



CANADA HEALTH ACT

ANNUAL REPORT 2018–2019

Public Administration | Comprehensiveness | Universality | Portability | Accessibility



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Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

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Health Canada would like to acknowledge the work and effort that went into producing this Annual Report. It is through the dedication and timely commitment of the following departments of health and their staff that we are able to bring you this report on the administration and operation of the *Canada Health Act*:

Newfoundland and Labrador Department of Health and Community Services

Prince Edward Island Department of Health and Wellness

Nova Scotia Department of Health and Wellness

New Brunswick Department of Health

Quebec Ministry of Health and Social Services

Ontario Ministry of Health

Manitoba Department of Health, Seniors and Active Living

Saskatchewan Ministry of Health

Alberta Department of Health

British Columbia Ministry of Health

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health

We also greatly appreciate the extensive work effort that was put into this report by our production team, including desktop publishers, translators, editors and concordance experts, printers and staff of Health Canada.



I am honoured to present to Parliament and to Canadians the Canada Health Act Annual Report 2018–2019, my first since being appointed Minister of Health.

As outlined in my mandate letter, one of the key responsibilities in my new role is to uphold the *Canada Health Act*, which ensures all Canadians have equitable access to health care services based on their need and not on their ability, or willingness, to pay. My personal and professional experiences, from running a homeless shelter, to protecting the rights of women and children, to tackling workplace harassment, have been based on a determination to increase the quality of life for all citizens, and, in particular, advocate for those who are more at risk of being left behind. The values that have underpinned my work are the very ones that form the foundation of the *Canada Health Act*, namely, equity, fairness, and solidarity.

It is these values that are under direct threat from a Charter challenge in British Columbia—*Cambie Surgeries Corporation v. British Columbia (Attorney General)*. While it is specific provisions in British Columbia's *Medicare Protection Act* that are being challenged, and not the *Canada Health Act*, these provisions reflect the principles of the *Canada Health Act* and discourage the development of a two-tiered health care system. It is for this reason that our government chose to participate in these proceedings and support British Columbia in its defense of universally accessible health care.

Charging patients at the point of care for medically necessary services undermines the principle that access to health care should be based on medical need rather than ability, or willingness, to pay. It increases overall system costs, reduces public commitment to universal coverage, and ultimately erodes equity. In fact, this is precisely the type of practice that was the impetus for the *Canada Health Act* at its inception in 1984. I assure you I will make every effort to protect and defend the Act, to ensure access to care continues to be based on relative health need.

Over the last number of years, significant strides have been made in eliminating patient charges, which create barriers to access. However, there is still more work to be done. I look forward to working with provinces and territories as we implement the Diagnostic Services Policy, which will ensure patients do not face charges for medically necessary diagnostic services, such as MRI and CT scans, when these services are provided in private clinics. This policy will come into effect as of April 1, 2020, after which point any charges to patients for these services will be a contravention of the *Canada Health Act* and will result in mandatory penalties. Jurisdictions currently allowing these charges have until April 1, 2020, to implement new policies and practices, or face the prospect of mandatory penalties in the form of Canada Health Transfer deductions.

I am also dedicated to addressing continued barriers to access to abortion services across the country. Women have the right to reproductive choice in Canada and abortion services should be readily available, if chosen. While these services are insured in all provinces and territories, access varies within, and among, jurisdictions. The Prime Minister asked me in my mandate letter to ensure that Canadians have full access to medical and surgical abortion services across the country.

The underlying value of equitable access to health care remains a point of pride for Canadians who rightfully expect that the only card they need to present to obtain medically necessary care is their health card, not a credit card. That is something worth fighting for.

— *The Honourable Patty Hajdu, Minister of Health*

CHAPTER 1

CANADA HEALTH ACT OVERVIEW

This section describes the evolution of Medicare in Canada, the *Canada Health Act*, its key definitions, requirements, regulations, and penalty provisions; and excluded persons and services. It also outlines letters from former federal Ministers of Health sent to their provincial and territorial counterparts, following months of consultation:

- › the Honourable Jake Epp provided guidance on the interpretation and application of the Act;
- › the Honourable Diane Marleau announced the Federal Policy on Private Clinics;
- › the Honourable A. Anne McLellan outlined the Canada Health Act Dispute Avoidance and Resolution process; and
- › the Honourable Ginette Petitpas Taylor formalized three new *Canada Health Act* initiatives—the Diagnostic Services Policy, the Reimbursement Policy, and strengthened *Canada Health Act* reporting.

THE EVOLUTION OF MEDICARE IN CANADA

Canada's single-payor public health insurance system, "Medicare", is financed through a progressive tax system, which allows risks to be pooled and costs to be shared by all Canadians. Our health care insurance system evolved into its present form over more than six decades. Saskatchewan was the first province to establish universal, public hospital insurance in 1947 and, 10 years later, the Government of Canada passed the *Hospital Insurance and Diagnostic Services Act* (HIDSA) (1957), to encourage provinces and territories to provide universal coverage for these services by sharing in their costs. The unanimous adoption of HIDSA by the federal Parliament launched the largest single program ever undertaken in peace-time Canada, and by 1961, all the provinces and territories had public insurance plans that provided universal access to hospital services. Saskatchewan again pioneered by providing insurance for physician services, beginning in 1962. The Government of Canada enacted the *Medical Care Act* in 1966, to encourage provinces and territories to provide universal coverage for physician services by sharing in their costs. By 1972, all provincial and territorial plans had been extended to include physician service.

In 1979, at the request of the federal government, Justice Emmett Hall undertook a review of the state of health services in Canada. In his report, he affirmed that health care services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user charges levied by hospitals were creating a two-tiered system that threatened the universal accessibility of care. This report, and the national debate it generated, led to the enactment of the *Canada Health Act*.

“The practice of extra-billing is inequitable. Not only does it deny access by the poor but it also taxes sick persons who... are already paying the major cost of the system through their taxes.”

Canada's National-Provincial Health Program for the 1980's: A Commitment for Renewal, August 29, 1980 (Page 26)

Adopted unanimously by Parliament in 1984, the *Canada Health Act*, Canada's federal health care insurance legislation, codified the national principles which underpinned federal funding for hospital and physician services and added prohibitions on patient charges which threatened to undermine universal access to care.

In Canada, the roles and responsibilities for the health care system are shared between the federal, provincial and territorial governments. The provincial and territorial governments have primary jurisdiction in health care administration and delivery. This includes setting their own priorities, administering their health care budgets and managing their own resources. The

federal government, under the *Canada Health Act*, defines the national principles that are to be reflected in provincial and territorial health care insurance plans.

WHAT IS THE CANADA HEALTH ACT?

In fiscal year 2018–2019, the CHT transfer was \$38,584,000. Additional information on federal, provincial and territorial funding arrangements is available by visiting the Department of Finance's website at: www.fin.gc.ca/access/fedprov-eng.asp

The *Canada Health Act* sets out the primary objective of Canadian health care policy, which is “... to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”

The Act establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive their full federal cash contributions under the Canada Health Transfer (CHT).

The aim of the Act is to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital, physician, and surgical-dental services that require a hospital setting, on a prepaid basis, without charges related to the provision of insured health care services. A copy of the Act is provided in Annex A.

KEY DEFINITIONS UNDER THE CANADA HEALTH ACT

Insured health services are medically necessary hospital, physician and surgical-dental services [performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures] provided to insured persons.

Extended health care services are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the Act as "... a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Insured hospital services include medically necessary in- and out-patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required; nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefor from the hospital.

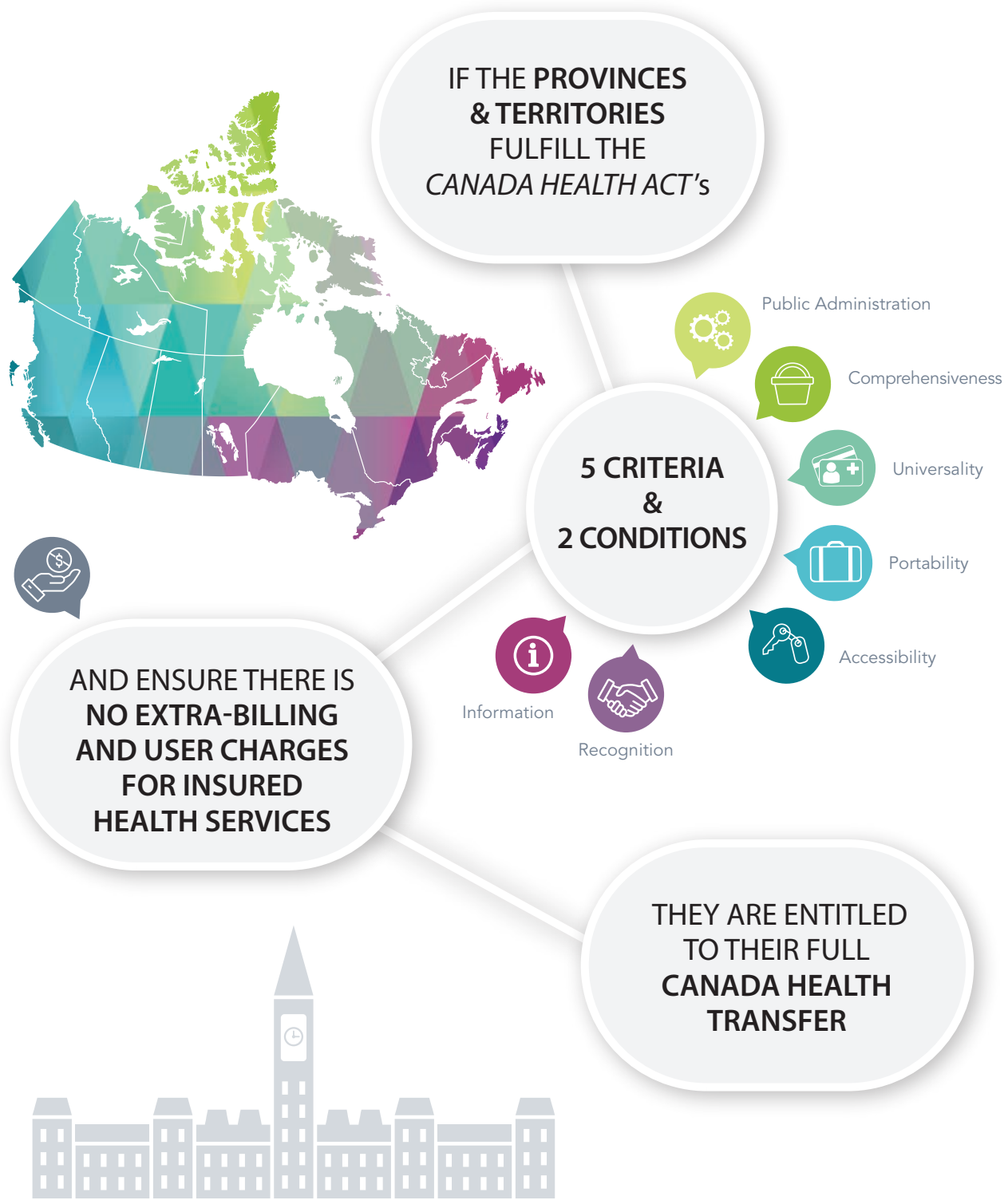
Insured physician services are medically required services rendered by medical practitioners. Medically required physician services are generally determined by the provincial or territorial health care insurance plan, in consultation with the medical profession.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required for the proper performance of the procedure.

"Thanks to medicare, no one need worry about any financial burden resulting from an unforeseen illness. Since health insurance is a collective program, all Canadians share the cost of medical care for which they could not pay individually. Their taxes provide anticipated payments towards the cost of the insured health services they will eventually need. This program is not only for the young, the wealthy and the healthy. It is designed also to help the poor, the old and the chronically ill. The latter group is the one most affected by the charging of direct fees."

April 11, 1984 debate on the enactment of the *Canada Health Act*, statement by Senator Jacques Hébert

CANADA HEALTH ACT



REQUIREMENTS OF THE CANADA HEALTH ACT

The *Canada Health Act* contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash entitlement under the CHT.

They are:

- › five program criteria that apply only to insured health care services;
- › two conditions that apply to insured health care services and extended health care services; and
- › two provisions, for extra-billing and user charges, that apply only to insured health care services.

THE CRITERIA



1. Public Administration (section 8)

The public administration criterion of the *Canada Health Act* requires provincial and territorial health care insurance plans to be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited. However, the criterion does not prevent the public authority from contracting out the services necessary for the administration of the provincial and territorial health care insurance plans, such as the processing of payments to physicians for insured health care services.

The public administration criterion pertains only to the administration of provincial and territorial health care insurance plans and does not preclude private facilities or providers from supplying insured health care services as long as no insured person is charged in relation to these insured health services.



2. Comprehensiveness (section 9)

The comprehensiveness criterion requires that the health care insurance plan of a province or territory must cover all insured health care services provided by hospitals, physicians or dentists (i.e., surgical-dental services that require a hospital setting).



3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health care services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plan to establish entitlement.



4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for health care services insured by the "home" jurisdiction during any waiting period (up to three months) imposed by the new province or territory of residence, before coverage is established in the new jurisdiction. It is the responsibility of residents to inform their province or territory's health care insurance plan that they are leaving and to register with the health care insurance plan of their new province or territory, in order to avoid any gaps in coverage.

Residents who are temporarily absent from their home province or territory, or from Canada, must continue to be covered for health care services insured by their home province or territory during their absence. If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive medically necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

Prior approval by the health care insurance plan in a person's home province or territory may be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from their province or territory.



5. Accessibility (section 12)

The intent of the accessibility criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services that require a hospital setting, on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (extra-billing or user charges) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" principle. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting. For example, if a hospital in one region of a province was providing highly specialised services, that would not mean that all hospitals in the province would be required to provide the same service. Rather, it means that all residents of the province should have access to the service wherever it is being offered, on the same basis.

In addition, the health care insurance plan of the province or territory must provide:

- › reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- › payment to hospitals to cover the cost of insured health care services.

THE CONDITIONS



1. Information (section 13[a])

The provincial and territorial governments are required to provide information to the federal Minister of Health as prescribed by regulations under the Act.



2. Recognition (section 13[b])

The provincial and territorial governments are required to recognize the federal financial contributions toward both insured and extended health care services.



THE PROVISIONS—EXTRA-BILLING AND USER CHARGES

The provisions of the *Canada Health Act* pertaining to extra-billing and user charges for insured health care services in a province or territory are outlined in sections 18 to 21. If it can be confirmed that either extra-billing or user charges exist in a province or territory, a mandatory dollar-for-dollar deduction from the federal health transfer (the Canada Health Transfer [CHT]) to that province or territory is required under the Act.

