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MEDICAL CARE AND SERVICES IN CANADA

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ABSTRACT

The paper traces the history of government-sponsored hospital and medical care schemes from their beginnings in the Prairie Provinces prior to World War I to the present day. Particular attention is paid to the "Health Charter for Canadians" contained in the Hall commission report and to the two relevant federal acts. A summary of the coverages and a history of the financing are provided. The sources of increasing costs are analyzed, and the future outlook is examined.

I. HISTORY

The earliest known contract for medical care in Canada was entered into in Montreal on March 3, 1665, by a master surgeon and seventeen families [1]. It was successful, and other families joined the plan in subsequent years. Other such contracts followed in French-speaking Canada. In the pioneer communities of the Maritimes and Ontario, responsibility for the sick and disabled fell on family and neighbors. As communities in all parts of Canada grew, charitable and religious organizations established hospital facilities, primarily for the care of the destitute and those without a family.

Accordingly, when the British North America Act was framed in the 1860s, it was not surprising to find that section 92 specified medical care as a provincial responsibility, as follows [2]:

> 92. In each Province the Legislature may exclusively make Laws in relation to Matters within the classes of subject next here-in-after enumerated; that is to say, —
>
> . . . . . .
>
> 7. The Establishment, Maintenance and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

In practice, the burden of such institutions fell on municipalities.

By the turn of the century, company-sponsored group insurance plans were well known (although often illegal) in the larger logging and mining

communities. From these plans grew the Blue Cross type hospital-sponsored prepayment plans and the commercial insurance contracts.

Public health had its beginnings on the Prairies (primarily in Saskatchewan) around the time of the First World War, when many community-owned and -financed hospitals were established. At the same time, some communities entered into contracts with physicians providing a retainer or a guaranteed minimum income in return for basic medical care for the community.

Despite considerable interest in some quarters, the next major step in the evolution of health care in Canada did not come until after the Second World War.

II. NATIONAL HEALTH GRANTS PROGRAMME

Recognizing the constitutional limitations of its authority but wishing to expand the availability of health care facilities in Canada, the federal government established the National Health Grants Programme in 1948. This program, which was to pay out over $825 million before it was integrated with other programs during the period 1969–72, had as its objectives (1) the construction of hospitals; (2) the upgrading of laboratory and radiological services; (3) the establishment and development of training facilities for certain types of health workers; (4) the training of health workers; (5) the development and maintenance of programs for the detection and treatment of cancer, mental illness, poliomyelitis, and tuberculosis; (6) the improvement of health services for mothers and children; and (7) the improvement of municipal public health services.

This program did a great deal to improve health care facilities. Not only were needed hospitals established or expanded, but cobalt treatment facilities for cancer were established in all major urban centers. One important by-product was a piece of research that made possible the development of the poliomyelitis vaccines.

III. EARLY PROVINCIAL HOSPITALIZATION PLANS

The first provincially sponsored hospital care program in Canada was introduced by the Alberta government in 1944 to provide maternity care.

In 1945, Saskatchewan introduced a comprehensive provincially funded program for the aged and indigent population. In 1947 a compulsory hospitalization scheme was enacted, providing basic hospital care for all residents of the province. Originally, this compulsory scheme was funded by a tax of $5 per person (to a maximum of $30 per family) per year plus provincial grants to cover specialized programs for cancer and other illnesses. Almost immediately, further provincial funding (in the form of a

50 percent increase in the provincial sales tax) was required to meet deficits.

By 1954, similar programs had been established in Alberta, British Columbia, and Newfoundland.

IV. HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT, 1957

In 1957 the federal government introduced the Hospital Insurance and Diagnostic Services Act for the purpose of extending compulsory basic hospital care to all residents of Canada by July 1, 1961 [3]. It contained the following provisions:

