

Canada's Federal-Provincial Program of Hospitalization Insurance

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THE inauguration of public hospitalization insurance in seven of the 10 Provinces of Canada has created widespread interest in the United States, both in the programs themselves and in the developments that led Canada to adopt a system of public health insurance.¹

Canada and the United States have many characteristics in common, even though the Canadian population is only one-tenth the size of that of the United States. The 10 Provinces are as diverse in their economy, extent of urbanization, and varying political philosophies as the 49 States. They guard their prerogatives and rights as zealously as the States guard theirs. Responsibility for the health of the population traditionally reposes in the Provinces, which provide public health services; care for the mentally ill and the tuberculous and for recipients of assistance; and control the licensing of physicians and hospitals. Like the United States, Canada has a system of private and public hospitals, but very little general care is provided in private hospitals. Medical care for veterans, Indians, sick mariners, and members of the Armed Forces has been made available by the Federal Government although the respective constitutional responsibilities of the Federal and Provincial governments in these areas have not always been clear. With respect to taxation the Canadian Provinces—unlike the States in this country—are restricted by the Federal Constitution to the use of direct taxes as a source of income; the Dominion Government can use all forms of taxation.

Reports on the extent of voluntary health insurance in Canada, written before the new law was implemented, read almost as if taken verbatim from

reports about coverage in the United States. Protecting only a small proportion of the population in the early 1940's, voluntary hospitalization insurance by 1958 was covering nearly 60 percent of the population living outside British Columbia and Saskatchewan, where government programs were established in 1949 and 1947. The extent of coverage was high in Ontario (70 percent), and low (25 percent) in the less economically advantaged Atlantic Provinces. Hospitalization was the most prevalent form of voluntary insurance, and it was meeting about half the private hospital bill in the six Provinces where there were no public hospitalization programs. Voluntary surgical insurance was held by about three-fourths of those insured for hospital care and medical insurance by about half. In all, about 7 million Canadians were insured under private plans by 1958.

This picture was drastically altered when Canada's Hospital Insurance and Diagnostic Services Act became effective. The law, enacted in April 1957 by the Canadian Parliament, required that a majority of the Provinces, containing a majority of the population of Canada, agree to participate in the program before the law would become effective. In 1958 a legislative amendment removed this restriction, and five Provinces—Alberta, British Columbia, Manitoba, Newfoundland, and Saskatchewan—began to receive Federal grants in aid for hospital insurance on July 1, 1958.

By the end of 1959, about 71 percent of the Canadian population will be covered by the public programs in the nine participating Provinces. Quebec, with more than a fifth of the entire population (almost 5 million persons), has given no indication so far of its intentions.

Under the law the Federal Government pays to participating Provinces approximately 50 percent of the costs of (1) comprehensive hospital insurance providing ward accommodations

with no limit on duration—that is, for as long as deemed medically necessary—and (2) hospital outpatient diagnostic services. The total annual costs per capita are expected to average about \$25 for general hospital care (including, in some of the Provinces, chronic and convalescent care).

The Federal share of total expenditures under the act will probably vary from 45 percent to 72 percent among the Provinces because of differences from Province to Province in actual costs of care. The Federal Government pays on behalf of each insured person 25 percent of the average per capita cost for all Provinces, plus 25 percent of the actual per capita cost in a given Province minus the per capita amount of coinsurance if the program includes a coinsurance feature. Provinces with high per capita costs will receive larger amounts per capita, but these amounts will represent a smaller percentage of total costs than the payments to Provinces with low per capita costs.

Terms of the Act

The Hospital Insurance and Diagnostic Services Act specifies that insured hospital services must be made available to all residents of a Province under uniform terms and conditions. The hospital services must include (1) room and board at ward levels for as many days as are deemed medically necessary; (2) necessary nursing services; (3) all necessary diagnostic procedures and drugs, and surgical supplies in the hospital; (4) operating room and anaesthetic facilities; and (5) radiotherapy and physiotherapy where available.

