Hospital insurance. The Hospital Insurance and Diagnostic Services Act, which took effect in July 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 previously for many residents.

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.

There are 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 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 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, more than 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 are provided in Section 5.3, Summary of provincial plans.

Insured in-patient services must include accommodation, meals, necessary nursing service, diagnostic procedures, most pharmaceuticals, the use of operating rooms, case rooms, anesthesia 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 a fairly comprehensive range of out-patient services.

The individual may select the hospital in which he will be treated provided his physician has admitting privileges, and the only limit to the duration of insured services is the extent of medical necessity. During a temporary absence, coverage is portable anywhere in the world for in-patient services, and in the case of most provinces for out-patient services also, although such benefits are subject to provincially regulated maxima for rates of payment and length of hospital stay.

Provinces may include additional benefits in their plans without affecting the federal-provincial agreements. Some provide additional services such as nursing home care. These additional services are not cost-shared under hospital insurance.

The principles of universal availability of benefits to all eligible residents and portability of benefits are reflected in provisions of each provincial program. Although provincial plans in general stipulate a waiting period of three months, coverage may continue from the province of previous residence. First-day coverage is generally provided for the newborn, immigrants, and certain other categories of persons without prior coverage in other provinces. A health insurance supplementary fund has been established for residents who have been unable to obtain coverage or who have lost coverage through no fault of their own.

Provinces may raise their portion of insurable costs as they wish, provided that access to services is not impaired. All provinces finance their share in whole or part from general revenue.

Medical care. Before the establishment of government-administered medical insurance, voluntary prepayment arrangements to cover the cost of physicians' services had developed in public and private sectors. By the end of 1968, basic medical or surgical coverage, or both, were being provided to about 17.2 million Canadians, 82% of the population. Voluntary plans in the private sector covered about 10.9 million, or 52%,