1. The program was to be administered by the provinces;
2. The coverage was to be universally available;
3. The provinces were to license, inspect, and supervise the standards of hospitals;
4. The federal government would supply 50 percent of the total financing;
5. For in-hospital patients, the provinces were required to provide at least (*a*) accommodation at the public ward level, (*b*) necessary nursing services, (*c*) diagnostic procedures, (*d*) drugs, (*e*) operating and anesthetic facilities, and (*f*) physiotherapy and radiotherapy.
6. For outpatients, the provinces had a choice of what services were to be provided. The exact services varied from province to province, but generally included minor surgical procedures, psychotherapy, physiotherapy and radiotherapy, and emergency care for injuries received as the result of an accident.
7. Certain costs were not to be covered, such as (*a*) capital costs of all hospitals, (*b*) operating costs for tuberculosis sanatoriums and mental hospitals, (*c*) nursing homes, homes for the aged, and facilities for custodial care, (*d*) costs covered by workmen's compensation, (*e*) costs for people covered by other statutory hospitalization schemes (e.g., armed services personnel, Royal Canadian Mounted Police, and inmates of the federal penitentiaries), (*f*) extra costs of semiprivate and private room care, (*g*) provincial administration costs, and (*h*) third-party liabilities arising from accidents and other similar events (the act specifically requires the provinces to be diligent in collecting these latter amounts).

V. EVOLUTION OF GOVERNMENT-OPERATED MEDICAL INSURANCE

Once hospital care services had been assumed by the government, attention focused on the provision of physicians' services. Private industry had made major strides in increasing coverage during the 1950s. For example, the membership in Blue Cross plans more than tripled. By 1961, an estimated 11.6 million Canadians, or 65 percent of the population, had some form of insurance for health services. This figure is more impressive when it is remembered that the private financing mechanism has difficulty

in coping with the unemployed, the permanently disabled, and the aged, groups that represent about 20 percent of the population.

Nevertheless, government activity went forward on three fronts. First, in 1962 the Saskatchewan government introduced a comprehensive program of medical care. Unfortunately, the terms were not acceptable to the majority of physicians in the province, and for a period of some weeks they refused to perform any services other than emergency ones. A compromise was eventually reached and the plan introduced.

Second, in 1963 the Alberta government introduced a plan for subsidizing coverage of the Blue Cross type for those unable to afford the premiums. This type of plan did have the backing of the physicians and private industry.

Third, in 1961 the federal government appointed a royal commission headed by Chief Justice Emmet M. Hall of the Supreme Court to inquire into all aspects of the provision and financing of health services in Canada. In 1964 this royal commission produced a report containing a proposed "Health Charter" for Canadians and some two hundred specific recommendations.

VI. THE HEALTH CHARTER FOR CANADIANS

The proposed Health Charter contained in the Hall commission report read as follows [4]:

> The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to a national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian people.
>
> IMPLEMENTED in accordance with Canada's evolving constitutional arrangements;
>
> BASED upon freedom of choice, and free and self-governing professions and institutions;
>
> FINANCED through prepayment arrangement;
>
> ACCOMPLISHED through the full co-operation of the general public, the health professions, voluntary agencies, all political parties, and governments, federal, provincial and municipal;
>
> DIRECTED towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being.

1. "Comprehensive" includes all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide.
2. "Universal" means that adequate health services should be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors.

3. "Health Services Programme" consists of legislative enactments and administrative arrangements to organize comprehensive universal health care including prepayment arrangements for financing personal health services introduced in stages. Such a programme will provide complete health care with due regard to human factors and the spiritual, social, economic and regional forces intrinsic in the Canadian way of life.
4. "Canada's evolving constitutional arrangements" take into account the primary jurisdiction of provincial governments with respect to health matters including staging, scope and administration of health services, as well as the necessity for federal financial assistance to enable each of the provinces to implement a comprehensive, universal Health Services Programme.
5. "Freedom of choice" means the right of a patient to select his physician or dentist and the right of the practitioner to accept or not to accept a patient except in emergency or on humanitarian grounds.
6. "Free and self-governing professions" means the right of members of health professions to practise within the law, to free choice of location and type of practice, and to professional self-government. With respect to "institutions" it means academic freedom to medical, dental and other professional schools, and for hospitals, freedom from political control or domination and encouragement of administration at the local level.
7. "Prepayment arrangements" means (*a*) financing within a province by means of premiums, subsidized premiums, sales or other taxes, supplements from provincial general revenues and (*b*) by federal grants taking into account provincial fiscal need.
8. "Full co-operation" means
   (*a*) the responsibility of the individual to observe good health practices and to use available health services prudently;
   (*b*) the responsibility of the individual to allocate a reasonable share of his income (by way of taxes or premiums or both) for health purposes;
   (*c*) the methods of remuneration of health personnel—fee-for-service, salary or other arrangements—and the rates thereof should be as agreed upon by the professional associations and the administrative agencies and not by arbitrary decision, with an appeal procedure in the event of inability to agree;
   (*d*) the maintenance of the close relationship between those who provide and those who receive health services, safeguarding the confidential nature of that relationship;
   (*e*) the provision of education facilities of the highest standards and the removal of financial barriers to education and training to enable all those capable and desirous of so doing to pursue health services careers;
   (*f*) the adequate support of health research and its application;
   (*g*) the necessity of retaining and developing further the indispensable work of voluntary agencies in the health care field;
   (*h*) the efforts to improve the quality and availability of health services must be supplemented by a wide range of other measures concerned with such

matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism and drug addiction;

(*i*) the development of representative health planning agencies at all levels of government, federal, provincial, regional and municipal, and integration of health planning.

A few sentences from the next page of the report help to place the charter in perspective:

We are opposed to state medicine, a system in which all of health services are functionaries under the control of the state. We recommend a course of action based upon social principle and the co-operation and participation of society as a whole in order to achieve the best possible health care for all Canadians, an aim that Canadians by their individual efforts cannot attain.

Such action we insist is based upon freedom of choice on the part of the citizen, and on services provided by free and self-governing professions. By safeguarding these elements, so vital to a free society, we believe we have avoided the difficulties inherent in a programme which attempts to nationalize the services which one group provides for others.

Thus, the Hall commission rejected both state medicine, on the one hand, and private funding of health care, on the other.

VII. PRINCIPAL RECOMMENDATIONS OF THE HALL COMMISSION

The two hundred Hall commission recommendations covered all aspects of health care in Canada. They can be summarized as follows:

1. Universal government-operated health insurance for medical and dental care, prosthetics, prescription drugs, and optical services.
2. Increased concern for the mentally retarded, with emphasis on integrating them into the community.
3. Availability of better facilities for the treatment of alcoholism and drug abuse.
4. Fluoridation of all community water systems.
5. Changes in the patent laws for drugs, and compulsory licensing of drug manufacturers.
6. Closer surveillance of surgical procedures, and other reforms in hospital administration.
7. Integration of tuberculosis sanatoriums into the regular hospitalization plans.
8. Reforms in nursing education, particularly to decrease the training period, provide assistance during training, and increase wages after graduation.
9. Increased facilities for the training of dentists and physicians.
10. Increased emphasis on medical research.
11. Provision for the provinces to fund their share of the programs as they see fit—including the use of lotteries.

12. Federal government assistance in the financing of medical insurance, either directly or by vacating tax fields. Any tax to support the scheme should be identified to the taxpayer.

VIII. MEDICAL CARE ACT

In 1966, Parliament passed the Medical Care Act, to be effective July 1, 1968. British Columbia and Saskatchewan qualified on July 1, 1968; Manitoba, Nova Scotia, and Newfoundland on April 1, 1969; Alberta on July 1, 1969; Ontario on October 1, 1969; Quebec on November 1, 1970; Prince Edward Island on December 1, 1970; and New Brunswick on January 1, 1971.

The act provided that the federal government would pay 50 percent[1] of the cost of an "approved plan" that met the following criteria:

1. It was administered and operated by a public authority on a nonprofit basis.
2. It provided for the furnishing of insured services upon uniform terms and conditions to all "insurable residents" of the province.
3. It provided for the payment of amounts in respect of the costs of insured services in accordance with a tariff of authorized payments established pursuant to the provincial law or in accordance with any other system of payment authorized by the provincial law, on a basis that provided for reasonable compensation for insured services rendered by medical practitioners and that did not impede or preclude either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to insured services by insured persons.
4. It covered 90 percent of the insurable population during the first two years, and 95 percent thereafter.[2]
5. The maximum waiting period was three months.
6. It provided for the costs of insured benefits while an insured person was temporarily absent from the province.
7. It continued coverage for an insured person when he moved to another province until that province's plan became effective.

