The Canadian Hospital Insurance Program

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SINCE July 1, 1958, Canada has had a national hospital care insurance program. Under this program the Canadian government bears approximately half the cost of provincial programs for the provision of general hospital care to their populations. To obtain federal aid, a Province must establish a program under which complete inpatient care in general hospitals is made available to all residents "upon uniform terms and conditions." All 10 Canadian Provinces now operate such programs.

This account of the Canadian program is based primarily upon a field study undertaken from November 1959 to July 1960. Initially, several days were spent in Ottawa with officials of the Canada Department of National Health and Welfare, which is in charge of the federal side of the program. Then all the Provinces were visited. Two weeks were spent in Ontario, a week each in the western Provinces, and an average of 3 or 4 working days in each of the other Provinces.

The procedure in visiting each Province was roughly the same. The first half of the time was spent with the key persons in charge of the program. The rest was spent in interviews with the administrators, and sometimes with the chiefs of medical staff, of three or four hospitals, the secretaries of the provincial hospital and the medical and registered nurses' associations, and with representatives of local governmental units, industry, labor, and farm organizations. The purpose was to learn how the program affected these groups and their attitude toward it. To get the views of the man on the street, taxi drivers, bellboys, chambermaids, waitresses, store clerks, and other persons were asked what they thought of the program.

The hospital insurance program can only be understood in the light of Canada's history. As early as 1945 the Canadian government proposed a program of health insurance to be introduced in stages. As a first step, Canada in 1948 initiated a program of grants to the Provinces for various health purposes, including health surveys and hospital construction.

Prior to any federal aid for hospital care a number of Provinces had developed programs for making hospital care available to the population. In 1947 Saskatchewan set up a hospital insurance system under which all residents were required to pay a hospitalization tax or premium and in return were entitled to complete inpatient hospital care. Two years later British Columbia placed in operation a similar program. Here, however, the premium system did not work well. Many people failed to pay the required taxes; so after 5 years and an election upset, premiums were dropped and the program was financed by an increase in the sales tax.

In Alberta, beginning in 1919, various local governmental units developed hospital insurance programs for their residents. Later the provincial government aided these programs with the result that by 1958 they covered three-fourths of the population. Newfoundland, much of its population poor and scattered in

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remote seacoast hamlets, started in the 1930's its "cottage hospital" program under which comprehensive medical and hospital care was made available to about 40 percent of the population. Almost all of the other Provinces had developed programs of grants to hospitals for the care of the indigent. Undoubtedly these on-going schemes helped to pave the way for development of the national hospital insurance program and certainly were a factor in its being placed on a federal-provincial basis.

Role of the National Government

The national hospital insurance program came into being with the enactment by the Canadian government in 1957 of the Hospital Insurance and Diagnostic Services Act. The act is short and simple. It authorizes the Canadian government to make contributions toward the cost of provincial programs of hospital care under which insured hospital services are made available to all residents of a Province "upon uniform terms and conditions." The federal contribution is one-quarter of the per capita cost of hospital care in the Province, plus one-quarter of the per capita cost of hospital care in Canada as a whole, times the population in the Province entitled to care. In other words the federal contribution is roughly one-half, but Provinces with relatively low per capita hospital costs get somewhat more than one-half and Provinces with an above-average per capita costs get less than one-half, the range being from a 62 percent federal share in Newfoundland to 43 percent in Saskatchewan. Since, as a rule, the poorer Provinces have a low per capita cost of hospital care, the formula provides, on the whole, a greater measure of aid to these Provinces.

The act defines the cost of hospital care in which the federal government will share as, in general, all net costs exclusive of depreciation on plant, interest, and repayment of debt. The program applies only to general hospitals, not to mental or tuberculosis hospitals. To obtain federal aid, a Province must agree (*a*) to provide complete inpatient care in standard ward accommodations, including X-ray and laboratory services, without limit on stay; (*b*) to have arrangements to insure that adequate standards are maintained in hospitals, including supervision, licensing, and inspection; and (*c*) to maintain adequate records and accounts.