EXTRA-BILLING (SECTION 18)

Under the Act, extra-billing is defined as a charge by an enrolled physician or dentist (i.e., a dentist providing insured surgical-dental services in a hospital setting) to an insured person for an insured service in addition to the amount paid by the provincial or territorial health care insurance plan. For example, if an enrolled physician was to charge a patient any amount for an office visit that is insured by the provincial or territorial health care insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore also contrary to the accessibility criterion.

USER CHARGES (SECTION 19)

A user charge is defined as any charge for an insured health care service, other than extra-billing. This includes any charge levied for insured hospital services, or any non-physician related services provided in conjunction with an insured physician service at a non-hospital facility (e.g., private clinic or private practice). In other words, if patients were charged a fee as a condition of receiving insured health care services, that fee would be considered a user charge. User charges are not permitted under the Act because, as is the case with extra-billing, they constitute a barrier or impediment to access.

WHAT IS A PATIENT CHARGE?



IF AN ENROLLED PHYSICIAN OR DENTIST...



CHARGES AN INSURED RESIDENT...



FOR AN INSURED SERVICE...



AN AMOUNT IN ADDITION TO THE AMOUNT
PAID BY THE PROVINCIAL OR TERRITORIAL HEALTH
INSURANCE PLAN...

THAT IS EXTRA-BILLING.

OTHER CHARGES (E.G., FOR SUPPLIES) RELATED TO
THE PROVISION OF INSURED HEALTH SERVICES...

ARE USER CHARGES.

OTHER ELEMENTS OF THE ACT

REGULATIONS (SECTION 22)

Section 22 of the *Canada Health Act* enables the federal government to make regulations for administering the Act in the following areas:

- › defining the services included in the Act's definition of extended health care services, e.g., nursing home care or home care;
- › prescribing which services are excluded from hospital services;
- › prescribing the types of information that the federal Minister of Health may reasonably require, as well as the format and submission deadline for the information; and
- › prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

To date, the only regulations in force under the Act are the *Extra-billing and User Charges Information Regulations*. These Regulations require the provinces and territories to report annually to Health Canada on the amounts of extra-billing and user charges levied. A copy of these Regulations is provided in Annex A.

PENALTY PROVISIONS OF THE CANADA HEALTH ACT

MANDATORY PENALTY PROVISIONS

Under the Act, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT. For example, if it is determined that any amount of extra-billing by physicians has occurred in a province or territory, the federal cash contribution to that province or territory will be reduced by that same amount. Although deductions are usually based on information provided by the province or territory, in accordance with the *Extra-billing and User Charges Information Regulations*, where information is not provided, Health Canada will make an estimate of the amount of extra-billing and user charges. This process requires consultation with the province or territory concerned. Deductions based on estimates have been made on numerous occasions.

DISCRETIONARY PENALTY PROVISIONS

Non-compliance with one of the five criteria or two conditions of the Act is subject to a discretionary penalty. The amount of any deduction from CHT payments is based on the magnitude of the non-compliance, and is approved by Cabinet.

The *Canada Health Act* sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been used.

EXCLUDED SERVICES AND PERSONS

Although the *Canada Health Act* requires that insured health care services be provided to insured persons in a manner that is consistent with the criteria and conditions set out in the Act, not all health care services or Canadian residents fall under the scope of the Act.

EXCLUDED SERVICES

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health care insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation (unless prescribed by a physician or when standard ward level accommodation is unavailable), private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice; the provision of medical certificates required for work, school, insurance purposes and fitness clubs; the transfer of medical records; testimony in court; and cosmetic services. Amounts for these services are governed by provincial and territorial Colleges of Physicians, which generally require that charges be reasonable and reflect the cost of services provided.

The definition of insured health services excludes services to persons provided under any other Act of Parliament (e.g., certain services provided to veterans) or under the workers' compensation legislation of a province or territory.

In addition to the medically necessary hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a wide range of other programs and services, such as prescription drug coverage, non-surgical dental care, ambulance services, and optometric services, at their discretion and on their own terms and conditions. These services are often targeted to specific population groups (e.g., seniors, children, and those receiving social assistance), with levels of funding and scope of coverage varying from one province or territory to another.

EXCLUDED PERSONS

The *Canada Health Act* definition of an insured person excludes members of the Canadian Forces and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programs.

The exclusion of these persons from insured health care service coverage predates the adoption of the Act and is not intended to constitute differences in access to publicly insured health care.

POLICY INTERPRETATION LETTERS

There are three key policy statements that clarify the federal position on the *Canada Health Act*. These statements were made in the form of ministerial letters from former federal Ministers of Health to their provincial and territorial counterparts, following months of consultation. Copies of the letters are provided in Annex B of this report.

EPP LETTER

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, federal Minister of Health and Welfare Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the Act. The letter sets forth statements of federal policy intent that clarify the Act's criteria, conditions and regulatory provisions. The letter highlighted the fundamental change signified by the *Canada Health Act*, which was the prohibition of all patient charges for insured services provided to insured residents. The Epp letter remains an important reference for assessing and interpreting compliance with the Act.

MARLEAU LETTER—FEDERAL POLICY ON PRIVATE CLINICS

Between February and December of 1994, a series of seven federal, provincial and territorial meetings dealing wholly, or in part, with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients, and their impact on Canada's universal, publicly funded health care system.

At the September 1994 federal, provincial and territorial meeting of Health Ministers in Halifax, all Ministers of Health present, with the exception of Alberta's Health Minister, agreed to "...take whatever steps are required to regulate the development of private clinics in Canada".

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial Ministers of Health on January 6, 1995, to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of hospital contained in the Act includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial or territorial health care insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

PETITPAS TAYLOR LETTER

On August 8, 2018, the former federal Health Minister Ginette Petitpas Taylor wrote to her provincial and territorial counterparts formalizing three new *Canada Health Act* initiatives—the Diagnostic Services Policy, the Reimbursement Policy, and strengthened *Canada Health Act* reporting. These initiatives were the subject of discussion at the federal, provincial and territorial officials' level and adjustments were made to the requirements of these initiatives based on feedback received from the provinces and territories.

Diagnostic Services Policy

The Diagnostic Services Policy will take full effect from April 1, 2020. This policy is a formalization of the application of the *Canada Health Act* to diagnostic services. It confirms the longstanding federal position that medically necessary diagnostic services are insured services, regardless of the venue where the services are delivered.

Reimbursement Policy

Should a province or territory be subject to a deduction, the federal Minister of Health has the discretion to provide a reimbursement if the province or territory eliminates the patient charges that led to the deductions within a specified timeframe. The first deductions eligible for reimbursement under the policy were those taken in March 2018.

Starting with this report, annual provincial and territorial financial statements of extra-billing and user charges are published in the Canada Health Act Annual Report. These are provided in Annex D.

Strengthened Canada Health Act Reporting

The aim of strengthened *Canada Health Act* reporting is to ensure Health Canada has the information required to accurately assess compliance with the Act, as well as to increase transparency for Parliament and Canadians on the administration of the Act, and the state of the publicly funded health care insurance system.

DISPUTE AVOIDANCE AND RESOLUTION PROCESS

In April 2002, former federal Minister of Health A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal, provincial and territorial interests of avoiding disputes related to the interpretation of the principles of the Act and, when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues as they arise; active participation of governments in ad hoc federal, provincial and territorial committees on Act-related issues; and *Canada Health Act* advance assessments of proposed provincial and territorial policies, regulations and legislation, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issue to a third-party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

A copy of Minister McLellan's letter is provided in Annex C of this report.



CHAPTER 2

ADMINISTRATION AND COMPLIANCE

ADMINISTRATION

In administering the *Canada Health Act*, the federal Minister of Health is assisted by Health Canada staff and by the Department of Justice.

THE CANADA HEALTH ACT DIVISION

The Canada Health Act Division of Health Canada is responsible for supporting the Minister in the administration of the *Canada Health Act*. Members of the Division fulfill the following ongoing functions:

- › monitoring and analyzing provincial and territorial health care insurance plans for compliance with the criteria, conditions, and extra-billing and user charges provisions of the Act;
- › asking provincial and territorial health ministries to investigate and provide information and clarification when possible compliance issues arise, and, when necessary, recommending corrective action to them, in order to ensure the criteria, conditions, and extra-billing and user charges provisions of the Act are upheld;
- › conducting issue analysis and policy research to provide strategic advice;
- › informing the federal Minister of Health (the Minister) of possible non-compliance and recommending appropriate action to resolve the issue;
- › disseminating information on the Act, and its administration;
- › responding to enquiries about the Act and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, federal government departments, other governments, stakeholder organizations, and the media;
- › developing and maintaining relationships with health officials in provincial and territorial governments, for information sharing;
- › collaborating with provincial and territorial health department representatives through the Interprovincial Health Insurance Agreements Coordinating Committee;
- › working with Health Canada Legal Services and Justice Canada on litigation issues that implicate the Act; and
- › producing the Canada Health Act Annual Report on the administration and operation of the Act.

CANADA HEALTH ACT COMPLIANCE

The Canada Health Act Division monitors the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the *Canada Health Act*. Sources for this information include: provincial and territorial government officials and publications; nongovernmental organizations; media reports; and correspondence received from the public.

Staff in the Canada Health Act Division assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate action. Verifying the facts with provincial and territorial health officials sometimes reveals issues that are not directly related to the Act, while others may pertain to the Act but are a result of misunderstanding or miscommunication, such as eligibility for health care insurance coverage and portability of health services within and outside Canada. In these instances, matters are generally resolved quickly with provincial or territorial assistance.

In instances where a *Canada Health Act* issue has been identified and remains after initial enquiries, Division officials ask the jurisdiction in question to investigate the matter and report back. Division staff discuss the issue and its possible resolution with provincial or territorial officials. Only if the issue is not resolved to the satisfaction of the Division, after following the aforementioned steps, is it brought to the attention of the federal Minister of Health.

DEDUCTIONS AND REIMBURSEMENTS UNDER THE ACT

For the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the *Canada Health Act*. However, some issues and concerns remain. The most prominent of these relate to accessibility issues, and specifically patient charges for medically necessary health services at private clinics. There are also concerns under the portability criterion. These issues and concerns are described below.



NEWFOUNDLAND AND LABRADOR

On the basis of its health ministry's report to Health Canada, a deduction in the amount of \$1,349 was taken from the March 2019 Canada Health Transfer (CHT) payments to Newfoundland and Labrador in respect of user charges for insured health services provided by an enrolled physician at a private ophthalmological clinic in fiscal year 2016–2017. Subsequently, the province worked collaboratively with Health Canada to create a mutually agreed-upon Reimbursement Action Plan (RAP) to eliminate these patient charges. Under the Reimbursement Policy, described earlier in this report, if the province carries out this plan to the satisfaction of Health Canada, and successfully eliminates patient charges, it will be eligible for a reimbursement of the March 2019 deduction. A copy of Newfoundland and Labrador's RAP as well as the January 2020 status update on the implementation of their RAP are presented in Annex E of this report.



QUEBEC

On the basis of amounts of patient charges confirmed by the Quebec Ministry for the reporting period, a deduction in the amount of \$8,256,024 was levied to Quebec's March 2019 CHT payments. Because the province had already taken action to eliminate these charges in 2017, Health Canada issued an immediate reimbursement to Quebec in the same amount, under the Reimbursement Policy.



BRITISH COLUMBIA

Following an audit of selected private clinics undertaken by the British Columbia health ministry, as part of a 2017 agreement with Health Canada, the province submitted a financial statement to Health Canada indicating extra-billing and user charges in the amount of \$16,177,259 during the reporting period. This amount was based on patient complaints, completed audit results, and publicly available evidence of \$4.7 million of patient charges to insured residents by enrolled physicians at the Cambie Surgery Centre. A deduction in the same amount was taken from British Columbia's March 2019 CHT payments.

British Columbia continues to work with Health Canada to implement a RAP to eliminate these patient charges. A copy of the RAP is presented in Annex E of this report. At the time of this report's publication, British Columbia's status update on its RAP was not available. Once available it will be published at www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2018-2019/british-columbia-status-update-reimbursement-action-plan.html

The province has implemented some elements of its plan, but the elimination of patient charges has been hindered by an injunction related to the ongoing Charter challenge, known as *Cambie Surgeries Corporation v. British Columbia (Attorney General)* in the British Columbia Supreme Court.

As reported in last year's Canada Health Act Annual Report, on March 31, 2016, the Government of Canada gave notice that it would appear as a party in the litigation, pursuant to British Columbia's *Constitutional Question Act*.

The plaintiffs in the litigation are seeking to invalidate provisions of British Columbia's *Medicare Protection Act* that prohibit user charges, extra-billing and private insurance for health services covered under British Columbia's provincial health care insurance plan, on the basis that these provisions violate sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*. In the spring of 2019, Canada presented arguments to the Court in support of the constitutionality of provisions of the *Medicare Protection Act*, which reflect the principles of the *Canada Health Act*. The federal Government expects to conclude its final argument in February 2020, and a decision from the Court is anticipated later in the year.

ADDITIONAL COMPLIANCE ISSUES

Health Canada continues to monitor provincial and territorial compliance with the Act. The following key developments occurred since the 2017–2018 Canada Health Act Annual Report was tabled in Parliament.



ABORTION SERVICES

Abortion services are insured in all provinces and territories; however, access to both medical and surgical abortion varies within and between jurisdictions across the country. In some provinces, access to medical abortions is impeded by the lack of physicians willing to prescribe them. In New Brunswick, surgical abortion services are only covered under the provincial health insurance plan if performed in a hospital; procedures provided in the private clinic in Fredericton are not covered. In Ontario, media stories have highlighted fees some women have been charged to access surgical abortion services in private clinics. Subsequently, Health Canada learned that while the Ontario Health Insurance Plan provides coverage for physicians' fees related to abortion services in all private clinics, it only covers facility fees in the four private abortion clinics authorized under the province's *Independent Health Facilities Act*.

In July 2019, the federal Minister of Health wrote to all provinces and territories with regard to persistent barriers to access for abortion services across the country, which pose concerns under the accessibility and comprehensiveness criteria of the Act. As well, the Minister wrote to the health ministers of New Brunswick and Ontario to signal that any patient charges for surgical abortions would be considered extra-billing and user charges under the Act, and would result in penalties. Health Canada continues to consult with the health ministries of New Brunswick and Ontario on this issue.



OUT-OF-COUNTRY PORTABILITY

In April 2019, Ontario announced that it would end its program covering emergency hospital and physician services received by Ontario residents while outside Canada. The province officially eliminated this coverage on January 1, 2020. This is a direct contravention of the *Canada Health Act's* requirement that provincial and territorial health care insurance plans provide coverage to residents while outside the country. While Health Canada had long been concerned by the coverage levels in some provinces—only Prince Edward Island and the territories appear to be meeting this requirement—Ontario is the first province to eliminate coverage altogether.

In July 2019, the federal Minister of Health wrote to her counterparts in all provinces and territories to remind them of their obligations under the Act, in this regard.