The insured costs included, in all provinces, medically required services of medical practitioners and certain surgical dental procedures undertaken by dental surgeons in a hospital. In addition, all provinces except the Maritimes covered optometric services, and Alberta and British Columbia covered chiropractic and other types of care.

[1] Fifty percent of the average Canadian per capita cost multiplied by the number of insured persons.

[2] Coverage was 100 percent in the four Maritime Provinces, Quebec, and Manitoba; 95 percent in Ontario; and 99 percent elsewhere.

The insured costs excluded (*a*) any cost of administration of the plan, (*b*) deterrent fees, (*c*) any premiums payable, and (*d*) costs for persons covered under other acts. These acts are the Aeronautics Act, the Civilian War Pensions and Allowances Act, the Government Employees' Compensation Act, the Merchant Seamen's Compensation Act, the National Defence Act, the Pension Act, the RCMP Act, the RCMP Pension Continuation Act, the RCMP Superannuation Act, the Veteran Rehabilitation Act, and the Workmen's Compensation Act.

IX. COST OF THE PLANS

Table 1 provides a résumé of the expenditures on personal health care in Canada during the period 1960–71. While this table and Table 2 are very dated, they do provide a means of analyzing the "cost-benefits" associated with the installation of government-run medical care. Table 3 provides, on a different basis, figures for the 1970s.

Table 1 shows a 305 percent increase in the costs of general and allied special hospital services and a 248 percent increase in the cost of physicians' services over the period 1960–71. Since the reasons for these increases are often the subject of public speculation, a brief analysis is a worthwhile exercise.

Table 2, which analyzes the causes of increase for hospital insurance, aids in the analysis. It shows that population growth provided just under 13 percent of the total increase. Increased utilization, usually a source of concern under "free" plans, does not appear to be a major contributor to increased costs, accounting for less than 11 percent of the increase. (However, since 1960 was chosen as the base year, it is possible that much of this increase in utilization had already occurred, since many provinces had plans in place by then.) In addition, the increases in paid hours of work per patient-day and in some of the miscellaneous items primarily reflect better patient care, a very desirable goal.

The biggest factor is the increase in hospital salaries and wages per paid hour of work—almost 45 percent of the total increase. (The wages for these workers were increasing more quickly than the national average wage.)

From Table 3 it can be seen that hospital expenses rose dramatically from $2.6 billion in 1971 to $7.4 billion in 1978, an increase of 178 percent—a figure much greater than could be predicted on the basis of population increases and inflation. As a percentage of total government health care expenditures, hospital costs rose from 62 percent to 65 percent.

The total cost of physicians' services (Table 1) also increased markedly in the period 1960–71. One factor causing this was the rapid increase in

TABLE I

EXPENDITURE ON PERSONAL HEALTH CARE, CANADA, 1960–71

(In Thousands of Dollars)

YEAR	HOSPITAL SERVICES					PHYSICIANS SERVICES	DENTISTS SERVICES	PRESCRIBED DRUGS	TOTAL
	General and Allied Special	Mental	Tuberculosis	Government of Canada	All Hospitals				
1960	$ 640,587	$121,794	$28,730	$ 53,877	$ 844,988	$ 355,014	$109,644	$132,601	$1,442,247
1961	722,057	134,882	28,184	63,891	949,014	388,304	116,730	135,842	1,589,890
1962	811,848	144,419	27,600	70,314	1,054,181	406,075	121,491	144,431	1,726,178
1963	909,762	163,049	28,294	73,782	1,174,887	453,395	136,946	161,734	1,926,962
1964	1,015,148	182,064	26,204	76,812	1,300,228	495,657	147,824	178,584	2,122,293
1965	1,144,479	211,605	26,044	79,788	1,461,916	545,056	160,062	211,541	2,378,575
1966	1,319,048	241,793	25,855	82,072	1,668,768	605,200	176,402	231,955	2,682,325
1967	1,523,035	283,875	26,037	83,349	1,916,296	686,187	187,166	265,479	3,055,128
1968	1,789,968	314,334	27,085	87,008	2,218,395	788,088	213,730	297,286	3,517,508
1969	2,024,735	362,397	26,088	88,051	2,501,271	901,435	239,724	318,497	3,960,927
1970	2,302,580	407,635	23,708	92,175	2,826,098	1,028,900	262,120	360,411	4,477,529
1971	2,594,564	437,214	17,439	102,790	3,152,007	1,236,182	298,836	422,494	5,109,519

SOURCE.—Ref. [5].