A Province may or may not provide outpatient services; if it does, the federal government will share in the cost on the same basis as for inpatient care.

Federal aid for provincial programs became available July 1, 1958. By this date six Provinces had entered into agreements with the federal government, of which five had programs underway or ready to start. Three other Provinces followed within the next year or so, and Quebec, the last Province, began its program January 1, 1961.

In addition to financial aid the federal government provides technical assistance to the Provinces, endeavors to assure coordination among the provincial programs, and holds Federal-provincial conferences for discussion of problems relating to the program.

Provincial Programs

Within the limits of the conditions of federal aid, the Provinces are free to finance and operate their programs as they wish, and in fact, there is much diversity among the programs. The major differences among the provincial programs relate to method of financing, coverage of outpatient service, administrative setup, and provisions relating to capital costs.

Of the 10 Provinces, 6 (British Columbia, Alberta, Quebec, Nova Scotia, Newfoundland, New Brunswick) are financing their hospital care programs through general or sales taxes and care is available to all residents, except that in British Columbia the patient must pay $1 and in Alberta from $1.50 to $2.00, depending on size of hospital, for every day of care. The other four Provinces (Ontario, Manitoba, Saskatchewan, and Prince Edward Island) finance their programs mainly through premiums; for example, in Ontario $2.10 a month for a single person and $4.20 for a family. In Saskatchewan and Manitoba payment of the premiums or hospitalization taxes is mandatory for all persons, except those receiving welfare assistance; for these the Province pays the premiums. In the other two Provinces, payment of premiums is compulsory for persons in employed groups of more than a certain size—15 in

Ontario and 3 in Prince Edward Island—and is voluntary for all other persons.

The method of financing has an effect upon the proportion of the population covered. Where general or sales taxes are used, care is available to all residents; it is only necessary for the patient to show that he resides in the Province. Where the schemes are financed by premiums or hospitalization taxes something less than 100 percent of the population is covered. In the two Provinces where payment of premiums is compulsory for all, 98 to 99 percent of the population is covered—1 to 2 percent of the population do not pay because they cannot afford to or do not want to. In the two Provinces where the premiums are compulsory for some employed groups and voluntary for other persons, 95 and 90 percent, respectively, of the population are covered.

New Brunswick started its program on a compulsory premium basis. Premiums were collected from about 85 percent of the population. Dissatisfaction with the premium plan was pronounced and after a year and an election upset, premiums were discarded in favor of general taxes.

In conformity with the provisions of federal aid, all of the provincial programs provide complete inpatient care in standard ward accommodations for as long as may be necessary. Standard ward accommodations will usually mean care in rooms with three or four beds. The patient pays an extra charge for care in semiprivate or private accommodations. Care includes all of the hospital special services, including X-ray and laboratory services and drugs.

The Provinces vary with respect to outpatient services. Two provide no outpatient service. Three provide complete outpatient care, including X-ray and laboratory service. The rest provide only care for accidents within 24 or 48 hours of an accident, or such care and certain other services.

A covered person in one Province who is hospitalized in another Province will receive the same benefits as if hospitalized at home. A covered person hospitalized outside Canada will receive specified allowances, varying among the Provinces, against the cost of care. Through the efforts of the federal government, the provincial programs are coordinated so that a person moving his residence from one Province to another remains eligible for benefits from his former Province until he qualifies for benefits in his new Province.

Administrative units vary. In five Provinces the program is administered by a division of the provincial health department. In two it is administered by a unit which is responsible to the provincial minister of health but is separate from and has equal status with the unit which administers public health services. In the other three Provinces, the program is operated by a commission, usually of from three to eight individuals, some of whom are, in effect, nominees of the hospitals and the medical profession. In one of these Provinces, the tie with the health department is maintained by the fact that the deputy minister of health is also the executive director of the hospital services plan.