The Provinces may cover the entire costs through a service benefit, and five Provinces have elected this method. They may require payment of some authorized charges at the time service is received. Two Provinces require payments of \$1 or \$2 a day. Most Provinces have a scale of charges for outpatient or emergency benefits. Adequate records and ac-

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¹ For a more detailed description of certain aspects of the program, see Sylvia M. Gelber, "Hospital Insurance in Canada," *International Labour Review*, March 1959.

counts must be maintained, and licensing and inspection services must assure maintenance of high standards of hospital care.

The Provinces may elect to furnish some or all of the outpatient benefits provided under the Act; the Federal financing formula is the same as that used for hospital care. Outpatient benefits may include both emergency and diagnostic services. Three Provinces provide emergency and certain other specified diagnostic services, two provide only emergency outpatient services, and a sixth excludes emergency care but provides certain outpatient services.

Each Province decides for itself the form its program will take. The accompanying chart brings out the differences among the seven programs now in operation and indicates the expected nature of the programs starting in New Brunswick and Prince Edward Island later in 1959. Although the terms of population coverage vary slightly, the net effect will be nearly universal coverage in all nine participating Provinces. As the chart indicates, two of the Provinces—Alberta and British Columbia—will impose hesitation fees or daily authorized charges, continuing the pattern established under their previous Provincial hospitalization plans.

The Federal act also left it to the Provinces to select their individual methods of financing the Provincial share of the costs. One Province is using retail sales taxes, three are using general revenues, and three have insurance premiums. When New Brunswick and Prince Edward Island start their programs, it is expected that they, too, will require residents to pay premiums.

In those Provinces (Manitoba, Ontario, and Saskatchewan) financing the program through premiums paid by individuals the Provincial Government pays the cost of care received by public assistance recipients or pays their premiums. In Ontario the municipalities pay either costs or premiums for the medically indigent. In Manitoba the municipalities are responsible for premiums for persons receiving social assistance and pay the costs of care for those who are uninsured and indigent. In the Provinces financing the program from general revenues or from a sales tax,

no distinction need be made between assistance recipients and the remainder of the population except when daily authorized patient charges are imposed. In these instances such charges are assumed by the Provincial government.

The Federal Government's share of the annual costs for the seven Provinces now under the act is expected to be at the rate of \$160 million, equivalent to about 2.75 percent of the Federal budget. When the other Provinces come in, Federal costs will rise to about 4 percent of the Federal budget.

Voluntary Hospitalization Insurance

About 4 million Canadians had been members of the five Canadian Blue Cross plans. Blue Cross operations in the Province of Quebec will continue as before. The Manitoba Blue Cross plan is being dissolved and its personnel absorbed by the new Provincial hospital insurance commission. The three other Blue Cross plans are undergoing a period of radical readjustment and are changing their voluntary programs to offer coverage in excess of ward care. The Alberta plan expects to write this supplementary hospital coverage in Manitoba and Saskatchewan, as well as in Alberta.

The Blue Cross-Blue Shield plan located in New Brunswick will provide supplementary hospital coverage in the four Atlantic Provinces and will continue to provide medical and surgical benefits in these localities, except in Newfoundland, to children under age 16. Administrators of the Blue Cross plans anticipate that persons who have become accustomed to benefits for semiprivate accommodations will wish to purchase this type of protection to supplement the ward coverage of the Government program. Presumably commercial hospitalization insurance companies throughout Canada will be offering similar protection applicable to costs in excess of those for ward care provided under the Hospital Insurance and Diagnostic Services Act.