TABLE 2

APPROXIMATE SOURCES OF INCREASE IN BUDGET REVIEW HOSPITAL EXPENDITURE FOR PERIOD 1961–70

Source	Annual Average Percentage Increase of Expenditure by Source	Percentage of Total Increase
1. Population growth	1.79%	12.85%
2. Increase in number of patient-days per capita	1.48	10.66
3. Increase in hospital salaries and wages per paid hour of work	6.25	44.88
4. Increase in paid hours of work per patient-day	1.67	11.97
5. Increase in cost and/or volume per patient-day of		
a) Medical and surgical supplies	0.30	2.17
b) Drugs	0.22	1.60
c) Food	0.13	0.90
d) Other nonlabor items	2.09	14.97
Total	13.93%	100.00%

SOURCE.—Ref. [5].

the number of physicians—nearly 48 percent in eleven years—which accounted for 45.5 percent of the increase. Second, there was a definite increase in the qualifications of the physicians (i.e., the proportion of specialists) over the period, a factor that is difficult to measure. Third, productivity increased at least 20 percent. The first two of these increases were the result of public policy, which was designed to increase the availability and quality of medical care.

Table 4 analyzes the factors that contributed to the increase in aggregate payments to physicians between the fiscal years 1972 and 1979. Although the methodology used to obtain these figures is subject to criticism, they do give a rough idea of what has happened in the years since medicare was implemented. Again, population growth and change, government initiatives to increase the quality of care, and increased utilization have accounted for most of the increases. Politicians would like to present all of these increases as benefits, but the form of the analysis gives little indication as to how much of the increase is due to better care and how much is due simply to increased utilization. The percentage attributed to increases in the fee scale seems large, but average Canadian wages increased 92 percent during the period, approximately double the increase in physicians' fees.

The above analyses are only approximate, but they illustrate the need to be very careful in making statements about the causes of increases in the cost of health services.

TABLE 3

CANADIAN PUBLIC HEALTH CARE EXPENDITURES, 1961–78

(In Thousands of Dollars)

YEAR	FEDERAL EXPENDITURES				PROVINCIAL EXPENDITURES						MUNICIPAL EXPENDITURES	TOTAL
	Hospitals	Medical Care	Other	Subtotal	Cost Shared, Hospital	Cost Not Shared, Hospital	Medical Care	Workmen's Compensation	Other Medical Care	Subtotal		
1961	$ 206,660	.....	$102,620	$ 309,280	$ 237,510	$ 244,053	.....	$ 35,570	$ 114,567	$ 631,700	$ 65,540	$ 1,006,520
1962	294,740	.....	101,000	395,740	310,380	255,954	.....	37,850	84,876	689,060	66,650	1,151,450
1963	337,200	.....	107,170	444,370	348,920	279,737	.....	42,770	87,237	758,664	73,700	1,276,734
1964	384,070	.....	111,770	495,840	388,780	236,542	.....	47,590	137,598	810,510	54,830	1,361,180
1965	434,280	.....	117,580	551,860	436,860	310,274	.....	52,950	135,696	935,780	57,940	1,545,580
1966	497,200	.....	125,480	622,680	497,020	347,099	.....	60,890	145,181	1,050,190	73,400	1,746,270
1967	580,950	.....	146,650	727,600	581,540	402,983	.....	53,730	226,017	1,264,270	68,740	2,060,610
1968	681,110	.....	184,130	865,240	682,700	475,546	.....	57,320	301,234	1,516,800	76,220	2,458,260
1969	811,640	.....	227,870	1,039,510	814,000	450,731	.....	61,720	426,499	1,752,950	94,870	2,887,330
1970	928,090	$ 201,470	155,800	1,285,360	930,550	482,891	$196,850	64,050	443,019	2,117,360	101,680	3,504,400
1971	1,059,590	424,210	209,800	1,693,600	1,059,470	529,157	428,700	75,460	379,046	2,471,833	104,050	4,269,483
1972	1,208,510	586,240	217,450	2,012,200	1,199,420	551,756	586,110	77,370	388,903	2,803,559	68,060	4,883,819
1973	1,342,940	640,180	250,920	2,234,040	1,334,020	718,643	640,190	83,890	413,774	3,190,517	112,220	5,536,777
1974	1,554,800	686,510	295,550	2,536,860	1,544,360	726,246	686,430	88,750	472,546	3,518,332	95,530	6,150,722
1975	1,930,640	731,530	353,670	3,015,840	1,917,260	864,395	731,530	102,220	734,430	4,349,835	99,240	7,464,915
1976	2,365,040	838,900	389,800	3,593,740	2,343,230	1,130,150	838,890	130,990	898,415	5,341,675	128,220	9,063,635
1977	2,713,410	955,730	423,710	4,092,850	2,621,610	1,128,432	965,420	186,290	968,532	5,870,284	173,850	10,136,984
1978	3,256,341	1,154,809	386,462	5,050,964	2,618,610	1,241,275	949,561	195,585	1,109,302	6,114,333	226,012	11,391,309