PATIENT CHARGES FOR MEDICALLY NECESSARY DIAGNOSTIC SERVICES

As mentioned earlier in this report, in August 2018, the federal Minister of Health wrote to her provincial and territorial counterparts to announce the Diagnostic Services Policy, which formalized the longstanding federal position that medically necessary diagnostic services received in private clinics are considered insured health services. While Saskatchewan is the only province that expressly encourages this practice through legislation, there is evidence of residents paying out-of-pocket to secure faster access to diagnostic services in other provinces, including British Columbia, Alberta, Manitoba, Quebec, New Brunswick and Nova Scotia. To give jurisdictions time to align their health care systems with the requirements of this policy, the effective date was set

for April 1, 2020. Once the policy is in effect, provinces and territories that permit patients to be charged for these services will be subject to deductions from federal transfers under the *Canada Health Act*. During the reporting period, Health Canada consulted with provinces and territories to offer assistance in preparation for the policy's implementation. British Columbia has taken action on this issue by increasing public capacity through the purchase of two private MRI clinics and increasing funding for the service, and is preparing to implement legislation in April 2020 that will preclude patient payment for these services.



PATIENT CHARGES IN PRIMARY HEALTH CARE CLINICS

During 2018–2019, Health Canada continued to consult with Alberta Health about private primary health care clinics that charge patients annual enrollment and membership fees. If the receipt of insured health services is conditional upon the payment of fees, it would pose concerns under the extra-billing and user charges provisions of the Act. Typically, the fees cover a basket of uninsured services but also promise quick access to, and unrushed appointments with, family physicians. Health Canada was informed that the audit of the Copeman Healthcare Centre in Calgary had concluded and a report on the audit's findings had been provided to the Alberta Minister of Health for review and determination of next steps. Health Canada will continue to monitor this issue.



PREFERRED ACCOMMODATION IN PRIVATE HOSPITALS

Under the Act, the definition of hospital services specifies that standard or public ward level accommodation is an insured service. Charges for preferred accommodation, i.e., private or semi-private rooms, are not permissible under the Act when such accommodation is medically required, or no ward level accommodation is available. Health Canada has been consulting with the Ontario Ministry of Health on this issue, due to reports that hospitals with only semi-private and private rooms were charging patients for preferred accommodation when they receive insured health services. During the reporting period, Ontario officials notified Health Canada that the province has amended the regulations under its *Health Insurance Act* to ensure that patients cannot be charged for preferred accommodation when ward level accommodation is unavailable.



PATIENT CHARGES FOR SERVICES PROVIDED BY NON-PHYSICIANS

In May 2019, Health Canada wrote to Manitoba Health to express concern about several private practices led by nurse practitioners where patients were being charged for services that would be covered under the provincial health insurance plan if they were provided by physicians. In particular, Health Canada expressed concern about the migration of services from a setting where access is universal and based on medical need to one where access depends on the ability, and willingness, of the patient to pay. Manitoba responded, saying that while it considers the provision of services by nurse practitioners in the province to be compliant with the requirements of the Act, it is examining the scope of practice of nurse practitioners in private and public practice, and the implications of potential overlap with insured physician services.

During 2018–2019, Health Canada continued to monitor the following ongoing compliance and interpretation issue:



IN-COUNTRY PORTABILITY

Physician services received by Quebec residents when out-of-province are not reimbursed at host province rates, which is a requirement of the portability criterion of the Act. Canadians from provinces and territories other than Quebec also report difficulties having their provincial or territorial health care insurance cards honoured while out-of-province, particularly by walk-in clinics, which runs counter to the spirit of the Act.

HISTORY OF DEDUCTIONS, REFUNDS AND REIMBURSEMENTS UNDER THE CANADA HEALTH ACT

The *Canada Health Act*, which came into force April 17, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

CANADA HEALTH ACT COMPLIANCE FROM 1984–1987

During the period 1984 to 1987, subsection 20(5) of the Act provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces in which patients had been subject to extra-billing and user charges had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of \$244,732,000 in deductions was refunded to New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta and British Columbia.

DEDUCTIONS AND SUBSEQUENT REFUNDS FOR EXTRA-BILLING AND USER CHARGES FROM 1984–1987

	1984–1985	1985–1986	1986–1987	TOTAL
NB	3,078,000	3,306,000	502,000	6,886,000
QC	7,893,000	6,139,000	-	14,032,000
ON	39,996,000	53,328,000	13,332,000	106,656,000
MB	810,000	460,000	-	1,270,000
SK	1,451,000	656,000	-	2,107,000
AB	9,936,000	11,856,000	7,240,000	29,032,000
BC	22,797,000	30,620,000	31,332,000	84,749,000
TOTAL	85,961,000	106,365,000	52,406,000	244,732,000

Following the Act's initial three-year transition period, during which refunds to provinces and territories for deductions were possible, penalties under the Act did not reoccur until fiscal year 1994–1995. See the chart later in this chapter for penalties occurring from fiscal year 1994–1995 to the present.

The subject of penalties under the Act for patient charges returned in January 1995, when federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary surgical services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the Act. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia, and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

Please refer to the table at the end of this section for a summary of deductions and refunds that have been made to provincial or territorial transfer payments since 1994–1995.

BRITISH COLUMBIA

In the early 1990s, as a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health care insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health care insurance plan. This higher amount constituted extra-billing under the Act. Deductions began in May 1994, relating to fiscal year 1992–1993, and continued until extra-billing by physicians was banned when changes to British Columbia's *Medicare Protection Act* came into effect in September 1995. In total, \$2,025,000 was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992–1993 and 1995–1996.

In January 2003, British Columbia provided a financial statement in accordance with the *Canada Health Act Extra-billing and User Charges Information Regulations*, indicating aggregate amounts actually charged with respect to extra-billing and user charges in private surgical clinics during fiscal year 2000–2001, totaling \$4,610. Accordingly, a deduction of \$4,610 was made to the March 2003 Canada Health and Social Transfer (CHST) cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001–2002. As a result of reports that British Columbia was investigating 55 cases of user charges, a \$126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount the federal Minister estimated to have been charged during fiscal year 2001–2002.

Since 2005, \$33,680,875 in cash transfer deductions have been taken from British Columbia's Canada Health Transfer (CHT) payments in light of patient charges reported by the province to Health Canada. The deduction taken in 2012–2013 in respect of fiscal year 2010–2011 was estimated by the federal Minister of Health and represents the aggregate of the amounts reported to Health Canada by British Columbia and those reported publicly as the result of an audit performed by the Medical Services Commission of British Columbia. This methodology was used in subsequent years. As reported earlier in this chapter, the deduction of \$15,861,818 was taken in March 2018 and \$16,177,259 taken in March 2019 to British Columbia's CHT payment was derived primarily from the results of an audit of patient charges levied by private clinics in that province.

ALBERTA

Under the Federal Policy on Private Clinics, total deductions of \$3,585,000 were made, from November 1995 until June 1996, to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health care insurance plan.

MANITOBA

From November 1995 to December 1998, deductions totaling \$2,055,000 were taken from Manitoba's federal health transfer, under the Federal Policy on Private Clinics. These deductions ended with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001–2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of \$50,034 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured health services in fiscal years 1997–1998 and 1998–1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to \$2,355,201.

QUEBEC

In March 2017, on the basis of amounts of extra-billing and user charges reported by the Quebec Auditor General with respect to accessory fees charged in 2014–2015, the federal Minister estimated a deduction amount of \$9,907,229. In light of corrective action the provincial government had already taken to eliminate accessory fees in January 2017, that amount was subsequently returned to Quebec by the Government of Canada. Similar deductions and reimbursements were made in March 2018 and March 2019, in respect of extra-billing and user charges in 2015–2016 and 2016–2017, respectively. Quebec's March 2019 reimbursement was the first made under the new Reimbursement Policy.

NOVA SCOTIA

With the closure of a private clinic in Halifax, effective November 27, 2003, penalties to Nova Scotia for non-compliance with the Federal Policy on Private Clinics ceased. Before it closed, total deductions of \$372,135 were made to Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients, while paying the physician fee. A final deduction of \$5,463 was taken from the March 2005 CHT payment to Nova Scotia as a reconciliation of deductions that had already been taken for 2002–2003. A one-time positive adjustment in the amount of \$8,121 was made to Nova Scotia's March 2006 CHT payment to reconcile amounts actually charged in respect of extra-billing and user charges with the penalties that had already been levied based on provincial estimates reported for fiscal 2003–2004.

The March 2007 CHT payment to Nova Scotia was reduced by \$9,460 in respect of extra-billing during fiscal year 2004–2005. This amount was reported to Health Canada by the province based on the findings of an audit, concluded in 2006, of the billing practices of a Nova Scotia physician.

NEWFOUNDLAND AND LABRADOR

Pursuant to the Federal Policy on Private Clinics, a total of \$280,430 was deducted from Newfoundland and Labrador's cash contribution due to facility fees in a private abortion clinic, before these fees were eliminated, effective January 1, 1998.

A deduction of \$1,100 was taken from the March 2005 CHT payment to Newfoundland and Labrador as a result of patient charges for an MRI scan in a hospital which occurred during 2002–2003.

From March 2011 to March 2013, deductions totaling \$102,249 were taken from CHT payments to Newfoundland and Labrador for extra-billing and user charges, based on charges reported by the province to Health Canada. These charges resulted from services provided by an opted-out dental surgeon who has since left the province and Health Canada considers this matter resolved.

In March 2019, a deduction of \$1,349 was taken from CHT payments to Newfoundland and Labrador for extra-billing and user charges, based on patient charges for insured health services at a private ophthalmological clinic that occurred in 2016–2017, reported by the province to Health Canada.

Since the passage of the Act, from April 1984 to March 2019, deductions totaling \$70,612,008 have been taken from transfer payments in respect of the extra-billing and user charges provisions of the Act. This amount excludes deductions totaling \$244,732,000 that were made between 1984 and 1987, and subsequently refunded to the provinces when extra-billing and user charges were eliminated.

DEDUCTIONS AND RECONCILIATIONS TO CHST/CHT CASH CONTRIBUTIONS IN ACCORDANCE WITH THE CANADA HEALTH ACT (IN DOLLARS)—1994–1995 TO 2018–2019

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YT	NT	NU	TOTAL
1994/95	-	-	-	-	-	-	-	-	-	1,982,000	-	-	-	1,982,000
1995/96	46,000	-	32,000	-	-	-	269,000	-	2,319,000	43,000	-	-	-	2,709,000
1996/97	96,000	-	72,000	-	-	-	588,000	-	1,266,000	-	-	-	-	2,022,000
1997/98	128,000	-	57,000	-	-	-	586,000	-	-	-	-	-	-	771,000
1998/99	53,000	-	38,950	-	-	-	612,000	-	-	-	-	-	-	703,950
1999/00	(42,570)	-	61,110	-	-	-	-	-	-	-	-	-	-	18,540
2000/01	-	-	57,804	-	-	-	-	-	-	-	-	-	-	57,804
2001/02	-	-	35,100	-	-	-	300,201	-	-	-	-	-	-	335,301
2002/03	-	-	11,052	-	-	-	-	-	-	4,610	-	-	-	15,662
2003/04	-	-	7,119	-	-	-	-	-	-	126,775	-	-	-	133,894
2004/05	1,100	-	5,463	-	-	-	-	-	-	72,464	-	-	-	79,027
2005/06	-	-	(8,121)	-	-	-	-	-	-	29,019	-	-	-	20,898
2006/07	-	-	9,460	-	-	-	-	-	-	114,850	-	-	-	124,310
2007/08	-	-	-	-	-	-	-	-	-	42,113	-	-	-	42,113
2008/09	-	-	-	-	-	-	-	-	-	66,195	-	-	-	66,195
2009/10	-	-	-	-	-	-	-	-	-	73,925	-	-	-	73,925
2010/11	3,577	-	-	-	-	-	-	-	-	75,136	-	-	-	78,713
2011/12	58,679	-	-	-	-	-	-	-	-	33,219	-	-	-	91,898
2012/13	50,758	-	-	-	-	-	-	-	-	280,019	-	-	-	330,777
2013/14	(10,765)	-	-	-	-	-	-	-	-	224,568	-	-	-	213,803
2014/15	-	-	-	-	-	-	-	-	-	241,637	-	-	-	241,637
2015/16	-	-	-	-	-	-	-	-	-	204,145	-	-	-	204,145
2016/17	-	-	-	-	9,907,2291	-	-	-	-	184,508	-	-	-	10,091,737
2017/18	-	-	-	-	9,907,2291	-	-	-	-	15,861,818	-	-	-	25,769,047
2018/19	1,349	-	-	-	8,256,0241	-	-	-	-	16,177,259	-	-	-	24,434,632
TOTAL	385,128	0	378,937	0	28,070,482	0	2,355,201	0	3,585,000	35,837,260	0	0	0	70,612,008

¹ These amounts were subsequently refunded to the province in light of corrective actions the provincial government had already taken to address the issue of accessory fees at the time of the deduction.

Understanding This Chart

- The first deductions under the Act were taken during the first three years after the Act's passage and were subsequently refunded. They are described earlier in this chapter and listed in a chart on page 24. There were no deductions taken between fiscal year 1987–1988 and 1993–1994.
- In instances where provinces and territories estimate anticipated amounts of extra-billing and user charges for the upcoming year, a deduction was taken in respect of those charges in the fiscal year for which they are estimated.
- In addition to forming the basis for most deductions under the Act, the statements of actual extra-billing and user charges provide an opportunity to reconcile any estimated charges with those that actually occurred. These reconciliations form the basis for further modifications to provincial and territorial cash transfers. Numbers in parentheses represent reconciliations made to the province or territory.

INTERPROVINCIAL HEALTH INSURANCE AGREEMENTS COORDINATING COMMITTEE

The Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC) was formed in 1991 to address issues affecting the interprovincial billing of insured hospital and physician services. The Committee includes members from each province and territory and a non-voting chair from the Canada Health Act Division. The Canada Health Act Division also provides secretariat functions for IHIACC.

All provinces and territories participate in hospital reciprocal billing agreements, and all, with the exception of Quebec, participate in physician reciprocal billing agreements. These agreements generally ensure that a patient's health care insurance card will be accepted, in lieu of payment, when the patient receives insured hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province at agreed-upon rates. The intent of these agreements is to ensure that Canadian residents do not have to pay directly for medically necessary hospital and physician services when they travel within Canada. Of note, these agreements are interprovincial, not federal, and while they facilitate the portability criterion, they are not a requirement of the Act.

During the reporting period, IHIACC implemented a new method for reciprocally billing out-patient chemotherapy services and expanded the list of high cost implants and devices that could be reciprocally billed.