All of the Provinces remunerate or finance hospitals in roughly the same way. Typically, each hospital in October or November submits a budget to the administrative agency for the year ahead. This budget gives an estimate of the days of service to be provided, the number and types of personnel required by each department and the salaries to be paid them, other expenses, and the amount of funds required. Comparable data for the preceding year and an estimate of costs for the current year, based on the first 6 or 9 months' experience, are also shown.

The budget of each hospital is reviewed by a rate board consisting of senior members of the staff of the administrative agency. Ratios of personnel to patients and the costs of food, drugs, and medical supplies per patient day are worked out. The budget is compared with the budgets of other hospitals of similar size. If the estimates are considered reasonable the budget is approved. If estimated requirements for personnel, proposed salaries, and so on, appear excessive, the budget may be cut, in which case, if the hospital feels that the cuts are unwarranted, it can appeal. Occasionally a hospital will be allowed more than it asked for, in order that it may improve its services.

From the hospital's total expenses there are deducted, in accordance with the federal definition of sharable hospital costs, generally (*a*) at

least 50 percent (some Provinces require deduction of 60 or 100 percent) of estimated income from charges for semiprivate and private accommodations and (*b*) income from other sources, such as patient income from workmen's compensation cases and noncovered persons, outpatient services if not covered by the hospital insurance program, cafeteria service, and so on. The remainder, representing the net cost of patient care, is reduced by an amount equal to, say, $2.00 multiplied by the estimated number of patient days to be provided during the year. The balance, representing the relatively fixed costs of operation, is paid to the hospital monthly or bimonthly. Then, as discharge reports are received from the hospital, the administrative unit pays the hospital $2.00 for each patient day of care provided. The effect of this procedure is that the hospital receives its approved costs for the year, with slight increments or decrements for days of service in excess of or below the original estimates.

At the end of the year audited costs are reviewed and an adjustment is usually made for such additional expenses as are deemed to have been reasonable and necessary.

In every Province the administrative unit of the hospital insurance program is also responsible for administration of grants for hospital construction, control of hospital construction, inspection and licensure, and efforts to improve standards. Licensure takes a different form than in the United States, since no hospital could exist without funds from the program. Therefore a decision to finance a given hospital is equivalent to licensure.

An exceedingly important function of the administrative agencies in all Provinces is the provision of counseling services to hospitals. Each administrative unit has a staff of counselors or consultants in such fields as hospital administration, accounting, dietetics, nursing, radiology, laboratory, and pharmacy. These counselors visit the hospitals periodically, or go to them on request to aid with various problems. These counselors are especially helpful to the smaller hospitals whose standards generally are most in need of improvement. They are in a different position than hospital licensure inspectors in the United States in that they can, in effect, say to a hospital, "if you will improve your service in this or that respect, we [the program] will pay the bill."

All of the provincial programs have procedures for controlling unnecessary utilization of hospital services. They require hospitals to send in reports on all patients who have been in the hospital 30 days or more, giving data on diagnosis, treatment, and prognosis. The program checks on patients whose reports indicate that they do not seem to require further hospital care. Several Provinces require all hospitals to set up committees of the medical staff to review all admissions and discharges.

Capital costs involve the financing of new construction and the payment of interest, debt charges, and depreciation on existing plant. The federal government makes smaller contributions toward these costs than to the operating costs of hospitals.

Federal grants for hospital construction amount to $2,000 per bed, with the Province required to contribute an equal amount. (For renovations the federal government will contribute up to one-third, which must be matched by the Province.)

As already indicated, hospital costs which will be shared by the federal government include depreciation on equipment but not depreciation on plant, interest, or retirement of debt. The reasoning behind the federal government's decision not to share in the latter items was that it was imperative that hospitals should remain locally owned and operated and that if the provincial and federal governments paid depreciation and debt charges they would, in effect, be meeting the full capital cost of construction; the local community would then have little stake in the hospital; and the basis of local control and operation would be weakened.