SOURCE.—Refs. [6] and [7].

TABLE 4

CONTRIBUTION TO INCREASES IN AGGREGATE FEE PAYMENTS TO PHYSICIANS
(Annual Averages, 1971/72 to 1978/79)

	Amount (in Millions)	Percentage
Growth in population	$ 21.0	12.1%
Number of physicians per capita	46.3	26.7
Utilization per physician*	27.6	15.9
Price of physicians' services	78.5	45.3
Total	$173.4	100.0%

* Changes in the age-sex composition of the population account for 4.1 percent of the total change in fee payments, and thus represent a major portion of the change in utilization.

X. FINANCING OF HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Federal

For the fiscal years 1969–77 the Medical Care Act provided that in each province the federal government would pay 25 percent of the average per capita cost of inpatient services in Canada plus 25 percent of the per capita cost of inpatient services in the province. These percentages were also applied to outpatient costs. If a province charged a deterrent fee for services, such fees were deducted from the federal grant.

A ceiling of 13 percent was placed on the increase in federal per capita contributions for the fiscal year 1977 [8]. Subsequently, the provincial and federal governments agreed to new financial arrangements for hospital insurance and medical care. Since April 1, 1977, federal contributions to the established programs of hospital insurance, medical care, and post-secondary education no longer are directly related to provincial costs but take the form of transferring a predetermined number of tax points and related equalization and cash payments. In general terms, total federal contributions are based on the escalated value of the 1975–76 federal contributions for the programs. The tax room vacated by the federal government permitted the provinces to increase their income tax rates without necessarily increasing the total tax burden on Canadians. The yield from the new provincial taxes is expected to grow faster than the gross national product. The cash payments are conditional upon the provincial health insurance plans meeting the criteria of the federal health insurance legislation. They are on a per capita basis and escalate yearly in accordance with changes in the GNP. They are reduced by the tax room transferred, but the net amount cannot be negative. This net amount was not significant at the outset. The per capita cash payments are adjusted

each year so that by 1982 all provinces will be receiving equal per capita contributions.

Provincial

Today, Newfoundland, Prince Edward Island, New Brunswick, Nova Scotia, Manitoba, and Saskatchewan use general revenues alone to finance their plans (see [7]; [11]). In the other provinces, the following charges and taxes are specifically intended for hospital and medical care costs.

Quebec—An income tax surcharge of 1.5 percent of net income subject to a maximum of $235 for those employees whose salary constitutes three-fourths or more of their net income, and $375 for other taxpayers, plus an employers' payroll tax of 3.0 percent (with no maximum). If net income is less than $2,600 (single) or $5,200 (married), no tax is payable by the individual. A fee of $8.00 per day is charged to chronic care patients.

Ontario—A monthly premium of $23.00 for single persons and $46.00 for families, of which 70 percent is paid by the employer. Premiums are waived for those over age 65 and for the indigent. A fee of $9.80 per day is charged to chronic care patients [9].

Alberta—A monthly premium of $9.50 for a single person and $19.00 for a family. For hospital care (except for newborn infants) a deterrent charge of $5.00 is made for the first 120 days and $3.00 per day after the stay exceeds 120 days. For nursing homes a daily deterrent charge of up to $3.00 is made for standard ward care, $5.00 for semiprivate, and $8.00 for private [10].