The Interprovincial Health Insurance Agreements Coordinating Committee's Rate Review Working Group is responsible for determining reciprocal billing rates to ensure that the host province or territory that is providing the health service is compensated by the home province at a reasonable rate.

Issues related to registration and eligibility requirements are addressed through IHIACC's Eligibility and Portability Agreement Working Group, which is responsible for reviewing eligibility issues and identifying potential inter-jurisdictional gaps in health care coverage.

The Policy Research Working Group examines policy-related issues that impede coverage of insured health services with the aim of increasing the consistency and coordination of interprovincial health care coverage and billing practices.

CHAPTER 3

PROVINCIAL AND TERRITORIAL HEALTH CARE INSURANCE PLANS IN 2018–2019

The following chapter presents the 13 provincial and territorial health care insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* program criteria and conditions in 2018–2019.

Officials in the provincial, territorial and federal governments have collaborated to produce the detailed plan overviews contained in Chapter 3. The information that Health Canada requested from the provincial and territorial departments of health for the report consists of two components:

- › a narrative description of the provincial or territorial health care system relating to the criteria and conditions of the Act, which can be found following this introduction; and
- › statistical information related to insured health services.

The narrative component is used to help with the monitoring and compliance of provincial and territorial health care insurance plans with respect to the requirements of the Act, while statistics help to identify current and future trends in the Canadian health care system. While all provinces and territories have submitted detailed descriptive information on their health care insurance plans, Quebec chose not to submit supplemental statistical information which is contained in the tables in this year's report.

To help provinces and territories prepare their submissions to the annual report, Health Canada provided them with the document; *Canada Health Act Annual Report 2018–2019: A Guide for Updating Submissions (User's Guide)*. The User's Guide is designed to help provinces and territories meet Health Canada's reporting requirements. Annual revisions to the guide are based on Health Canada's analysis of health care insurance plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for the Canada Health Act Annual Report 2018–2019 was launched summer 2019 with bilateral teleconferences. An updated User's Guide was also sent to the provinces and territories at that time.

INSURANCE PLAN DESCRIPTIONS

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health care insurance plan. The descriptions follow the program criteria areas of the *Canada Health Act* in order to illustrate how the plans satisfy these criteria. This narrative format also allows each jurisdiction to indicate how it met the *Canada Health Act* requirement for the recognition of federal contributions that support insured and extended health care services.

KEY DEFINITIONS PROVIDED TO PROVINCES AND TERRITORIES TO GUIDE THEIR SUBMISSIONS TO THIS REPORT

Participating Physician or Dentist is a licensed physician or dentist who is enrolled in a provincial or territorial health care insurance plan.

Non-Participating Physician or Dentist practises completely outside a provincial or territorial health care insurance plan. Neither the physician or dentist nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health care insurance plans. A non-participating physician or dentist may therefore establish their own fees, which are paid directly by the patient.

Opted-out Physician or Dentist is a physician or dentist who is enrolled in the provincial or territorial health insurance plan but has voluntarily opted out of the plan and will therefore bill their patients directly. These charges can be up to, but not more than, the provincial or territorial amount allowed under the fee schedule agreement. The provincial or territorial plans reimburse patients of opted-out physicians or dentists for these charges.

PROVINCIAL AND TERRITORIAL HEALTH CARE INSURANCE PLAN STATISTICS

Over time, the section of the annual report containing the statistical information submitted from the provinces and territories has been simplified and streamlined based on feedback received from provincial and territorial officials, and based on reviews of data quality and availability. The supplemental statistical information tables can be found at the end of each provincial or territorial narrative, except for Quebec.

The purpose of the statistical tables is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental services by province and territory for five consecutive years ending on March 31, 2019. All information was provided by provincial and territorial officials.

Although efforts are made to capture data on a consistent basis, differences exist in the reporting on health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions are not made. Provincial and territorial governments are responsible for the quality and completeness of the data they provide.

ORGANIZATION OF THE INFORMATION

Information in the statistical tables is grouped according to the nine subcategories described below.

Registered Persons: Registered persons are the number of residents registered with the health care insurance plans of each province or territory.

Insured Hospital Services within Own Province or Territory: Statistics in this sub-section relate to the provision of insured hospital services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Hospital Services Provided to Residents in Another Province or Territory: This sub-section presents out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada.

Insured Hospital Services Provided Outside Canada: This represents residents' hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory.

Insured Physician Services within Own Province or Territory: Statistics in this sub-section relate to the provision of insured physician services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Physician Services Provided to Residents in Another Province or Territory: This sub-section reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents.

Insured Physician Services Provided Outside Canada: This represents residents' medical costs incurred while travelling outside of Canada that are paid by their home province or territory.

Insured Surgical-Dental Services within Own Province or Territory: The information in this subsection describes insured surgical-dental services provided in each province or territory.

NEWFOUNDLAND AND LABRADOR



The Department of Health and Community Services (the department) is responsible for setting the overall strategic directions and priorities for the health and community services system throughout Newfoundland and Labrador.

The department works with stakeholders to develop and enhance policies, legislation, provincial standards and strategies to support individuals, families and communities to achieve optimal health and well-being. The department provides a lead role in policy, planning, program development, and support to the four regional health authorities (RHA). The department also works with stakeholders to ensure that high quality, cost effective and timely health services are available for all Newfoundlanders and Labradorians.

The department provides leadership, coordination, monitoring, and support to the RHA which deliver the majority of publicly funded health services in the province, as well as to other entities that deliver programs and services. This ensures quality, efficiency, and effectiveness in areas such as the administration of health care facilities; access and clinical efficiency; programs for seniors, persons with disabilities and persons with mental health and addictions issues as well as long-term care and community support services; health professional education and training programs; the control, possession, handling, keeping and sale of food and drugs; the preservation and promotion of health; the prevention and control of disease; and public health and the enforcement of public health standards.

With an annual budget of approximately \$3.1 billion, the department accounts for approximately 39 per cent of Newfoundland and Labrador's total budget. Budget 2018–2019 provided funding to support the implementation of the recommendations of Towards Recovery: The Mental Health and Addictions Action Plan for Newfoundland and Labrador, the Provincial Home Support Program Review, the expansion of primary health care teams, the repair and renovation of health facilities, and the replacement and upgrading of medical equipment.

In Newfoundland and Labrador, health services are provided to over 526,000 residents by approximately 31,400 people in the health and community services sector. Of this total, approximately 19,000 people are employed by the four RHA and approximately 200 people are employed by the Department of Health and Community Services.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department of Health and Community Services (the department) include the Medical Care Plan (MCP) and the Hospital Insurance Plan (HIP). Both plans are non-profit and publicly administered.

The *Medical Care and Hospital Insurance Act* came into force on October 1, 2016, replacing both the *Medical Care Insurance Act*, 1999, and the *Hospital Insurance Agreement Act*. The *Medical Care and Hospital Insurance Act* can be viewed on the Newfoundland and Labrador House of Assembly website.

As per section 5 of the Act, the Minister of Health and Community Services (the Minister) is required to administer a plan of medical care and hospital insurance for residents of the province. The Act provides authority to make regulations defining who is a resident, prescribing which services are insured services and under what circumstances insured services shall be paid by the Minister.

The MCP facilitates the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures, and systems that permit appropriate compensation to providers for rendering insured professional services.

The HIP covers insured hospital services received within the province when recommended by a medical practitioner. Eligibility for coverage under the plan is linked with eligibility for the MCP. All beneficiaries of the MCP are automatically entitled to coverage under the HIP.

Both the HIP and the MCP operate in accordance with the provisions of the *Medical Care and Hospital Insurance Act* and related regulations, and in compliance with the *Canada Health Act*.

During the 2018–2019 year, two amendments were made to the *Medical Care Insurance Insured Services Regulations* under the *Medical Care and Hospital Insurance Act*. First, amendments were made that specifically included services provided by a physician via telephone as an insured service, if specified in the fee schedule. Second, amendments were made to clarify that the medically necessary removal and replacement of a cataract lens by any procedure is an insured service and must be performed in a hospital or a facility designated by the Lieutenant-Governor in Council.

The *Hospital Insurance Regulations* under the Act were also updated to clarify that the medically necessary removal and replacement of a cataract lens is an insured service and must be performed in a hospital or a facility designated by the Lieutenant-Governor in Council.

1.2 Reporting Relationship

The department is mandated with administering the HIP and the MCP. The department reports on these plans through the regular legislative processes, as well as through other public reporting mechanisms (e.g., Public Accounts and the Social Services Committee of the House of Assembly).

The Government of Newfoundland and Labrador has a provincial planning and reporting requirement for all government departments, including the Department of Health and Community Services. Under the *Transparency and Accountability Act*, the Department of Health and Community Services and the 10 other entities that report to the Minister, including the regional health authorities (RHA), produce a strategic plan once every three years and report annually on their performance. Plans and reports are tabled in the House of Assembly and posted on the [department's website](#).

The 2018–2019 Department of Health and Community Services annual report was tabled in the House of Assembly on September 30, 2019.

1.3 Audit of Accounts

Each year, the province's Auditor General independently examines provincial Public Accounts. The MCP expenditures are considered a part of the Public Accounts. While respecting privacy and personal information, the Auditor General has full and unrestricted access to code-based records of the MCP. There were no Auditor General reviews of the department's programs, services, or the MCP expenditures in 2018–2019.

The four RHA are subject to financial statement audits, reviews, and compliance audits. Financial statement audits are performed by independent auditing firms that are selected by the RHA. Review engagements are conducted using the Generally Accepted Auditing Standards of the Canadian Institute of Chartered Accountants. Various compliance and physician audits are carried out by personnel from the Department under the authority of the *Medical Care and Hospital Insurance Act*.

Physician records and professional medical corporation records are reviewed to ensure that the records supported the services billed and that the services are insured under the MCP. Beneficiary audits are performed by personnel from the department under the *Medical Care and Hospital Insurance Act*.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

As of March 31, 2019, the *Medical Care and Hospital Insurance Act* and the *Hospital Insurance Regulations* provided for insured hospital services in Newfoundland and Labrador. All the hospital services as defined under the *Canada Health Act* are insured services in Newfoundland and Labrador.

Insured hospital services are provided for in-patients and out-patients in 15 hospitals, 23 community health centres and 65 community clinics throughout the province. As indicated in the statistics table, the change in the number of clinics reflects a change in how the department classifies public health facilities. Hospital insured services include:

- › accommodations and meals at the standard ward level;
- › nursing services;
- › laboratory, radiology and other diagnostic procedures;
- › drugs, biologicals and related preparations;
- › medical and surgical supplies;
- › operating room, case room and anaesthetic facilities;
- › rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology);

- › radiotherapy services (e.g., radiotherapy facilities, radioactive isotopes);
- › in-patient, out-patient and emergency visits; and
- › day surgery.

The coverage policy for insured hospital services is linked to the coverage policy for insured medical services. The department manages the process of adding or de-listing a hospital service from the list of insured services based on direction from the Lieutenant-Governor in Council.

2.2 Insured Physician Services

As of March 31, 2019, the enabling legislation for insured physician services was the *Medical Care and Hospital Insurance Act* and the relevant regulations continued thereunder, which included the:

- › *Medical Care Insurance Insured Services Regulations*;
- › *Medical Care Insurance Beneficiaries and Inquiries Regulations*; and
- › *Physicians and Fee Regulations*.

In 2018–2019 (as of March 31, 2019) there were 1,262 physicians (salaried and fee-for-service) active in practice in the province.

For purposes of the Act, the following services are covered:

- › all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice (including services provided by telephone if indicated in the fee schedule);
- › group immunizations or inoculations carried out by physicians at the request of the appropriate authority;
- › diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Medical Care and Hospital Insurance Act* and regulations made under the Act; and
- › the medically necessary removal and replacement of a cataract lens by any procedure and performed in a hospital or a facility designated by the Lieutenant-Governor in Council.

Physicians can choose not to participate in the health care insurance plan as outlined in section 8 of the *Medical Care and Hospital Insurance Act*, namely:

- › 8. (3) A practitioner may, in writing, notify the minister of his or her election to collect payments in respect of insured services provided by the practitioner to beneficiaries otherwise than from the minister.
- › 8. (4) An election under subsection (3) shall have effect from the first day of the first month beginning after the expiration of 60 days after the date on which the minister receives the notice of election.

- › 8. (5) A practitioner who has made an election under subsection (3) may revoke the election by written notice to the minister.
- › 8. (6) A revocation of election under subsection (5) shall have effect from the first day of the first month beginning after the expiration of 60 days after the date on which the minister receives the notice of revocation.
- › 8. (7) Notwithstanding subsections (4) and (6), the minister may waive the time periods in those subsections where, in his or her opinion, it is reasonable to do so.

As of March 31, 2019, there were no physicians who had opted-out of the Medical Care Plan (MCP).

Lieutenant-Governor in Council approval is required to add to or to de-insure a physician service from the list of insured services. This process is managed by the department in consultation with various stakeholders.

2.3 Insured Surgical-Dental Services

The provincial Surgical-Dental Program is a component of the MCP. Surgical-dental treatments provided to a beneficiary and carried out in a hospital by a licensed oral surgeon or dentist are covered by the MCP if the treatment is specified in the Surgical-Dental Services Schedule.

There were 22 dentists providing insured services under the Surgical-Dental Program as of March 31, 2019.

Dentists may opt out of the MCP as per section 8 of the *Medical Care and Hospital Insurance Act* referenced above. These dentists must advise the patient of their opted-out status, state the fees expected, and provide the patient with a written record of services and fees charged. As of March 31, 2019, there were no opted-out dentists. There was no extra-billing in 2018–2019.

Because the Surgical-Dental Program is a component of the MCP, management of the program is linked to the MCP process regarding changes to the list of insured services.

Any addition of a surgical-dental service to the list of insured services must be approved by the Minister of Health and Community Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the MCP include:

- › preferred accommodation at the patient's request;
- › ambulance or other patient transportation before admission or upon discharge;
- › private duty nursing arranged by the patient or any private practitioner in a hospital facility requested by the patient;
- › non-medically required x-rays or other services for employment or insurance purposes;
- › drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital;

- › bedside telephones, radios or television sets for personal, non-teaching use;
- › services provided in non-approved Canadian diagnostic imaging facilities;
- › in-vitro fertilization and other procreative measures;
- › services covered by WorkplaceNL or by other federal or provincial legislation; and
- › services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the College of Physicians and Surgeons of Newfoundland and Labrador.

