The individual may select the hospital in which he or she is treated provided the physician has admitting privileges. During a temporary absence, coverage is portable anywhere in the world for emergency in-patient services, and in most provinces for out-patient services also. Benefits are subject to provincially regulated maxima for rates of payment, length of hospital stay and, in cases of non-emergency services, prior approval by the provincial plan.

The principles of availability and portability of benefits are reflected in provisions of each provincial insurance plan. Although the plans in general stipulate a waiting period of three months when a person moves from one province to another, coverage will 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.

Medical care insurance. The Medical Care Act, 1966-67 authorized the federal government to make payments to provinces which operate medical care insurance plans meeting certain minimum criteria. Federal contributions became payable in July 1968. By early 1972, all 10 provinces and both northern territories had met the federal criteria. Since then, virtually the entire eligible population has been insured for all medically required services of physicians, plus a limited range of surgical-dental services in hospitals. Physicians' services such as examinations for life insurance which are not medically required are not covered. Also excluded are services to treat work-related conditions already covered by worker compensation or other federal legislation.

There can be no dollar limit or exclusion except when a service is not medically required. The federal program includes services traditionally covered as benefits by the health insurance industry, and also preventive and curative services traditionally covered through the public sector in each province, such as medical care of patients in mental and tuberculosis hospitals and preventive services provided to individuals by physicians in public health agencies.

A uniform terms and conditions clause in the act is intended to ensure that all residents have unimpeded access to insured services. This condition prevents discrimination on the basis of 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. The individual province may determine whether insurance will be voluntary or compulsory.

Under the Canada Health Act, utilization charges at the time of service are discouraged as it is believed that they impede, either by their amount or by the manner of their application, reasonable access to necessary medical care, particularly for low-income groups.

Provincial and territorial plans. Methods of organizing, financing and administering health insurance plans vary. In some provinces, hospital and medical care plans are administered directly by provincial departments of health. In others, the plans are under separate public agencies reporting directly to the responsible provincial minister. Some provinces have one plan administered by the department of health and the other by a public agency.

Until 1977, the federal government reimbursed the provinces for about 50% of approved expenditures for services provided under the provincial hospital and medical care insurance plans. With the introduction of established programs financing legislation in April 1977, the federal contributions to the provinces were no longer tied to provincial spending but to the average rate of growth in gross national product and population changes. Contributions took the form of a cash transfer plus a transfer of tax and associated equalization payments to the provinces. Provinces must continue to meet criteria under federal legislation to be eligible for financing. Per capita cash contributions were also made to the provinces toward the cost of certain extended health care services, such as nursing homes, and adult residential, ambulatory and home care services. Methods of administering and financing these programs and the provision of associated services are left to the provinces.

Each province is free to determine how its share of the cost will be financed. Most provinces finance their share from general revenue, while Ontario, Alberta, British Columbia and Yukon impose premiums. Premium assistance is available in these provinces for certain categories of residents with limited income, and premium exemption is provided in Alberta and Ontario for most residents over 65 years of age.

Arrangements likewise vary across provinces for delivery of medical services and payment of physicians. Most physicians are paid on a