There is much variation among the Provinces in dealing with capital costs. One Province pays charges for depreciation (but requires that it be funded), notwithstanding the lack of federal reimbursement. Several have set up special capital cost funds from which payments are made to hospitals which they may use for new construction or for interest on or repayment of debt. Alberta took over the existing debts of all hospitals when it instituted its program and provides 100 percent of the cost of all new approved construction; here the local com-

munity is relieved of all responsibility for the cost of past or future hospital construction.

In all Provinces the federal and matching provincial grants for hospital construction will meet generally one-fourth of the cost of construction. A few Provinces go further, one putting up one-half, another two-thirds, and a third up to 70 percent of constructions costs. In all provinces there can be no hospital construction without approval of the provincial agency. The reason for this is obvious. Under the programs, the provincial government is meeting 100 percent of the cost of operation of all hospitals in the Province; it must therefore be able to approve any new plant.

The existing arrangements, varying as they do from Province to Province, still leave some hospitals with problems of financing expansion or replacement of plant. Mainly, the hospitals so affected are ones owned by religious orders which have not been accustomed to going to the public for funds for new construction. Just what the final solution will be remains unclear. There is considerable pressure by the Provinces upon the federal government to share in plant depreciation and debt charges. Whether the federal government will yield to these pressures remains to be seen. A more likely development is the provision of increased federal grants for construction.

From this review it will be apparent that the programs are not solely or even primarily fiscal programs. They are essentially programs for the provision of hospital care to the population, and the really important considerations are improving the quality of care, developing necessary hospital facilities, and seeing that hospital care is provided as effectively and economically as possible. The fundamental purpose of the program naturally gives the provincial authority a strong interest in regional coordination, in avoidance of duplicating facilities, and in control of unnecessary utilization of hospital services; and the provincial unit has the power to make its interests felt.

Evaluation

From the standpoints of the public, the hospitals, and the medical profession, the hospital insurance programs have both advantages and disadvantages.

Effect on the Public

Based on talks with people in different walks of life and with hospital administrators, physicians, nurses, industry representatives, and labor leaders, I believe that these programs are good for the public. They have made hospital care available to all or virtually all of the population. People now can obtain hospital care when they need it, and the dread of high hospital bills has been removed from their lives. Formerly Blue Cross and other private insurance programs covered a certain percentage of the population, ranging from perhaps 20 percent in Newfoundland to 67 percent in Ontario. But these programs, in general, covered the better-off portion of the population and did not reach those who were least able to pay hospitalization costs. Now, in all except two Provinces, coverage is universal or almost so, and in these two, over 90 percent of the population are reached.

Furthermore, now the coverage is complete. The patient receives hospital care for as long as he needs it, and all hospital services are provided. For almost all Canadians, hospital bills for standard ward accommodations are nonexistent. (A qualification must be made as regards Saskatchewan, where the program does not cover the cost of certain drugs, and patients receive bills for these.)

Often hospital administrators, after telling me how the hospital insurance program affected their hospitals and making minor complaints about this or that aspect of it, would exclaim, "But, oh, how wonderful this program is for the patients!" They meant that it is wonderful for people to be able to get hospital care when they need it, without fear of pauperization, without asking for charity. The nurses say that now patients recover faster because they need not worry over the hospital bill.

Of course, the effect of these programs upon the quality and overall cost of hospital care is also of vital concern to the public.

Effect on Hospitals

Probably the primary effect of these insurance programs upon hospitals is that their financing is now assured. The programs provide to hospitals their necessary and reasonable costs of operation. In most Provinces there are

no longer any charity patients. Deficits, except when a hospital, knowingly or unknowingly, overspends its budget are a thing of the past.