The use of the hospital setting for any services deemed uninsured by the MCP are also uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care and Hospital Insurance Act*, the following is a list of uninsured physician services:

- › the dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- › the preparation by a physician of records, reports or certificates for, or on behalf of, or any communication to, or relating to, a beneficiary;
- › any services rendered by a physician to the spouse and children of the physician;
- › any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- › the time taken or expenses incurred in travelling to consult a beneficiary;
- › ambulance service and other forms of patient transportation;
- › acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosing the illness proposed to be treated by acupuncture;
- › examinations not necessitated by illness or at the request of a third party except as specified by the department;
- › plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- › laser treatment of telangiectasia;
- › testimony in a court;
- › visits to optometrists, general practitioners and ophthalmologists solely for determining whether new or replacement glasses or contact lenses are required;
- › the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- › fluoride dental treatment for children under four years of age;
- › excision of xanthelasma;
- › circumcision of newborns;

- › hypnotherapy;
- › medical examination for drivers;
- › alcohol/drug treatment outside Canada;
- › consultation required by hospital regulation;
- › therapeutic abortions performed in the province at a facility not approved by the College of Physicians and Surgeons of Newfoundland and Labrador;
- › sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- › in-vitro fertilization and ovarian stimulation and sperm transfer (OSST);
- › reversal of previous sterilization procedure; and
- › other services not within the ambit of section 3 of the *Medical Care Insurance Insured Services Regulations*.

The majority of diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the province. Hospital policy concerning access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practice. Patients retain the right to financially upgrade standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

The *Medical Care and Hospital Insurance Act* provides the Lieutenant-Governor in Council the authority to make regulations prescribing which services are or are not insured services for the purpose of the Act. This would involve consultation with the Newfoundland and Labrador Medical Association. No services were de-listed from the MCP during 2018–2019.



3.0 UNIVERSALITY

3.1 Eligibility

There were 526,278 people registered with the Medical Care Plan (MCP) as of March 31, 2019. Residents of Newfoundland and Labrador are eligible for coverage under the *Medical Care and Hospital Insurance Act*. This Act defines a “resident” as a person who is lawfully entitled to be or to remain in Canada, makes his or her home in the province, and is ordinarily present in the province, but does not include a tourist, transient or visitor to the province.

The *Medical Care Insurance Beneficiaries and Inquiries Regulations* identify those residents eligible to receive coverage under the plans. The MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications for coverage. The MCP applies the standard that persons moving to Newfoundland and Labrador from another province become eligible on the first day of the third month following the month of their arrival. Every resident of the province is required to register for the MCP.

Persons not eligible for coverage under the plans include:

- › students and their dependents already covered by another province or territory;
- › dependents of residents if covered by another province or territory;
- › refugee claimants and their dependents;
- › foreign workers with employment authorizations that do not meet the established criteria;
- › international students with student authorizations that do not meet the established criteria;
- › foreign seasonal workers, tourists, transients, visitors and their dependents;
- › Canadian Armed Forces personnel;
- › inmates of federal prisons; and
- › armed forces personnel from other countries who are stationed in the province.

If the status of these individuals changes, they must meet the criteria as noted above in order to become eligible. Applicants wishing to appeal an eligibility issue may request a formal file review from the Minister of Health and Community Services.

3.2 Other Categories of Individuals

Foreign workers, international students, foreign clergy and dependents of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Returning Canadian citizens and their dependents born out-of-country, returning permanent residents who hold valid documentation, holders of Minister's permits, convention refugees, resettled refugees or "persons in need of protection" with valid immigration documents are also eligible, subject to the MCP approval. Dependents of the MCP beneficiary may also be eligible for coverage.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Persons who meet the eligibility criteria who are moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage on the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Armed Forces, and individuals released from federal penitentiaries. For coverage to be effective, registration is required under the Medical Care Plan (MCP). Immediate coverage is provided to persons from outside Canada authorized to work in the province for one year or more and their eligible dependents, and to international post-secondary students attending a recognized Newfoundland and Labrador educational institution who have a valid study permit entitling them to stay in Canada for more than 365 days and their eligible dependents.

4.2 Coverage during Temporary Absences in Canada

Newfoundland and Labrador is a party to the Interprovincial Agreement on Eligibility and Portability regarding matters pertaining to portability of insured services in Canada.

Sections 12 and 13 of the *Hospital Insurance Regulations* denote portability of hospital coverage during absences both within and outside Canada. The eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services.

Coverage is provided to residents during temporary absences within Canada. The Government of Newfoundland and Labrador has entered into formal agreements (e.g., the Hospital Reciprocal Billing Agreement) with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient, high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans through the Interprovincial Health Insurance Agreements Coordinating Committee.

Medical services incurred in all provinces (except Quebec) or territories are paid through the Medical Reciprocal Billing Agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and the MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province for at least four consecutive months in each 12-month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include the following:

- › Before leaving the province for extended periods (more than 30 days), a resident is encouraged to contact the MCP to obtain an out-of-province coverage certificate (a certificate). For out-of-province trips lasting more than 30 days, a certificate is recommended as proof of a resident's ability to pay for services while outside the province.
- › Beneficiaries who have resided in the province for greater than 12 months who:
 - › leave for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months. Upon return, beneficiaries are required to reside in the province for a minimum four consecutive months; thereafter, certificates will only be issued for up to eight months of coverage;
 - › are Newfoundland and Labrador students and who leave the province may receive a certificate, renewable each year, provided they submit proof of full-time enrollment in a recognized educational institution located outside the province; and
 - › leave the province for employment purposes may receive a certificate for coverage up to 12 months, and verification of employment may be required.
- › Persons must not establish residency in another province, territory or country while maintaining coverage under the MCP.

- › For out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request.

Failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay for medical or hospital costs incurred outside the province.

Insured residents moving permanently to other parts of Canada are covered up to, and including, the last day of the second month following the month of departure.

4.3 Coverage during Temporary Absences Outside Canada

The province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in-patient and out-patient services are covered for emergencies, sudden illness, and elective procedures at established rates listed below. Hospital services are considered under the plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the MCP for out-of-country in-patient hospital care is \$350 per day, if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is \$465 per day. The approved rate for out-patient services is \$62 per visit and haemodialysis is \$220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness, and are also insured for elective services not available in the province or within Canada. Emergency physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the elective services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province where they are available.

Coverage is immediately discontinued when residents move permanently to other countries.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories. However, physicians may seek advice on coverage from the MCP so that patients may be made aware of any financial implications.

Prior approval is mandatory in order to receive funding at host country rates if a resident of the province has to seek specialized hospital care outside the country because the insured service is not available in Canada. The referring physicians must contact the department for prior approval. If prior approval is granted, the provincial health care insurance plan will pay the costs of insured services necessary for the patient's care. Prior approval is not granted for out-of-country treatment or elective services if the service is available in the province or elsewhere within Canada. If an individual opts to receive the service outside Canada it will be covered at the provincial rate if

available in Newfoundland and Labrador. If the service is not available in Newfoundland and Labrador, it is usually paid at Ontario rates, or at rates that apply in the province where they are available. Applicants wishing to appeal out-of-province coverage may request a formal file review by the Minister.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. Co-insurance charges for insured hospital services and extra-billing by physicians is prohibited in the province.

Section 7 of the *Medical Care and Hospital Insurance Act* outlines that a practitioner who provides insured services, whether or not he or she has made an election to opt out of participation in the Medical Care Plan (MCP), shall not charge or collect from a beneficiary a fee for those insured services in excess of the amount payable under the Act and the regulations. A practitioner or other person who contravenes this is guilty of an offence and liable on summary conviction to a fine of up to but not more than \$20,000 for each contravention. Cases of extra-billing and user charges may be identified through the audit process described under section 21 of the *Medical Care and Hospital Insurance Act* or may be reported from residents. These instances may be discovered when residents submit claims to the Department of Health and Community Services (the department) for reimbursement.

Complaints from residents regarding charges for insured health services are managed by the department. Depending on the circumstance, the department may investigate or refer the matter to the College of Physicians and Surgeons of Newfoundland and Labrador, the regulatory body for physicians in the province, for potential disciplinary action. Residents may also contact the college directly if they feel that they have been subject to improper billing by their physician.

Regarding repayment, section 25 of the *Medical Care and Hospital Insurance Act* provides the Minister with powers to recover overpayments and interest that were discovered via audit. The Minister of Health and Community Services may do this by entering into an agreement with the practitioner or their professional corporation or the Minister may order the practitioner to pay to the Minister the overpaid amount plus interest.

Residents wishing to file a complaint regarding medical care that they have received are encouraged to call or email the Complaints Coordinator at the College (1-709-726-8546 or complaints@cpsnl.ca) or call the Medical Care Plan general inquiries line (Avalon area: 1-866-449-4459; all other regions: 1-800-563-1557).

The department works closely with post-secondary educational institutions within the province to maintain an appropriate supply of health professionals. The province also works with external organizations for health professionals not trained in this province. Targeted recruitment incentives are in place to attract health professionals. Several programs have

been established to provide targeted sign-on bonuses, bursaries, opportunities for upgrading, and other incentives for a wide variety of health occupations.

With respect to wait times to access insured health services, the department led a number of initiatives, including the Strategy to Reduce Hip and Knee Joint Replacement Surgery Wait Times, the Provincial Emergency Department Wait Time Strategy and the Provincial Endoscopy Wait Time Strategy. These strategies ended in 2017–2018 and no new initiatives were commenced in 2018–2019.

5.2 Physician Compensation

Physicians in the province are paid via fee-for-service, salary, or alternate payment plan. As of March 31, 2019, the legislation governing payments to physicians and dentists for insured services was the *Medical Care and Hospital Insurance Act*. Compensation agreements are negotiated between the government and the Newfoundland and Labrador Medical Association (NLMA), on behalf of physicians, and the Newfoundland and Labrador Dental Association (NLDA) on behalf of dentists. A Memorandum of Agreement was reached with the NLMA in December 2017, which increased overall physician compensation by approximately five per cent. The agreement expired on September 30, 2017, but remains in effect until such time as a new agreement is negotiated. The current agreement with the NLDA expires on March 31, 2022. The agreement was signed effective April 1, 2018, with no fee increases.

The *Medical Care and Hospital Insurance Act* authorizes the Minister to appoint auditors to audit the accounts and claims for payment submitted by physicians and dentists. The Act prescribes the power and duties of auditors, sets out the remedies available and details the processes to be followed. The Act also details the review and appeal processes available to practitioners. Individual providers are randomly selected on a bi-weekly basis for audit.

5.3 Payments to Hospitals

The department is responsible for funding regional health authorities (RHA) for ongoing hospital operations and capital acquisitions. Payments are made in accordance with the *Medical Care and Hospital Insurance Act*, the *Regional Health Authorities Act*, and *Financial Administration Act*. As part of their accountability to the department, the RHA are required to meet the department's annual reporting requirements, which include submitting audited financial statements and other financial and statistical information throughout the year as required.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer and the Canada Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador in the annual provincial budget, through press releases, government websites and various other documents. For fiscal year 2018–2019, these documents include the Public Accounts and Estimates 2018–2019. The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available and are shared with Health Canada for information purposes.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	533,156	532,415	530,144	526,692	526,278

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	51	51	103 ¹	104	103
3. Payments for insured health services (\$)	1,131,546,830	1,164,174,814	1,187,786,538	1,199,247,288	1,260,708,567

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services (\$)	914,135	899,538	899,418	939,422	1,023,737

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	1,773	1,607	1,549	1,515	1,648
7. Total payments, in-patient (\$)	22,423,411	21,928,705	25,223,361	22,013,818	26,701,044
8. Total number of claims, out-patient	26,671	23,105	21,915	24,093	22,701
9. Total payments, out-patient (\$)	9,147,633	8,428,054	8,279,887	9,102,027	9,161,383

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	4
11. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	261,277
12. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	17
13. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	69,682

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	85
15. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	85,231
16. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	309
17. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	31,343

¹ Classification of public facilities changed in 2016–2017.² Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians ³	1,199	1,212	1,214	1,231	1,262
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$)	not available	not available	not available	not available	not available
22. Total payments for services provided by physicians paid through fee-for-service (\$)	294,572,803	299,597,724	309,039,732	361,707,782	317,338,718

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY⁴

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	106,000	114,000	123,000	128,000	119,100
24. Total payments (\$)	6,836,000	6,910,000	9,124,000	8,511,000	7,885,750

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA^{2,5}

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not applicable	not applicable	not applicable	not applicable	2,700
26. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	262,200

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not applicable	not applicable	not applicable	not applicable	not available
28. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	19	19	22	18	22
30. Number of opted-out dentists ⁶	not available	not available	not available	0	0
31. Number of non-participating dentists ⁶	not available	not available	not available	0	0
32. Number of services provided	1,709	3,397	4,843	4,924	5,638
33. Total payments (\$)	279,350	592,660	885,610	927,020	1,231,180

³ Excludes inactive physicians. Total salaried and fee-for-service.

⁴ Numbers are rounded to the nearest thousand.

⁵ The claims in NL's data system cannot be separated into pre-approved or non pre-approved, therefore, the numbers reflect the total claims and payments as reported for previous years.

⁶ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

PRINCE EDWARD ISLAND



In Prince Edward Island (PEI) the Department of Health and Wellness is responsible for providing policy, strategic, and fiscal leadership for the health care system.

The *Health Services Act*, R.S.P.E.I. 1988, Cap. H-1.6 provides the regulatory and administrative frameworks for improvements to the health care system in PEI by:

- › mandating the creation of a provincial health plan;
- › establishing mechanisms to improve patient safety and support quality improvement processes; and
- › creating a Crown corporation (Health PEI) to oversee the delivery of operational health care services.

Within this governance structure Health PEI has the responsibility to:

- › provide, or provide for the delivery of, health services;
- › operate and manage health facilities;
- › manage the financial, human and other resources necessary to provide health services and operate health facilities; and
- › perform such other duties as the Minister may direct.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Hospital Services Insurance Plan, under the authority of the Minister of Health and Wellness (the Minister), is the vehicle for delivering hospital care insurance in Prince Edward Island (PEI). The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* R.S.P.E.I. 1988, Cap. H-8. The Medical Services Insurance Plan provides for insured physician services under the authority of the *Health Services Payment Act* R.S.P.E.I. 1988, Cap. H-2. Together, the plans insure services as defined under section 2 of the *Canada Health Act*. The Department of Health and Wellness (the Department) is responsible for providing policy, strategic and fiscal leadership for the health care system, while Health PEI is responsible for service delivery and the operation of hospitals, health centres, manors and mental health facilities. Health PEI is responsible for the hiring of physicians, while the Public Service Commission of PEI hires nurse practitioners, nurses and all other health related workers.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister who tables it in the Legislative Assembly. The report provides information about the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions and statistical highlights for the year.

Health PEI prepares an annual business plan which functions as a formal agreement between Health PEI and the Minister responsible, and documents accomplishments to be achieved over the coming fiscal year.

1.3 Audit of Accounts

The provincial Auditor General conducts annual audits of the public accounts of PEI. The public accounts of the province include the financial activities, revenues and expenditures of the Department of Health and Wellness.