British Columbia—A monthly premium of $11.50 for single persons, $23.00 for two, and $28.75 for three or more. In addition, there is a deterrent charge of $4.00 per day for inpatients (except for newborn infants). For chronic care patients there is a deterrent charge of $10.50 per day for extended care patients under the age of 19, and $6.50 per day for all others. There are fees of $1.00–$2.00 per day for outpatient-type services [10].

These four provinces decided to levy charges in order to (*a*) deter unnecessary use of services, (*b*) raise further revenue, and (*c*) bring home the fact that medical care is costly. Their financial effect is relatively insignificant. Even the substantial Ontario premiums pay less than 20 percent of the total cost.

Originally, Manitoba and Nova Scotia levied the following special taxes:

Nova Scotia—A 3 percent retail sales tax.

Manitoba—A charge of 6 percent of federal personal income tax, plus 1 percent of taxable income for corporations, plus a premium that was different for single and married people.

The financing in these two provinces was later derived from general revenues.

XI. COVERAGE

In Alberta a person can "opt out" of the plan. In Manitoba and Prince Edward Island coverage is compulsory only for those in employee groups of three or more, and in Ontario only for those in employee groups of fifteen or more. In all other provinces, coverage is compulsory for all.

XII. BENEFITS OUTSIDE THE PROVINCE OF COVERAGE

Federal law requires portability of benefits between provinces to avoid gaps in coverage for people moving between provinces. All plans provide coverage at the standard ward rate for hospital admissions elsewhere in Canada.

When a person is hospitalized outside Canada, the provincial plans provide coverage as set out below:

British Columbia—A maximum of $75 per day.

Alberta, New Brunswick, Newfoundland, and Saskatchewan—The amount otherwise payable in the province for similar services, or the actual charge if less.

Manitoba—Up to 75 percent of the charges.

Ontario and Quebec—100 percent of all emergency charges and lesser amounts for elective admission and outpatient services.

Nova Scotia and Prince Edward Island—Ward rate up to $100 per day, plus 75 percent of the remainder.

Since charges outside Canada tend to be well above these coverages, travelers abroad generally need supplementary private hospital and medical care insurance.

XIII. FUTURE OUTLOOK

Several events are likely to occur in the health care field in the future. Dental care has already been introduced for children in several provinces and for retired people in at least one province. Further extensions in this direction are likely as money and manpower permit. However, several major provinces have announced that, because of cost considerations, there will be no expansion in the near future into denticare. As a result, considerable expansion of private sector denticare coverage is underway.

Most provinces are finding that the cost of the health care programs has far exceeded expectations. In many cases, health care is now the largest single item in the provincial budget and accounts for over 25 percent of expenditures. As a percentage of gross national product, the expenditures have been growing rapidly, and there is major concern in government circles over future financing. Cost projections to 1985 indicate that large increases in taxation, stringent cost control, increased deterrent

fees, or reductions in services may be needed to avert provincial bankruptcy. No one of these alternatives is completely realistic, but there are definitely rough times ahead.

Although there have been definite advantages to the medical profession in having provincial governments as "employers," nevertheless a number of difficulties have arisen. In Ontario [9] the fee-schedule increases from inception of the plan to 1979 amounted to about 43 percent, while the Consumer Price Index rose approximately 150 percent in the same period. Taking into account overtime and fringe benefits, the average wage of a general practitioner works out to under $15.00 per hour. These facts have led to a very concerned attitude on the part of physicians; however, from a political standpoint, fee-schedule increases are a very touchy subject. As a result, negotiations are becoming increasingly acrimonious. In addition, the federal government wishes to limit the number of physicians in the cities, and many of the provinces want to obtain better care for their rural populations. There is pressure, therefore, to force physicians to practice where the government desires. Since costs are so related to the number of physicians, some advocate limiting the number of medical school graduates as a means of controlling utilization. Disputes seem bound to occur in the future and will cause problems for all concerned.

In summary, medicare has worked reasonably well, but the future of health care in Canada is somewhat uncertain and difficult to predict.

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