Many hospital administrators reported that prior to establishment of the hospital care insurance program, it was always touch and go to keep the hospital's doors open. The prime job of the hospital board and even of the administrator was to raise additional money to pay the hospital's bills. The hospital insurance programs have brought an end to this. No longer does the hospital administrator or the board, in effect, have to scrounge around for money. Now they submit a budget for what they need and, assuming that the budget is approved, they have the required funds in hand.

In a number of Provinces, prior to inauguration of the insurance program, hospitals were in financial straits. For example, in British Columbia in 1948, the financial position of many hospitals was such that they felt they could not go on. They had appealed to the provincial government for help, and this appeal was a prime factor in leading the government to establish the scheme. In Ontario, the government decided to inaugurate a hospital insurance program largely because of appeals from the hospitals for further financial help.

A second and corollary effect of the insurance program upon hospitals is that overall expenditures for hospital care have increased somewhat more than they would have in the absence of a program. In Ontario, for example, the 1960 budgets of hospitals are about 16 percent more than the 1959 figures, compared with an average increase of 12 to 13 percent a year during the past few years.

In Saskatchewan, per capita operating expenses of hospitals increased by 141 percent between 1946, the year before the program started, and 1950; the increase over the same period in Canada as a whole was 78 percent. In British Columbia, per capita operating costs increased by 61 percent between 1948, the year prior to the program, and 1952, compared with 45 percent in Canada as a whole.

Available statistical data show that in almost all of the Provinces with newly established hospital care insurance programs the per capita and per diem cost of hospital care increased more in the first year or two of the program than in the preceding few years. Hospital costs have been rising rapidly in Canada, as in the United States. Certainly, the testimony of hospital administrators and program officials is to the effect that the institution of the program eased the financial position of hospitals and generally enabled them to increase the number of personnel and to improve the pay and working conditions of their employees. In general, Canadian hospitals have lower ratios of personnel to patients than hospitals in this country, and hospital costs per diem are much lower than in the United States—$16.59 in short-term general hospitals in 1958 compared with $28.27 here.

Talks with hospital administrators, plan officials, secretaries of nurses' associations, and representatives of hospital employee unions leave no question in my mind but that the hospital insurance programs have been beneficial for hospital employees. In Canada, as in the United States, hospital employees have in some areas been underpaid. There, as here, pay has been increasing and the differentials in pay and working conditions between hospitals and other industries have been decreasing. The hospital insurance programs accelerated this process and made it easier for hospitals to grant wage increases.

One very tangible effect of the programs is in the area of pensions. In Canada prior to the programs, as in the United States today, relatively few hospitals had pension programs for their employees. Now all or virtually all of the Provinces are in process of developing provincewide pension programs for hospital employees, in several cases as a joint activity with the provincial hospital association. There will be one scheme in which all hospitals in a Province will participate so that an employee going from one hospital to another will carry his pension rights with him.

These hospital care insurance programs are concerned naturally and inevitably with the quality of service and with doing whatever needs to be done to bring that quality to as high a level as possible. The examination of hospital budgets becomes an opportunity for the provincial administrative unit not merely to give the hospital the money it requests for carrying on its work but for examination of the stand-

ards of care in that hospital, for suggesting steps to improve services, and for providing the money to make the improvements possible.

Undoubtedly the hospitals lose some degree of their autonomy under these programs. This worries some hospital administrators. But the great majority recognize and accept this as a necessary price to pay for the advantages of assured financing. I asked many hospital administrators whether the programs reduce the incentive to do a good job or make his job less interesting or less responsible. The majority answered that the programs did not lessen incentives or responsibilities; that with the financial problem solved the hospital administrator can concentrate on his primary job—operating his hospital effectively and providing good care to the patients.

Will the hospital insurance programs make for less interest and responsiblity on the part of hospital boards? Possibly yes, possibly no. Certainly the precise activities of boards are different since the advent of the programs. Formerly a board had to find the money to cover any deficit that the hospital incurred. Now there is no longer need for that type of activity. But the board is still responsible for selection of the hospital administrator and for seeing that he does a proper job. The board must review and approve the budget which the hospital administrator proposes to submit to the provincial authority. If the provincial rate board gives the hospital less money than it needs for proper operation, then the hospital board must take steps, in one way or another, to see that the hospital receives the funds it really needs. This responsibility cannot be abdicated.