The provincial Auditor General, through the *Audit Act*, R.S.P.E.I. 1988, c A-24, has the discretion to conduct further audit reviews on a comprehensive or program specific basis.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act*. The accompanying Regulations define the insured in-patient and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include, but are not limited to:

- › necessary nursing services;
- › laboratory, radiological and other diagnostic procedures;
- › accommodations and meals at a standard ward rate;
- › formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital;
- › operating room, case room and anaesthetic facilities;
- › routine surgical supplies; and
- › radiotherapy and physiotherapy services performed in hospital.

The process to add a new hospital service to the list of insured services involves extensive consultation and negotiation between the Department of Health and Wellness (the Department), Health PEI and key stakeholders. The process involves the development of a business plan which, when approved by the Minister of Health and Wellness, would be taken to Treasury Board for funding approval. Executive Council (Cabinet) has the final authority in adding new services.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act*. Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The total number of practicing practitioners who billed the Medical Services Insurance Plan as of March 31, 2019, was 412. This includes all physicians (complement, locums, visiting specialists, and other non-complement physicians). Under section 10 of the Health Services Payment Act, a physician or practitioner who is not a participant in the

Medical Services Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are non-participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Department. Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside the Plan or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2019, no physicians had opted out of the Medical Services Insurance Plan.

All basic health services rendered by physicians that are medically required are covered by the Medical Services Insurance Plan. These include:

- › most physicians' services in the office, at the hospital or in the patient's home;
- › medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary;
- › obstetrical services, including pre-natal and post-natal care, newborn care or any complications of pregnancy such as miscarriage or caesarean section;
- › certain oral surgery procedures performed by an oral surgeon when it is medically required, with prior approval that they be performed in a hospital;
- › sterilization procedures, both female and male;
- › treatment of fractures and dislocations; and
- › certain insured specialist services, when properly referred by an attending physician.

The process to add a physician service to the list of insured services involves negotiation between the Department, Health PEI and the Medical Society of Prince Edward Island (PEI). The process involves development of a business plan which, when approved by the Minister, would be taken to Treasury Board for funding approval. Insured physician services may also be added or deleted as part of the negotiation of a new Master Agreement with the Medical Society of PEI (Section 5.2). Cabinet has the final authority in adding new services.

2.3 Insured Surgical-Dental Services

Most dental services are not insured under the Medical Services Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently four surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital or in an office with prior approval, as confirmed by the attending physician.

Any new surgical-dental services added to the list of insured services covered by the Medical Services Insurance Plan is done through negotiations of the Dental Agreement between the Department, Health PEI and the Dental Association of PEI. In 2018–2019, no new services were added to the Dental Agreement.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services not covered by the Medical Services Insurance Plan include:

- › services that persons are eligible for under other provincial or federal legislation;
- › mileage or travel, unless approved by Health PEI;
- › telephone consultation except by internists, palliative care physicians, pediatricians, out-of-province specialists, and orthopedic surgeons, provided the patient was not seen by that physician within three days of the telephone consult;
- › examinations required in connection with employment, insurance, education, etc.;
- › group examinations, immunizations or inoculations, unless prior approval is received from Health PEI;
- › preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- › testimony in court;
- › travel clinic and expenses;
- › surgery for cosmetic purposes unless medically required;
- › dental services other than those procedures included as basic health services;
- › dressings, drugs, vaccines, biologicals and related materials;
- › eyeglasses and special appliances;
- › chiropractic, podiatry, optometry, chiropody, osteopathy, naturopathy, and similar treatments;
- › physiotherapy, psychology, and acupuncture except when provided in hospital;
- › reversal of sterilization procedures;
- › in-vitro fertilization;
- › services performed by another person when the supervising physician is not present or not available;
- › services rendered by a physician to members of the physician's own household, unless approval is obtained from Health PEI; and
- › any other services that the Department may, upon the recommendation of the negotiation process between the Department, Health PEI and the Medical Society, declare non-insured.

Hospital services not covered by the Hospital Services Insurance Plan include:

- › private or special duty nursing at the patient's or family's request;
- › preferred accommodation at the patient's request;
- › hospital services rendered in connection with surgery purely for cosmetic reasons;
- › personal conveniences, such as telephones and televisions;
- › drugs, biologicals and prosthetic and orthotic appliances for use after discharge from hospital; and
- › dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of Health PEI.

The process to de-insure services covered by the Medical Services Insurance Plan is done in collaboration with the Department, Health PEI and the Medical Society of PEI. No services were de-insured during the 2018–2019 fiscal year.

All Prince Edward Island residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Board of PEI do not receive priority access to services through additional payment.

Prince Edward Island has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Department and Health PEI to monitor usage and service concerns.



3.0 UNIVERSALITY

3.1 Eligibility

The *Health Services Payment Act* and the *Hospital and Diagnostic Services Insurance Act*, define eligibility for the Medical Services Insurance Plan and the Hospital Services Insurance Plan respectively. These plans are designed to provide coverage for eligible Prince Edward Island (PEI) residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in PEI. While there is no formal appeal process, an individual can seek clarification regarding their eligibility determination.

All new residents must register with Health PEI in order to become eligible. Persons who establish permanent residence in PEI from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival. PEI currently does not have a process where a resident can opt out of the health care insurance plan.

Residents who are ineligible for insured hospital and medical services coverage in PEI are those who are eligible for certain services under other federal or provincial government programs, such as members of the Canadian Forces, inmates of federal penitentiaries, and clients of Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in certain circumstances. For example, members of the Canadian Forces become eligible on discharge or completion of rehabilitative leave. Penitentiary inmates become eligible upon release. In such cases, the province where the individual in question was stationed at the time of discharge or release, or release from rehabilitative leave, would provide initial coverage during the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged prisoners.

New or returning residents must apply for health coverage by completing a registration application from Health PEI. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks of becoming eligible. Renewal of coverage takes place every five years and residents are notified by mail six weeks before renewal.

The number of residents registered with the Medical Services Insurance Plan and the Health Services Insurance Plan in PEI as of March 31, 2019, was 153,861.

3.2 Other Categories of Individuals

Foreign students, tourists, transients or visitors to PEI do not qualify as residents of the province and are, therefore, not eligible for hospital and medical insurance benefits.

Temporary workers, refugees and Minister's Permit holders are not eligible for hospital and medical insurance benefits.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island (PEI) from another province or territory in Canada are eligible for health insurance on the first day of the third month following the month of arrival in the province.

4.2 Coverage during Temporary Absences in Canada

Residents absent each year for any reasons must reside in PEI for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province, as allowed under section 11 of the *Health Services Payment Act Regulations*. A person, including a student, who is temporarily absent from the province for up to 182 days in a 12 month period must notify Health PEI before leaving.

PEI participates in the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements along with other jurisdictions across Canada.

4.3 Coverage during Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside of Canada, as allowed under section 11 of the regulations thereunder.

Persons must reside in PEI for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province, as allowed under section 11 of the *Health Services Payment Act Regulations*.

Insured residents may be temporarily out of the country for up to a 12 month period in some circumstances.

Students attending a recognized learning institution in another country must provide proof of enrollment from the educational institution on an annual basis. Students must notify Health PEI upon returning from outside the country.

For PEI residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For PEI residents travelling outside Canada, coverage for emergency or sudden illness will be provided at PEI rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by Health PEI.

4.4 Prior Approval Requirement

Prior approval is required from Health PEI before receiving non-emergency, out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a PEI physician. If approval is not granted, a letter can be submitted to Health PEI to appeal a medical insurance decision. Full coverage may be provided for (PEI insured) non-emergency or elective services, provided the physician completes an application to Health PEI. Prior approval is required from the Medical Director of Health PEI to receive out-of-country hospital or medical services not available in Canada.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Both of Prince Edward Island's (PEI) Hospital Services Insurance Plan and the Medical Services Insurance Plan provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons. While there is no formal complaints process for inappropriate charges, an individual can seek clarification on the appropriateness of any charges through the Department of Health and Wellness (the Department). The Department can be contacted at:

Prince Edward Island Department of Health and Wellness
P.O. Box 2000
Charlottetown, PE C1A 7N8
(902) 368-6414

PEI has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*.

The Government of PEI recognizes that the health system must constantly adapt and expand to meet the needs of residents.

Several examples of initiatives from the 2018–2019 fiscal year include:

- › implementation of an Ostomy Supplies Program to help cover the cost of supplies for patients with permanent ostomies;
- › expansion of haemodialysis services to support increased patient need and enable more community-based treatment;
- › expansion of the Hepatitis C Treatment Program, which previously treated patients diagnosed with Genotype 1 of the disease, to include treatment for those diagnosed with the other five hepatitis C genotypes;
- › expansion of Medicare coverage to include a variety of gender-confirming surgeries;
- › expansion of the PEI Pharmacare Formulary to include 28 new drugs used to treat cancer, cystic fibrosis, epilepsy, ADHD, liver disease and several other illnesses; and
- › the addition of 53 new nursing positions including nurse practitioners, registered nurses and licensed practical nurses. Two nursing recruitment programs were also established: the Nursing Recruitment Incentive Program and the RN Bridging Program for Internationally Educated Nurses.

5.2 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and the government to represent their interests in the process. The last five-year Master Agreement between the Medical Society of PEI, the Department and Health PEI covered the period of April 1, 2015, to March 31, 2019.

Many physicians continue to work on a fee-for-service basis; however, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are expanding and seem to be the preference for new graduates. Currently, 66 per cent of PEI's physicians (excluding locums and visiting specialists) are compensated under an alternate payment method (non-fee-for-service) as their primary means of remuneration.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*. Health PEI is responsible for auditing physician claims for compliance with legislative requirements and the Master Agreement tariff, as permitted under the *Health Services Payment Act* and delegated by the Minister. The *Health Services Payment Act* allows for audits of physician payments to assist in efficient and effective use of resources. Health PEI's audit rights are affirmed in the Master Agreement with the Medical Society of PEI. Health PEI approved its Practitioner Claims Monitoring, Compliance, and Recovery Policy on December 22, 2015, and continues to conduct physician payment audits on a go-forward basis. The policy information was communicated to physicians in January 2016.

Physicians submit bills for services provided to insured residents to Health PEI's Claims Payment System (CPS). The CPS contains billing rules aligned with the Master Agreement which help to ensure billings which do not meet Master Agreement criteria are rejected or flagged for review. As part of Health PEI's monitoring process, physicians are randomly selected and requested to provide Health PEI with documentation to support sample billings. Overall physician billings are periodically reviewed to identify unusual billing profiles when compared to peers, significant increases in fee code billings and irregularities in the use of new fee codes. Any irregularities discovered may trigger an audit.

The audits include specific steps for:

- › Risk-ranking physicians based on unusual billing profiles compared to peers and other factors;
- › Auditing samples of claims documentation in the physician's office;
- › Statistical extrapolation of results to estimate any recovery of overbillings; and
- › Communication of audit results and any recovery via a letter to the physician.

The *Health Services Payment Act* allows for recovery of overpayments and provides for appeal of adjustments to claims. The initial stage for appeal is a discussion with the Executive Director, Medical Affairs or designate. If no agreement can be reached, the matter is appealed to the Health Services Payment Advisory Committee which will provide a recommendation to the Minister.

5.3 Payments to Hospitals

Payments (advances) to provincial hospitals and community hospitals for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The usual funding method includes using a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Prince Edward Island (PEI) strives to recognize the federal contributions provided through the Canada Health Transfer whenever appropriate. Over the past year, this has included reference in public documents such as the Province of PEI 2018–2019 Annual Budget and in the 2018–2019 Public Accounts, both of which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

It is also the intent of the Department of Health and Wellness to recognize this important contribution in the 2018–2019 Annual Report.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	146,170	146,930	150,194	150,990	153,861

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	7	7	7	7	7
3. Payments for insured health services (\$)	206,026,400	210,797,200	218,043,400	222,523,865	227,859,554

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	2,412	2,616	2,612	2,683	2,736
7. Total payments, in-patient (\$)	26,099,415	28,867,047	28,644,094	27,621,152	27,458,162
8. Total number of claims, out-patient	19,881	20,397	19,166	20,008	19,522
9. Total payments, out-patient (\$)	7,385,351	7,930,682	8,234,123	8,866,851	8,667,961

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA¹

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	0
11. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	0
12. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	0
13. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	0

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	22
15. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	121,344
16. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	100
17. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	36,992

¹ Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	335	357	367	382	412
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$)	95,037,546	98,070,004	102,691,590	104,240,026	107,814,785
22. Total payments for services provided by physicians paid through fee-for-service (\$)	59,425,077	64,477,376	65,226,925	69,491,809	72,228,583

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	98,980	107,666	113,338	111,377	115,918
24. Total payments (\$)	9,868,637	11,973,879	11,782,835	11,366,710	11,498,714

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA¹

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not applicable	not applicable	not applicable	not applicable	11
26. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	2,584

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not applicable	not applicable	not applicable	not applicable	441
28. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	26,316

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	2	2	2	3	4
30. Number of opted-out dentists ²	-	-	0	0	0
31. Number of non-participating dentists ²	-	-	0	0	0
32. Number of services provided	446	373	365	481	401
33. Total payments (\$)	169,386	129,361	127,385	171,255	145,910

² Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

NOVA SCOTIA



The Nova Scotia Department of Health and Wellness' (the Department) vision and mission are:

- › **Vision:** An innovative and sustainable health system for generations of healthy Nova Scotians.
- › **Mission:** Providing leadership to the health system for the delivery of care and treatment, prevention of illness and injury, and promotion of health and healthy living.

The health and wellness system includes the delivery of health care as well as the prevention of disease and injury and the promotion of health and healthy living. The *Health Authorities Act* establishes roles and responsibilities of the Department, the Nova Scotia Health Authority and the Izaak Walton Killam Health Centre.

The Department is responsible for providing leadership and ensuring accountability for funding for the health system.

The Nova Scotia Health Authority and the Izaak Walton Killam Health Centre are responsible for governing, managing and providing health services in the province and engaging with the communities they serve.

Insured services in Nova Scotia cover hospital services and physician services. Services such as home care, long-term care, and pharmaceuticals are also provided.

Nova Scotia continues to be committed to the delivery of hospital services and medically required services consistent with the principles of the *Canada Health Act*.

Additional information related to health care in Nova Scotia may be obtained from the [Department of Health and Wellness](#) website.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: The Hospital Insurance and the Medical Services Insurance (MSI) Plans, which both operate under the *Health Services and Insurance Act*.

The Nova Scotia Department of Health and Wellness (the Department) administers the Hospital Insurance Plan and the MSI Plan is administered and operated by Medavie Blue Cross (MBC).

Section 8 of the *Health Services and Insurance Act* gives the Nova Scotia Minister of Health and Wellness (the Minister), with approval of the Governor in Council, the power to enter into agreements and vary, amend or terminate the same agreements with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

The Department and MBC entered into a service level agreement, effective August 1, 2005. Under the agreement, MBC is responsible for operating and administering programs contained under MSI, Pharmacare Programs and Health Card Registration Services.