With respect to the effect of the new Government hospital plans providing ward care, it has been pointed out that little insurance to supplement the Provincial programs had

been purchased in British Columbia and Alberta in the past. In Ontario, there has already been some demand for supplementary hospitalization benefits of \$3-\$6 a day to provide semiprivate and private accommodations. These supplementary benefits are frequently combined with coverage for anesthetic and X-ray diagnostic charges (considered as "hospital extras" in Ontario and not covered by the Government plan except in emergencies) and with supplementary major medical protection. Eighty percent of those who previously had carried hospitalization insurance with one Ontario insurance company continued with a supplementary benefit policy. The Ontario Blue Cross plan is continuing to provide hospitalization insurance in the form of supplementary benefits. A company with headquarters in the United States is offering hospitalization coverage on a supplementary basis; up to 120 days of benefits and ambulance services and anesthetics are provided. This company has a comprehensive major medical plan with a deductible amount of \$25-\$50, generally with 25-percent coinsurance applicable to surgery costs only for the amounts by which they exceed those in the schedule.

Some collective bargaining agreements now require that supplementary hospitalization coverage be provided. The decrease in group accident and sickness premiums as a result of the Government hospitalization plan is estimated by persons in the private insurance field to amount to 15-20 percent.

In the recent past, experience had been unfavorable under the voluntary hospitalization plans. With the scope of their programs narrowed, they anticipate more favorable results in the future.

Background and Development

Canada's more westerly Provinces established public medical care programs almost 4 decades ago, not because of any underlying philosophical convictions about public or private health insurance but as a way of bringing hospital and medical services to the pioneer residents of these areas. In the United States a parallel development under private rather than public auspices occurred through

the comprehensive medical and hospital programs started in the West by the railroads and the lumbering and mining industries. In western Canada the municipalities built the hospitals and paid the doctors from local tax funds in order to distribute the costs among all the residents. This municipal system has continued to the present; approximately 180 municipalities in Saskatchewan, 19 in Manitoba, and six in Alberta have contracts with municipal doctors providing basic medical services for an

estimated 200,000 persons. The populations of the prairie Provinces are accustomed, therefore, to government participation in the financing of personal medical care programs.

Newfoundland, where many of the settlements are remote and the population is scattered and with generally low incomes, established a system of small cottage hospitals in 1934, and doctors were employed to provide medical care in certain outlying areas. This program was expanded gradually over the years. In 1957 a

children's health service plan was established that originally provided children up to age 16 with hospital care and, since February 1958, with physicians' services in hospitals. Both programs will in the future apply only to physicians' services. The cottage hospital plan will continue to provide physicians' services for residents in certain outlying areas of the Province, and the children's health service plan will provide only free medical and surgical services for hospitalized children.

*Canada's Federal-Provincial hospital insurance plan: Comparison of Provincial programs, May 1959*¹