Some observers believe that the provincial authorities will necessarily assume more and more responsibility for setting levels of pay for various categories of hospital employees, leaving less latitude to the hospital board. Perhaps so, but with the spread of unionization of hospital employees—and in Canada their unionization is far advanced—more and more of these matters are taken out of the hands of the individual hospital.

The hospital care insurance programs have immensely improved hospital budgeting and accounting practices in Canada. Previously, as in the United States, only a minority of hospitals had budgets. Now all hospitals have a budget and must keep accounts in a uniform way so that valid comparisons among hospitals are possible. Hospital administrators complain a little about the work of developing a budget but admit that this makes for better planning and administration. Some bookkeeping work has been greatly lessened. No longer is it necessary to make charge slips for medicines, laboratory tests, and other items. The patient, as a rule, gets no bill or a bill only for extra charges for semiprivate or private accommodations.

These programs do not establish a utopia. There are and will continue to be problems. While most hospitals feel that now they have no financial problems, a few feel less well off than formerly. These hospitals are receiving their costs, but no more, from the provincial governments. Before introduction of the hospital care insurance program they were generally operated so that they accepted few patients who couldn't pay, their charges were somewhat more than their costs, and each year they had a surplus which they could put toward expansion of plant or other projects. Now, receiving only the cost of operation, they feel financially tighter than before.

In a situation where hospitals submit their budget requirements for the year ahead and a governmental unit provides the funds needed for the reasonable cost of operation, there will always be differences of opinion between the hospitals and the governmental unit as to what the hospitals really need. It will never be possible for hospitals to get all the money they feel is necessary. Individual hospitals will complain because they can't add all the employees they feel they need or pay quite as high salaries as they would like.

In British Columbia relationships between the hospitals and the provincial government at the time of my visit were rather unhappy. Hospital budgets had been cut without explanation, and the hospitals felt that the government was threatening their autonomy. In part, the friction seemed to be due to personalities and to the apparent inability of hospital and government representatives to talk their problems out. Some hospitals felt that they had

not been given the funds needed to improve their services and to provide a high standard of care, and that the government, in checking increasing costs, had held too tight a rein. Statistics seem to bear this out. During the first 5 years of the British Columbia program, hospital per diem costs rose more rapidly than in Canada as a whole; since 1953 they have risen less than in Canada as a whole; although per diem costs in British Columbia are still higher than in any other Province. Nevertheless, the secretary of the British Columbia Hospital Association stated that despite these complaints not one hospital administrator in the Province would be willing to go back to the old days.

The virtually universal testimony of hospital administrators in all the Canadian Provinces is to the effect that, on the whole, hospitals are better off under the program than they were before.

Except in Saskatchewan and British Columbia these hospital insurance programs are very new, and it is too early to make a final evaluation. In most Provinces the first year or two of the program seem to be a honeymoon period during which the provincial government gives hospitals almost everything they ask for, and there are rapid increases in hospital standards and costs. Then, as costs mount and the provincial authorities have to ask for increases in premium rates or in sales or other taxes, administrators of the provincial programs are under pressure to hold costs down.

Undoubtedly there is a risk to hospitals in these programs, which by controlling the finances of hospitals, control their standards. And, if the hospitals are not given the funds they need to provide proper care for their patients, the programs can have harmful effects. The situation forces upon hospital boards and administrators a new role. They must be prepared to educate provincial authorities, legislatures, and eventually the public as to the importance of high standards of hospital care and the need for giving hospitals the funds required for providing good care. A similar role is thrust upon the medical profession.

The hospital care programs have everywhere strengthened the provincial hospital associations. For example, some associations formerly did not have full-time secretaries; now they have them. This is important because hospital associations play a vital role in representing hospitals and in seeing that they obtain the funds necessary to enable them to provide good care.