In 2018–2019, no amendments were made to either the *Health Services Insurance Act* or the *Medical Services Insurance Regulations*.

1.2 Reporting Relationship

A. Hospital Insurance

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the *Hospital Insurance Regulations*, under this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health and Wellness.

B. Medical Insurance

In the service level agreement between MBC and the Department, MBC is obliged to provide reports to the Department under various Statements of Requirements as listed in the contract. Medavie Blue Cross is audited every year on various areas of reporting.

1.3 Audit of Accounts

The Auditor General audits all expenditures of the Department. Under its service level agreement with the Department, MBC provides audited financial statements of MSI costs to the Department. The Auditor General and the Department have the right to perform audits of the administration of the agreement with MBC.

Academic Funding Plan (AFP) departments are required to submit their audited financial statements to the Department (Physician Services) annually.

Long-term care facilities are required to provide the Department with annual financial statements. Nursing Homes are required to submit annual audited statements and Residential Care Facilities are required to submit Reviewed Financial Statements.

Home care and home support agencies are required to provide the Department with annual audited financial statements.

Under section 36(4) of the *Health Authorities Act*, a health authority is required to submit to the Minister, no later than June 30 each year, an audited financial statement for the preceding fiscal year.

1.4 Designated Agency

Medavie Blue Cross administers and has the authority to receive monies to pay physician accounts under the service level agreement with the Department. The rates of pay and specific amounts are based on the physician contracts (Master Agreement and Academic Funding Plan) negotiated between Doctors Nova Scotia and the Department.

The Department and the Office of the Auditor General, have the right, under the terms of the service level agreement, to audit all MSI and Pharmacare transactions.

Green Shield Canada administers and has the authority to receive monies to pay dentists under a service level agreement with the Department. The tariff of dental fees is negotiated between the Nova Scotia Dental Association and the Department.

Medavie Blue Cross is responsible for providing a number of regular and ad hoc reports to the Department pertaining to health card administration, physician claims activity, financial monitoring, provider management, audit activities and program utilization. These reports are submitted on a monthly, quarterly, or annual basis. A complete list of reports can be obtained from the Department.

As part of an agreement with the Department, Green Shield Canada also provides monthly, quarterly and annual reports with regard to dental programs in Nova Scotia. This includes dental services provided in hospitals as outlined in the *Canada Health Act*. These reports address provider claims and payment, program utilization, and audit. A complete list of reports can be obtained from the Department.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*. *Hospital Insurance Regulations* were made pursuant to the Act.

Under the Hospital Services Insurance Plan, in-patient services include:

- › accommodation and meals at the standard ward level;
- › necessary nursing services;
- › laboratory, radiological and other diagnostic procedures;
- › routine surgical supplies;
- › use of operating room(s), case room(s) and anaesthetic services;
- › use of radiotherapy and physiotherapy services for in-patients, where available; and
- › blood or therapeutic blood fractions.

Out-patient services include:

- › laboratory and radiological examinations;
- › diagnostic procedures involving the use of radiopharmaceuticals;
- › electroencephalographic examinations;
- › use of occupational and physiotherapy facilities, where available;
- › necessary nursing services;
- › drugs, biologicals and related preparations;
- › blood or therapeutic blood fractions;

- › hospital services in connection with most minor medical and surgical procedures;
- › day-patient diabetic care;
- › services provided by the Nova Scotia Hearing and Speech Clinics, where available;
- › ultrasonic diagnostic procedures;
- › home parenteral nutrition, where available; and
- › haemodialysis and peritoneal dialysis, where available.

Each year, the Nova Scotia Health Authority and the Izaak Walton Killam Health Centre submit business plans outlining budgets and priorities for the coming year to ensure safe and high-quality access to care. Under the *Health Authorities Act*, business plans are to be submitted on November 1 every year and will be approved by the Minister of Health and Wellness.

2.2 Insured Physician Services

The legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27–31, 35, and the *Medical Services Insurance Regulations*.

As of March 31, 2019, 2,762 physicians were paid through the Medical Services Insurance (MSI) Plan.

Physicians retain the ability to opt in or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. MSI reimburses patients who pay the physician directly due to opting out. As of March 31, 2019, no physicians had opted-out.

Insured services include those that are medically necessary. Additional services were added to the list of insured physician services in 2018–2019. A complete list can be obtained from the Nova Scotia Department of Health and Wellness (the Department). On an as needed basis, new fee codes are approved that represent enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes, or adjustment to existing fee codes, to the list of insured physician services is accomplished through a collaborative committee structure comprised of the Department, Nova Scotia Health Authority and Doctors Nova Scotia. Public consultations are not generally undertaken when listing or delisting insured medical services. Physicians wishing to have a new fee code added to the MSI Physician Manual submit a formal application to the Fee Committee (FC) for review. Each request is thoroughly researched. The FC (under the terms and conditions of the Master Agreement) has the decision-making authority to approve adjustments and new fees based on consensus and available budget. If the fee is approved, Medavie Blue Cross is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association, must be certified competent in the practice of dental surgery, and must also have privileges from the health authorities to deliver services at specific hospitals. The *Health Services and Insurance Act* is written so that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who chooses not to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. In 2018–2019, 18 dentists submitted claims through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a public health care facility. Insured services are detailed in the Department's MSI Dentists Guide (Dental Surgical Program) and are reviewed annually. Services under this program are insured when the condition of the patient is such that it is medically necessary for the procedure to be done in a public hospital and the procedure is of a surgical nature.

Generally included as insured surgical-dental services are extractions and oral and maxillofacial surgery. Requests for an addition to the list of surgical-dental services are accomplished through the Dental Association of Nova Scotia which submits a proposal to the Department. Then, in consultation with experts in the field, the Department renders a decision on the addition of the procedure as an insured service. Public consultations are not undertaken during the consideration of additions to the list of insured services.

Insured services in the "Other extraction services" (routine extractions) category are approved for the following groups of patients: cardiac patients, transplant patients, immunocompromised patients, and radiation patients. This is the case only when patients are undergoing active treatment in a hospital setting and the attendant medical procedure must require the removal of teeth that would otherwise be considered routine extractions.

At this time, there is one opted-out dentist and no non-participating dentists providing insured surgical-dental services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- › preferred accommodation at the patient's request;
- › telephones;
- › televisions;
- › drugs and biologicals ordered after discharge from hospital;
- › cosmetic surgery;
- › reversal of sterilization procedures;
- › in-vitro fertilization;

- › procedures performed as part of clinical research trials;
- › services such as gastric bypass for morbid obesity, breast reduction/augmentation and newborn circumcision (these services may be insured when approved as special consideration for medical reasons only); and
- › services not deemed medically necessary that are required by third parties, such as insurance companies

Uninsured Physician Services include:

- › services available to residents of Nova Scotia who are covered under any statute or law of any other jurisdiction, either within or outside of Canada;
- › diagnostic, preventive or other physician's services available through the Nova Scotia Hospital Insurance Program, the Department, or other government agencies;
- › services at the request of a third party;
- › provision of a prescription or a requisition for a diagnostic or therapeutic service provided to a patient without a clinical evaluation;
- › physician's services provided to their own families;
- › services performed for cosmetic purposes only;
- › group immunizations performed without receiving preapproval by MSI;
- › acupuncture;
- › electrolysis;
- › reversal of sterilization;
- › in-vitro fertilization;
- › provision of travel vaccines;
- › newborn circumcision;
- › release of tongue tie in newborn;
- › removal of cerumen, except in the case of a febrile child;
- › treatment of warts or other benign conditions of the skin;
- › comprehensive visits when there are no signs, symptoms or family history of disease or disability;
- › services, supplies and other materials not part of office overhead, including for example, photocopying or other costs associated with transfer of records;
- › items such as drugs, dressings, and tray fees; physician's advice by telephone, letter, fax or email, with exceptions; and
- › mileage or travelling time.

Major third party agencies currently purchasing medically required health services in Nova Scotia include Workers' Compensation and the Department of National Defence.

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as fibreglass casts, are offered as an alternative, the specialist or physician is responsible to ensure that the patient is aware of their responsibility for the cost. Patients are not denied service based on their inability to pay. The province provides alternatives to any of the enhanced goods and services.

The Department carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

If a service or procedure is deemed by the Department not to be medically required, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same also applies to dental services and hospital services. Public consultations are not undertaken during the determination of medical necessity and de-listing of insured services. The last time there was any significant de-insurance of services was in 1997.



3.0 UNIVERSALITY

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the *Hospital Insurance Regulations* made pursuant to section 17 of the *Health Services and Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia. Registration for the hospital and medical insurance plans is voluntary and residents may choose not to register.

In 2018–2019, a person was considered to be “ordinarily present” in Nova Scotia if the person:

- › makes his or her permanent home in Nova Scotia;
- › is physically present in Nova Scotia for at least 183 days in any calendar year (short term absences under 30 days, within Canada, are not monitored); and
- › is a Canadian citizen or “Permanent Resident” as defined by Immigration, Refugees and Citizenship Canada (IRCC).

Persons moving to Nova Scotia from another Canadian province will normally be eligible for Medical Services Insurance on the first day of the third month following the month of their arrival. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the province, provided they are Canadian citizens or hold “Permanent Resident” status as defined by IRCC.

Individuals insured under the *Workers' Compensation Act* or any other act in the Legislature or of the Parliament of Canada or under any statute or law of any other jurisdiction either within or outside of Canada are not eligible for MSI Coverage (such as members of the Canadian Forces, federal inmates and some classes of refugees). Once individuals are no longer covered under any of the acts, statutes or laws noted above, they are then eligible to apply for and receive Nova Scotia health insurance coverage, provided that they are either a Canadian Citizen, a permanent resident as defined by IRCC or meet the Nova Scotia residency requirements. An administrative review may be requested for individuals who are deemed ineligible.

In 2018–2019, the total number of residents registered with the health insurance plan was 1,034,476.

3.2 Other Categories of Individuals

Other individuals may be eligible for insured health care services in Nova Scotia if they meet specific eligibility criteria listed below:

Immigrants: Persons moving from another country to live permanently in Nova Scotia are eligible for health care on the date of arrival if they arrive as a permanent resident as determined by IRCC.

Non-Canadians married to Canadian Citizens or Permanent Residents (copy of marriage certificate required), who possess the required documentation from IRCC indicating they have applied for permanent residency, will be eligible for coverage on the date of arrival in Nova Scotia (if applied prior to their arrival to Nova Scotia), or the date of application for permanent residency (if applied after their arrival in Nova Scotia).

Convention refugees or persons in need of protection who possess the required documentation from IRCC indicating they have applied for permanent residency will be eligible for coverage on the date of application for permanent residency.

In 2018–2019, there were 52,014 permanent residents registered with the health care insurance plan.

Refugees: Refugees are eligible for MSI once they have been granted permanent residency status by IRCC, or if they possess either a work permit or study permit.

Work Permits: Persons moving to Nova Scotia from outside the country who possess a work permit can apply for coverage on the date of arrival in Nova Scotia, provided they will be remaining in Nova Scotia for at least one full year. A declaration must be signed to confirm that the worker will not be outside Nova Scotia for more than 31 consecutive days, unless required in the course of employment. MSI coverage is extended for a maximum of 12 months at a time. Each year, a copy of their renewed immigration document must be presented, and a declaration signed. Dependents of such persons, who are legally entitled to remain in Canada, are granted coverage on the same basis.

Once coverage has terminated, the person is to be treated as never having qualified for health services coverage as herein provided and must comply with the above requirements before coverage will be extended to them or their dependents.

In 2018–2019, there were 5,726 individuals with Employment Authorizations covered under the health care insurance plan.

Study Permits: Persons moving to Nova Scotia from another country and who possess a Study Permit will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, unless required in the course of their studies. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented, and a declaration signed. Dependents of such persons, who are legally entitled to remain in Canada, will be granted coverage on the same basis once the student has gained entitlement.

In 2018–2019, there were 1,734 individuals with Student Authorizations covered under the health care insurance plan.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for Medical Services Insurance (MSI) on the first day of the third month following the month of their arrival.

4.2 Coverage During Temporary Absences in Canada

The Interprovincial Agreement on Eligibility and Portability is followed in all matters pertaining to the portability of insured services.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months, per the Eligibility and Portability Agreement. Students and their dependents, who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI a letter directly from the educational institution which states that they are registered as a full-time student. MSI coverage will be extended on a yearly basis pending receipt of this letter.

Workers who leave Nova Scotia to seek employment elsewhere will still be covered by MSI for up to 12 months, provided they do not establish residence in another province or territory. Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement. Quebec is the only province that does not participate in the Medical Reciprocal Billing Agreement. Nova Scotia pays for services provided by Quebec physicians to Nova Scotia residents at Quebec rates if the services are insured in Nova Scotia. The majority of such claims are received directly from Quebec physicians. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. Nova Scotia pays the host province rates for insured services in all reciprocal billing situations.

The total amount paid by the plan in 2018–2019 for in-patient and out-patient hospital services received in other provinces and territories was \$35,595,008.

Nova Scotia residents remain eligible to receive MSI during vacation outside of the province for up to seven months in each calendar year and will continue to be deemed a resident if the following conditions are met:

- › the resident communicates to MSI of their absence from Nova Scotia;
- › the resident does not establish residency outside Nova Scotia; and
- › new or returning residents must be physically present in Nova Scotia for at least 183 days prior to the absence.

4.3 Coverage during Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident meets eligibility requirements, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. In order to be covered, procedures of a non-emergency nature must have prior approval before they will be covered by MSI.

Nova Scotia residents remain eligible to receive MSI during vacation out-of-country for up to seven months in each calendar year and will continue to be deemed a resident if the above stated conditions are met.

Students and their dependents who are temporarily absent from Nova Scotia and in attendance at an educational institution outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Persons who engage in employment (including volunteer, missionary work or research) outside Canada which does not exceed 24 months are still covered by MSI, providing the person has already met the residency requirements.

The total amount spent in 2018–2019 for insured in-patient services provided outside of Canada was \$2,718,227. Nova Scotia does not cover out-patient services out-of-country.

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services outside the country. Application for prior approval is made to the medical consultant of the MSI Plan by a specialist in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the province, or if it can be provided in another province or only out-of-country. The decision of the medical consultant is relayed to the patient's referring specialist. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI. An administrative review may be requested for individuals who are deemed ineligible.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the Regulations, all residents of the province are entitled to receive insured hospital services from hospitals on uniform terms and conditions. As well, all residents of the province are insured on uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. There are no user charges or extra charges allowed under the plan. In Nova Scotia, there is not a dedicated number or website to report cases of patient charges. Complaints generally come directly to the Department of Health and Wellness via telephone or e-mail; are received by Medavie Blue Cross and then directed to the Department; or are directed to the College of Physicians and Surgeons of Nova Scotia (CPSNS). Complaints are investigated and addressed.