Province, net population, ² and effective date ³	Coverage	Special benefit features	Method of financing Provincial share of costs	Method of financing hospital care of public assistance recipients	Provincial payments to hospitals	Provincial administration
<i>Alberta</i> (1,231,000), 1919; June 1, 1949; and July 1, 1958.	Automatic for all residents of Canada actually residing in Alberta. Those leaving Province are covered for 3 months or until eligible, under reciprocal Provincial agreement, in other participating Province (whichever period is shorter).	No outpatient benefits. Certain polio, arthritic, and cancer patients and all maternity cases have daily authorized charges paid for specified periods.	General revenues, 3-mill tax on municipalities, equalized assessment, and daily authorized patient charges: in hospitals of less than 30 beds, \$1.50; 30-89 beds, \$1.60; 90-179 beds, \$1.80; 180 beds or more, \$2. \$1 a day for newborn infants, up to \$30 maximum.	Province pays daily authorized charges; since April 1, 1959, outpatient services.	Per diem rate based on fixed operating costs.	Director of Hospitals Division, Provincial Department of Public Health, is Provincial authority.
<i>British Columbia</i> (1,561,000), Jan. 1, 1949, and July 1, 1958.	Automatic for all residents after 3 consecutive months in Province. Those leaving Province are covered for 3 months or until eligible, under reciprocal Provincial agreement, in other participating Province (whichever period is shorter).	No outpatient benefits.	General revenues and daily authorized patient charges of \$1.	Province pays daily authorized charges.	Per diem operating costs established from firm budget with adjustments when necessary for costs, which vary with occupancy.	Hospital Insurance Services, Provincial Department of Health and Welfare, is headed by a commissioner, directly responsible to the Provincial Minister of Health and Welfare.
<i>Manitoba</i> (871,000), July 1, 1958.	Mandatory for all residents. Those leaving Province are covered for 3 months or until eligible, under reciprocal Provincial agreement, in other participating Province (whichever period is shorter).	Emergency outpatient benefits, plus specified outpatient diagnostic benefits.	Annual premiums of \$24.60 for single person, \$49.20 for family head. Employers of 5 or more collect and transmit employees' premiums; others pay through municipality.	Province pays costs for specified public assistance recipients. Municipalities pay premiums for recipients of local social assistance and costs of care for uninsured "hospital indigent" residents.	Fixed per diem costs established from firm budget; payment made on a fixed-plus-variable basis, as in Saskatchewan.	Commissioner of Hospital Services Plan is responsible to the Provincial Minister of Health and Welfare and assisted by advisory hospital council (10-12 members), representing medicine, hospitals, nursing, municipal governments, and general public.
<i>New Brunswick</i> (584,000), July 1, 1959.	Mandatory for all residents.	Emergency outpatient service.	General revenues and annual premiums of \$25.20 for single person, \$50.40 for family head. Employers of 5 or more collect and transmit employees' premiums; others pay through municipality.	Not announced.....	Not announced.....	Hospital Service Commission (3-7 persons).
<i>Newfoundland</i> (443,000), 1934 and July 1, 1959.	Automatic for all residents. Those leaving Province are covered for 3 months or until eligible, under reciprocal Provincial agreement, in other participating Province (whichever period is shorter).	Specified outpatient diagnostic services and interpretations; no outpatient emergency care.	General revenues.....	No distinction between public assistance recipients and others in population.	Fixed rate established from budget and paid monthly on flat-rate basis.	A Division of the Provincial Department of Health; the Provincial Minister of Health is the Provincial authority.

See footnotes at end of table.

In Alberta in 1935 and in British Columbia in 1936 legislation was passed that provided for programs of government health insurance. Such a controversy arose, however, particularly in British Columbia, that the laws were not implemented. The controversy is said to have led to interest on the part of these Provinces in Federal action.

Not until 1942, however, did the Federal Government make any move in this direction. The Federal Government in that year established a special inquiry committee to study the health insurance question. After preparing an exhaustive report and drafting legislation, the committee referred the matter to the Federal House of Commons, and the question died there.

There followed a period of Provincial developments with little action at the Federal level. A free maternity hospital care program was introduced

in Alberta in 1945 for all mothers who had resided for a year in the Province or, under a 1949 amendment, whose husbands were qualified residents.

Two years later, in 1947, the Provincial government of Saskatchewan launched its hospitalization insurance program with premiums collected through the municipalities and the balance provided from general revenue and a sales tax. This action by a politically liberal government was followed in 1949 by the passage of a similar program by British Columbia's conservative government. In British Columbia the original scheme for financing the program through premiums was abandoned, and general revenues (including a Provincial sales tax), as well as a \$1-a-day charge to the patient, were used to finance the program until 1958.

In Alberta, the hospital insurance program inaugurated in 1949 allowed

local option; voters in each municipality or city decided whether to participate or not. About 75 percent of the population was under the scheme. Protection for ratepayers was financed by taxation, and nonratepayers were able to buy contracts for coverage.

This brief review of activity from 1934 onward indicates that most of the developments relating to public programs of hospital insurance were at the Provincial level — a fact of significance as the Federal program later unfolded; the role to be played by the Federal Government was not yet clear.