Effect on the Medical Profession

Based on talks with the secretaries of the Canadian and provincial medical associations and with many other physicians, it may be said that the medical profession accepts and approves the hospital care programs and thinks they are beneficial for all concerned. The profession finds the programs advantageous because they enable physicians to hospitalize their patients and to order X-ray and laboratory examinations and drugs without having to consider whether the patient can afford the costs. The programs are financially helpful because, with the hospital bill eliminated, physicians are more likely to be able to collect their fees.

The Canadian Medical Association did not oppose, in fact it favored, the passage of the Hospital Insurance and Diagnostic Services Act, and in no Province did the medical profession oppose the establishment of the hospital insurance program. Physicians seemed to be happiest about the program in the Provinces where they had played an active role in its design and feel that their views were and are consulted.

It is true that physicians are apprehensive that hospital care programs may lay the foundation for compulsory medical service insurance, and this they do not want. This fear has been realized in Saskatchewan, where the provincial government has announced that it will start a program of medical insurance. But hospital insurance is well accepted and approved by the medical profession. It is of interest that the establishment of the hospital care programs has in all Provinces stimulated enrollment in the voluntary medical service prepayment plans sponsored by the medical profession.

Other Facets

The hospital insurance programs have increased hospital utilization throughout Canada. Hospitals are crowded, more crowded than they were before. But the situation is not so acute that patients urgently needing care cannot be

admitted to a hospital. (The volume of hospital construction has doubled since the advent of the programs.) Since the insurance programs were established partly to help people to get hospital care, some increase in hospital utilization was to be expected.

There is about the same amount of talk in Canada as in the United States about unnecessary utilization of hospital care. Control of utilization seems to present similar problems under both voluntary and governmental insurance. In Canada, as in the United States, the provincial authorities are coming to hold that one way of controlling unnecessary utilization of hospital care is to limit the supply of beds—that if beds are available they will be used.

Canada uses more hospital care, proportionately, than the United States: in 1958, 1,684 days of care per 1,000 population in nonfederal general hospitals compared with 1,091 days per 1,000 population here. Utilization of hospital care in Canada has been steadily increasing—from 1,371 days per 1,000 population in 1946 to 1,684 days in 1958. This compares with an increase in utilization from 1,048 days to 1,091 days per 1,000 population over the same period in the United States. Much of the difference in utilization between Canada and the United States lies in the fact that Canada has very few nursing homes and cares for patients in hospitals who in the United States would be cared for in nursing homes.

A good feature of these hospital insurance programs is that the completeness of their coverage forces those in charge to come to grips with the whole problem of hospital and other care for the aged and the chronically ill. Everywhere hospital administrators report that a significant proportion of their beds are filled with long-stay patients who do not require active treatment but for whom there is no other place. Several Provinces are rapidly developing more beds in the chronic disease units of general hospitals or in chronic disease hospitals to care for these patients. If there are insufficient beds in chronic disease hospitals or in the chronic units of general hospitals, "chronic" patients will "back up" in the acute wards of general hospitals; if there are insufficient facilities for aged persons needing personal and some nursing care then these patients will "back up" in the chronic disease hospitals or chronic units of general hospitals. And so the hospital insurance programs are stimulating the development of homes for old folks and infirmaries for aged chronically ill patients. Only two or three programs are using proprietary nursing homes and these only as a temporary expedient.

