in aid of diagnosis.

The program incorporates five general principles: comprehensiveness of services; universal availability of coverage to all eligible residents; no barriers to reasonable accessibility of care; portability of benefits; and public administration of the provincial programs.

Facilities covered under the program include general, rehabilitation (convalescent), and extended care (chronic) hospitals together with specialized hospitals such as those providing maternity or pediatric care. The program may also cover diagnostic services in non-hospital facilities. Specifically excluded under the program are tuberculosis hospitals and sanatoria, hospitals or institutions for the mentally ill, and nursing homes, homes for the aged, infirmaries or other institutions whose purpose is to provide custodial care.

In development of hospital insurance legislation, existing traditions were maintained as far as possible. The pattern of hospital ownership and operation that existed before the act came into force was retained and provincial autonomy was not infringed. Consequently, even 20 years later, almost 90% of the beds covered by hospital insurance are located in facilities owned and operated by voluntary bodies and municipalities. The policy of provincial autonomy allows each province to decide on methods of administration and of financing its share of program costs while still ensuring a basic uniformity of coverage throughout the country. All provinces and territories have participated since 1961. Details of services provided are in Section 5.5.1, Provincial health insurance plans.