In 1945 a Federal-Provincial post-war conference on reconstruction was convened in Ottawa. Along with numerous other proposals in varied fields, the conference was presented with the proposal developed in 1942 by the advisory committee on health insurance. One of the basic questions

Canada's Federal-Provincial hospital insurance plan: Comparison of Provincial programs, May 1959 ¹—Continued

Province, net population, ² and effective date ³	Coverage	Special benefit features	Method of financing Provincial share of costs	Method of financing hospital care of public assistance recipients	Provincial payments to hospitals	Provincial administration
<i>Nova Scotia</i> (699,000), Jan. 1, 1959.	See Newfoundland.....	Emergency outpatient care and specified outpatient diagnostic services.	New 3-percent hospital (retail sales) tax.	No distinction between public assistance recipients and others in population.	Fixed per diem rate established from budget and paid on flat-rate basis.	Hospital Insurance Commission (5-7 members).
<i>Ontario</i> (5,894,000), Jan. 1, 1959.	Mandatory for all residents employed in establishments with 15 or more employees; voluntary for all others. Those leaving Province are covered for 3 months or until eligible, under reciprocal Provincial agreement, in other participating Province (whichever period is shorter).	Emergency outpatient benefits. (Insured care provided in institutions for mentally ill and the tuberculous without Federal sharing in costs).	Annual premiums of \$25.20 for single person, \$50.40 for family head. Employers of 15 or more collect and transmit employees' premiums. Those covered voluntarily pay directly.	Province pays premiums for public assistance recipients who receive care under the medical welfare plan except those on unemployment relief. The latter and any "hospital indigents" may have premiums or costs paid by the municipality. If costs are paid, statutory per diem payments are made to hospital by both municipality and Province.	Fixed per diem rate established from budget and paid on flat-rate basis.	Hospital Services Commission (3-7 members).
<i>Prince Edward Island</i> (100,000), late 1959.	No information.....	No information.....	Plan expected to be financed by premiums.	No information.....	No information.....	Hospital Services Commission.
<i>Saskatchewan</i> (899,000), Jan. 1, 1947, and July 1, 1958.	See Manitoba.....	Emergency outpatient benefits and pathological examination of tissue.	General revenues and annual premiums of \$17.50 for single person, \$35 for family head, collected by municipality.	In general, Province pays premiums for all public assistance recipients except those receiving municipal social assistance, for whom the municipality pays premiums or hospital costs as for resident "hospital indigents."	Under 2-part formula, payments are slightly more than costs of fixed expenses and slightly less than costs of items that vary with occupancy.	Minister of Public Health is Provincial authority. The Hospital Services Plan functions as a Division of the Provincial Department of Public Health.

¹ Excludes Quebec (population 4.6 million); no commitment to start plan. Also excludes the Northwest and the Yukon Territories (Federal areas with population of 33,000), for which no plan has been announced by the Federal Government.

² Estimated as of June 1, 1959, by the Dominion Bureau of Statistics; excludes the Armed Forces, the Royal Canadian Mounted Police, and inmates of peni-

tentiaris, who are entitled to hospital care under legislation other than the Hospital and Diagnostic Services Act or the Provincial hospital insurance acts.

³ Where more than one date is shown, the first is the date the Provincial or municipal program started and the last is the date the Federal-Provincial program started.

before the conference concerned the redistribution of the fiscal powers of the Provinces and the Dominion Government. A comprehensive health insurance program, to be implemented in stages, was among the Dominion Government's proposals to the Provinces, but no agreement was reached on the distribution of fiscal arrangements between the Federal and the Provincial governments.

In 1948 the Dominion Government established a program of national health grants designed to strengthen the general health and hospital facilities of the Provinces. The program provided for surveys of health needs and health services, new hospital construction, training grants for health workers, increased funds for health research, and improvements in local public health services and services to mothers and children. Programs in the fields of mental illness, tuberculosis, and cancer were all expanded. In 1954 grants for child and maternal health, medical rehabilitation, and laboratory and radiological diagnostic services were added. The parallel to postwar Federal programs in the United States is apparent. It might also be mentioned that the Canadian Government allows deduction of the portion of medical expenses exceeding 3 percent of income in computing

the Federal personal income tax.