The cost of administering these hospital care programs depends in large measure on whether the schemes are financed by premiums or by sales or general taxes. In 1959 Ontario and Saskatchewan, with their premium schemes, had administrative costs equal to about 2.6 and 3.2 percent, respectively, of the total hospital costs for the insured population. British Columbia, with no premiums to collect or eligibility records to keep, had an administrative cost ratio of about 1.2 percent. This does not include any expense for collection of the provincial sales taxes. The Province of Alberta, financing its program out of general taxes, in 1959 spent 0.5 percent on administration. At the time of my visit Alberta was running its whole program, costing $29 million, with 27 employees, too few to do all that needed to be done. For all the Provinces together administrative expense in 1959 was 2.6 percent of the cost of hospital care provided and $0.67 per capita of the population covered. In the United States administrative expenses came to 5 percent of premiums for Blue Cross. Including reserves and profits, they took 6 percent of insurance company group hospital policies and 47 percent of individual hospital policies.

In making this comparison, one must bear in mind that administrative costs of the Canadian programs cover the functions of financing hospitals, planning hospital construction and providing construction grants, and the provision of inspection and counseling services for hospitals; in the United States hospital insurance has only the one function of paying hospitals or providing indemnity benefits against the cost of hospital care.

What has happened to the Blue Cross hospital service plans as a result of these insurance programs? In Ontario the premium system took over the old Blue Cross organization and its entire personnel; the former director of Blue Cross is now the general manager of the

Ontario Hospital Services Commission. In Manitoba, similarly, the premium system there took over practically all the former Blue Cross personnel. Saskatchewan never had a Blue Cross plan. British Columbia had a small plan and it went out of existence with the inception of the governmental program there. In a number of Provinces the Blue Cross plan still continues but now writes contracts which cover the extra cost of a semiprivate room or give allowances against private room charges. This is so in Alberta, Manitoba, Ontario, and all the maritime Provinces.

What do the Blue Cross directors say about the governmental schemes which in effect displaced them? They say that these governmental programs are better; that they are really a blessing for the people; that they are doing for the whole population what Blue Cross could do for only a part of the population. No Province has in effect contracted with the former Blue Cross plan to administer its hospital care program.

These programs are not static; they will evolve and change with time.

There appear to be definite drawbacks to the premium systems. If they are partially voluntary, then a small part of the population is not reached. If they are compulsory for all, there are still 1 or 2 percent of the population who are not covered, even though premiums are paid or waived for those on public assistance. The plans seem to work more simply where they are financed out of sales or general taxes.

Do the plans work best when administered by a division of the provincial health department or by a separate commission? There are plans of both types which are well administered and are working well. There are advantages to each. In the long run, possibly, the programs will work best if administered by a division of the health department, but in the initial stages they may possibly get off to a better start if administered by a separate commission. One Province, New Brunswick, has shifted administration from a commission to a division of the health department.

Some problems of capital costs are still unsolved. It is not clear what the final answers will be. Payment of depreciation charges by the insurance plan has shortcomings since it does not assure an established hospital of funds to replace an obsolete plant; furthermore, not all hospitals should be replaced—the need may be for a hospital in another locality. The trend seems to be toward meeting a larger share of the cost of construction through construction grants.

One misreads the nature of these programs if he considers them merely as programs of hospital care insurance. While they spread the risk of hospital costs they go beyond insurance. Essentially, they are programs for providing hospital care to the whole population. In addition to patient care they involve (*a*) construction of facilities—seeing that the Province has the facilities, well designed, properly located, of the right type, and properly related to each other, necessary for good patient care; (*b*) maintenance of good standards of patient care in all hospitals—taking necessary steps to see that all hospitals provide as good a level of care as possible; (*c*) effective and economical operation of hospitals—seeing that hospitals have the funds to provide good care and that funds are prudently used; (*d*) training hospital personnel in sufficient numbers to provide adequate patient care. The programs are not now involved in all of these aspects of hospital care but potentially they may be.

The hospital care insurance programs make possible a planned, coordinated effort to meet the hospital needs of the public, and through control of hospital construction and of hospital finances they have the authority to assure the necessary coordination among individual hospitals. Potentially there are many inherent advantages in this planned approach. Whether plans will be well made or effectively carried out will depend on the caliber of administration.

All in all these hospital care programs seem to be good for the population of Canada, for their hospitals, for hospital personnel, and for the medical profession.