Another Federal-Provincial conference took place in 1954, and at this conference the request that consideration of health insurance be included on the agenda came from the Provinces. Later, in a statement dated January 26, 1956, the Prime Minister offered a Federal program limited to hospital insurance and diagnostic benefits. The legislative details were worked out during the next 15 months, and in April 1957 the Hospital Insurance and Diagnostic Services Act was passed by the Canadian Parliament. Its original terms required that it could not be implemented until a majority of the 10 Provinces, containing a majority of the population, had agreed to participate. Provinces that already had public programs agreed to the proposal promptly. The key to implementation of the law lay in the action that Ontario or Quebec might take, since 11 million of the 16 million Canadians live in these two Provinces. Ontario, with a population of 5.4 million, joined the four Provinces with public programs in March 1958 and was actually the first to sign the agreement. The little Province of Prince Edward Island, voting in April 1958 to come into the plan, brought to the necessary six the number of

Provinces agreeing to participate. Alberta, British Columbia, Newfoundland, Ontario, and Saskatchewan had already indicated their intention to become participants. At this stage, to avoid possible confusion regarding effective dates for grant-in-aid payments, the Federal Government amended its legislation to make the program effective on July 1, 1958. Manitoba and New Brunswick indicated their agreement slightly later, and Nova Scotia signed an agreement in October 1958.

Developments leading up to Canada's hospital insurance program were of a kind to cause little doubt of its wide acceptance by the Canadian people. Impetus for its passage developed largely at the Provincial level, where the nature of the economy made hospital programs under public auspices an acceptable *modus operandi*. The less populated and less industrialized Provinces favored Federal participation as a method of cost sharing by the more highly populated and industrialized Provinces. The Dominion Government proved flexible in adapting its offers of assistance to the tenor of Provincial thinking. Had the Province of Ontario been unwilling to join, the program in all probability would not have been started.

Notes and Brief Reports

1959 Amendments to the Railroad Retirement Act*

On May 19, 1959, President Eisenhower signed Public Law No. 86-28, significantly amending the Railroad Retirement Act, the Railroad Retirement Tax Act, and the Railroad Unemployment Insurance Act. The provisions affecting the Railroad Retirement Act are considered in some detail in the following pages. The principal provisions of the law as amended are summarized in the accompanying chart.

The new law increases all present and future benefits by 10 percent,

effective June 1959; raises the wage base from \$350 a month to \$400; liberalizes the disability earnings test; and permits early retirement for spouses and certain women workers on an actuarially reduced basis. Other provisions increase future tax rates and modify the work clause for survivor beneficiaries. All applicable maximum and minimum benefits are raised 10 percent, so that now, under the old-age, survivors, and disability insurance minimum guarantee provision, all beneficiaries are, in effect guaranteed at least 10 percent more than they would have received with the same earnings record under old-age, survivors, and disability insurance. No beneficiaries, therefore, received less than a 10-percent increase. The situation was unlike that after enactment of the 1956 amendments

to the Railroad Retirement Act,¹ which left the social security minimum provision unchanged—that is, the benefit was payable in the same amount as under old-age, survivors, and disability insurance.

The 1959 amendments bring the Railroad Retirement Act "into line" with the Social Security Act as amended in 1956 and 1958. Similarities include (1) the earnings base—\$400 a month under railroad retirement and \$4,800 a year under old-age, survivors, and disability insurance; (2) optional retirement for women at age 62, with benefits under the railroad program for both spouses and retired women workers reduced $\frac{5}{8}$ of 1 percent for each month under age 65—the same reduction as under old-age, survivors, and disability in-

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¹ See "1956 Amendments to the Railroad Retirement Act," *Social Security Bulletin*, May 1957.