The Department of Health and Wellness General Inquiry contact information is as follows:

By phone: 902-424-5818
1-800-387-6665 (toll-free in Nova Scotia)
1-800-670-8888 (TTY/TDD)

By mail: Department of Health and Wellness
PO Box 488
Halifax, NS B3J 2R8

By e-mail: MSI@medavie.ca

Nova Scotia continually monitors and reviews situations around access to insured health services across Canada to ensure equity of access.

5.2 Physician Compensation

The *Health Services and Insurance Act*, RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between Doctors Nova Scotia (the sole bargaining agent for physicians) and the Department. Fee-for-service is still the most prevalent method of payment for physician services; however, we continue to see growth in the share of total physician payments made through alternative payment arrangements.

In the 1997–1998 fiscal year, about nine per cent of doctors were paid solely through alternative funding. In 2018–2019, approximately 26 per cent of physicians were remunerated exclusively through alternative funding. Approximately 71 per cent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms such as academic funding agreements with clinical departments for the provision of clinical, academic, administrative and research services; and alternative payment plans for individual physicians and groups that provide guaranteed funding to physicians for patient-specific clinical services and support services (e.g., capacity building, systems planning). Other funding programs such as emergency agreements and sessional funding are also utilized across the province.

In Nova Scotia, payment and payment monitoring is tasked to Nova Scotia Medical Services Insurance (MSI). Annually, MSI develops an audit plan and audits are conducted based on risk analysis, concerns identified through service verification letters and ad hoc billing reports for select at risk services. The mandate of the audit function is to determine, on a post-payment basis, whether claims are valid and appropriately billed according to the terms of the Tariff Agreements and the Physician's Preamble. Post-payment monitoring is conducted to determine whether insured services were performed, whether the services were medically necessary, and whether the services were misrepresented in the claims for payment.

Payment rates for dental services in the province are negotiated between the Department and the Nova Scotia Dental Association following a process similar to physician negotiations. Dentists are generally paid on a fee-for-service basis. Pediatric dentists at the Izaak Walton Killam Health Centre receive remuneration through an Academic Funding Plan.

5.3 Payments to Hospitals

The Department establishes budget targets for health care services. It does this by receiving business plans from the Nova Scotia Health Authority and the Izaak Walton Killam Health Centre and other non-district health authority organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* establishes the Nova Scotia Health Authority and the Izaak Walton Killam Health Centre as the bodies responsible for overseeing the delivery of health services in the province of Nova Scotia and requires them to work collaboratively to do so.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the *Hospital Insurance Regulations* define the terms for payments by the Minister of Health and Wellness to hospitals for insured hospital services.

In 2018–2019, there were 2,961 hospital beds in Nova Scotia (3.2 beds per 1,000 population). Department direct expenditures for insured hospital services operating costs were \$1,862,969,024.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

In Nova Scotia, the *Health Services and Insurance Act* acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware of ongoing federal contributions to Nova Scotia health care through the Canada Health Transfer as well as other federal funds through press releases and media coverage.

The Government of Nova Scotia also recognized the federal contribution under the Canada Health Transfer in various published documents, including the following documents:

- › Public Accounts 2017–2018 released July 26, 2018; and
- › Budget Estimates and Supplementary Detail 2018–2019, released July 25, 2019.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	1,001,708	1,008,726	1,012,642	1,020,007	1,034,476

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	35	35	35	35	35
3. Payments for insured health services (\$)¹	1,735,234,990	1,720,856,746	1,790,425,313	1,862,969,024	1,917,181,492

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services²	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)	not applicable	not applicable	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY¹

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	2,020	2,019	1,882	2,995	2,934
7. Total payments, in-patient (\$)	17,984,193	19,022,461	19,801,011	19,474,523	19,879,822
8. Total number of claims, out-patient	41,207	40,344	37,910	39,706	40,361
9. Total payments, out-patient (\$)	13,352,105	14,174,680	14,428,730	15,209,411	15,715,186

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA³

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	not available
11. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	2,386,348
12. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	not available
13. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	not available
15. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	331,879
16. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	not available
17. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	not available

¹ This reflects payments made to the public facilities noted for indicator 2 above.

² Scotia Surgery is not considered private; it is designated as a hospital under the *Health Authorities Act* (funded by the Department of Health and Wellness). The Nova Scotia Health Authority (NSHA) rents available capacity at Scotia Surgery. Procedures performed at Scotia Surgery are scheduled by NSHA staff and completed by surgeons in the public system. Scotia Surgery has no involvement in managing the physician or patient scheduling. Patients are scheduled based on the same criteria utilized for scheduling at other Central Zone sites.

³ Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	2,580	2,602	2,562	2,688	2,672
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	not applicable	not applicable	not applicable	not applicable	not applicable
21. Total payments for services provided by physicians paid through all payment methods (\$)	730,417,814	740,465,887	735,418,537	769,657,951	800,367,900
22. Total payments for services provided by physicians paid through fee-for-service (\$)	317,048,025	378,290,569	377,118,049	352,410,103	357,558,840

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	210,771	222,026	220,932	215,616	221,096
24. Total payments (\$)	8,884,002	9,304,321	9,167,527	9,023,845	9,292,479

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA³

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not applicable	not applicable	not applicable	not applicable	38
26. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	119,968

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not applicable	not applicable	not applicable	not applicable	1,971
28. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	121,608

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	25	28	26	19	18
30. Number of opted-out dentists ⁴	not applicable	not applicable	0	0	1
31. Number of non-participating dentists ⁴	not applicable	not applicable	0	0	0
32. Number of services provided ⁵	8,492	8,591	7,713	8,123	9,543
33. Total payments (\$) ⁶	1,442,994	1,401,379	1,342,014	1,422,086	1,427,177

⁴ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.⁵ Total services includes block funded dentists. This also includes maxillofacial and cleft palate surgeries.⁶ Total payments does not include block funded dentists.

NEW BRUNSWICK



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the formal name for Medicare is the Medical Services Plan. The Minister of Health (Minister) is responsible for operating and administering the plan by virtue of *the Medical Services Payment Act* and its Regulations. The Act and Regulations set out who is eligible for Medicare coverage, the rights of the patient, and the responsibilities of the Department of Health (the Department). This law establishes a Medicare plan, and defines which Medicare services are covered and which are excluded. It also stipulates the type of agreements the Department may enter into. As well, it specifies the rights of a medical practitioner; how the amounts to be paid for medical services will be determined; how assessment of accounts for medical services may be made; and confidentiality and privacy issues as they relate to the administration of the Act.

1.2 Reporting Relationship

The Medicare and Physician Services Branch of the Department are mandated to administer the Medical Services Plan. The Minister reports to the Legislative Assembly through the Department's annual report and through regular legislative processes.

The *Regional Health Authorities Act* establishes the regional health authorities (RHA) and sets forth the powers, duties, and responsibilities of the same. The Minister is responsible for the administration of the Act, provides direction to each RHA, and may delegate additional powers, duties or functions to the RHA.

1.3 Audit of Accounts

Three groups have a mandate to audit the Medical Services Plan.

The Office of the Auditor General: In accordance with *the Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which includes the financial records of the Department. The Auditor General also conducts management reviews on programs as he or she sees fit.

The Office of the Comptroller: The Comptroller is the chief internal auditor for the Province of New Brunswick and provides accounting, audit and consulting services in accordance with responsibilities and authority set out in the *Financial Administration Act*.

Monitoring and Compliance Team: This team is tasked with managing compliance with the *Medical Services Payment Act* and Regulations, as well as the Negotiated Fee Schedule.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, section 9 of Regulation 84–167, and the *Hospital Act*. Under Regulation 84–167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured hospital services.

Insured in-patient services include:

- › accommodation and meals;
- › nursing;
- › laboratory/diagnostic procedures;
- › drugs;
- › the use of facilities (e.g., surgical, radiotherapy, physiotherapy); and
- › services provided by professionals within the facility.

Insured out-patient services include:

- › laboratory and diagnostic procedures;
- › mammography; and
- › the hospital component of available out-patient services for maintaining health, preventing disease and helping diagnose or treat any injury, illness or disability, excluding those related to the provision of drugs or third party diagnostic requests.

No new insured services were added in 2018–2019.

2.2 Insured Physician Services

The *Medical Services Payment Act* and corresponding regulations provide for insured physician services. As of March 31, 2019, there were 1,734 participating physicians in New Brunswick. No physicians rendering health care services elected to opt out of the Medical Services Plan. When a physician opts out of Medicare, they must complete the specified Medicare claim form and indicate the amount charged to the patient. The beneficiary then seeks reimbursement by certifying on the claim form that the services have been received and forwarding the claim form to Medicare. The charges must not exceed the Medicare tariff. If the charges are in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:

- › they have opted-out and charge fees above the Medicare tariff;
- › in accepting services under these conditions, the patient waives all rights to Medicare reimbursement;
- › the patient is entitled to seek services from another practitioner who participates in the Medical Services Plan; and
- › the physician must obtain a signed waiver from the patient on the specified form and forward the form to Medicare.

The services which residents are entitled to under Medicare include:

- › the medical portion of all medically required services rendered by medical practitioners; and
- › certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital.

A physician or the Department of Health may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is based on conformity to the definition of “medically necessary” and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and/or Canada. Considerations under the term “medically necessary” include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

In 2018–2019 there were no services added to the list of insured services through this process.

2.3 Insured Surgical-Dental Services

Schedule 4 of *Regulation 84–20* under the *Medical Services Payment Act* identifies the insured surgical- dental services that can be provided by a qualified dental practitioner in a hospital, providing the condition of the patient requires services to be rendered in a hospital.

In addition, a general dental practitioner may be paid to assist another dentist for medically required services under some conditions. In addition to Schedule 4 of *Regulation 84–20*, oral maxillofacial surgeons (OMS) have added access to approximately 300 service codes in the Physician Manual and can admit or discharge patients and perform physical examinations, including those performed in an out-patient setting. OMS may also see patients for consultation in their office.

As of March 31, 2019, there were 10 dentists and oral maxillofacial surgeons who provided services insured under the Medical Services Plan.

In 2018–2019 there were no services added to the list of insured services through this process.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- › take-home drugs;
- › third-party requests for diagnostic services;
- › visits to administer drugs;
- › vaccines;
- › sera or biological products;
- › televisions and telephones;

- › preferred accommodation at the patient's request; and
- › hospital services directly related to services listed under Schedule 2 of the Regulation under the Medical Services Payment Act. Services are not insured if provided to those entitled under other statutes.

The services listed in Schedule 2 of New Brunswick *Regulation 84–20* under the *Medical Services Payment Act* are specifically excluded from the range of entitled medical services under Medicare. They are as follows:

- › elective plastic surgery or other services for cosmetic purposes;
- › correction of inverted nipple;
- › breast augmentation;
- › otoplasty for persons over the age of eighteen;
- › removal of minor skin lesions, except where the lesions are, or are suspected to be pre-cancerous;
- › abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located;
- › surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than risk inherent in the removal of the cataract itself, due to existence of an illness or other complication;
- › medicines, drugs, materials, surgical supplies or prosthetic devices;
- › advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
- › examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
- › dental services provided by a medical practitioner or an oral and maxillofacial surgeon;
- › services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
- › services that are provided in conjunction with or in relation to the services referred to above;
- › testimony in a court or before any other tribunal;
- › immunization, examinations or certificates for purpose of travel, employment, emigration, insurance or at the request of any third party;
- › services provided by medical practitioners or oral and maxillofacial surgeons to members of their immediate family;
- › psychoanalysis;
- › electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or pediatrics;

- › laboratory procedures not included as part of an examination or consultation fee;
- › refractions;
- › services provided within the province by medical practitioners, oral and maxillofacial surgeons or dental practitioners for which the fee exceeds the amount payable under this Regulation;
- › the fitting and supplying of eye glasses or contact lenses;
- › radiology services provided in the province by a private radiology clinic;
- › acupuncture;
- › complete medical examinations when performed for the purposes of periodic check-up and not for medically necessary purposes;
- › circumcision of a newborn;
- › reversal of vasectomies;
- › second and subsequent injections for impotence;
- › reversal of tubal ligations;
- › intrauterine insemination;
- › bariatric surgery unless the person has a body mass index of 40 or greater or of 35 or greater but less than 40, as well as obesity-related comorbid conditions; and
- › venipuncture for purposes of taking blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services.

There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (e.g., fibreglass casts), provided in conjunction with an insured health service, do not compromise reasonable access to insured services.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of “medically necessary,” a review of medical service plans across the country, and the previous use of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any changes to the Regulation until the advice and recommendations of the New Brunswick Medical Society are received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

In 2018–2019, no services were removed from the insured services list.



3.0 UNIVERSALITY

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and *Regulation 84–20* define eligibility for the health care insurance plan in New Brunswick. Residents are required to complete a Medicare application and provide proof of identity, proof of residency, and proof of Canadian citizenship or a valid Canadian immigration document. A resident is defined as a person lawfully entitled to be, or to remain, in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient, or visitor to the province.

As of March 31, 2019, there were 775,093 persons registered in New Brunswick.

All persons entering or returning to New Brunswick (excluding children adopted from outside Canada) have a waiting period before becoming eligible for Medicare coverage. Coverage commences on the first day of the third month following the month of arrival.

Exceptions are as follows:

- › Dependents of Canadian Armed Forces personnel or their spouses moving from within Canada to New Brunswick are entitled to first day coverage under the program, provided they are deemed to have established permanent residency in New Brunswick.
- › Immigrants or Canadian residents moving or returning to New Brunswick from outside of Canada are entitled to first day coverage, provided they are deemed to have established permanent residency in the province. Proper documentation is required from Immigration, Refugees, and Citizenship Canada. Decisions on coverage and residency are reviewed on a case-by-case basis.
- › Non-Canadians who are issued Student Authorization. Proper documentation is required from Immigration, Refugees, and Citizenship Canada as well as proof of enrollment at a New Brunswick university or other approved educational institution.

Residents who were not eligible for Medicare coverage during this reporting period included:

- › regular members of the Canadian Armed Forces;
- › inmates at federal institutions;
- › temporary residents;
- › a family member who moves from another province to New Brunswick before other family members move;
- › persons who have entered New Brunswick from another province to further their education and who are eligible to receive coverage under the medical services plan of that province; and
- › non-Canadians who are issued certain types of Canadian authorization permits.

Persons who are discharged or released in New Brunswick from the Canadian Armed Forces, or a federal penitentiary, become eligible for coverage on the date of their discharge or release. An application must be completed and signed, and have proof of Canadian citizenship, proof of residency and the official date of release.

3.2 Other Categories of Individuals

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided that they are legally married to, living in a common-law relationship with or are a dependent of an eligible New Brunswick resident and possess a valid immigration permit. They are required to provide an updated immigration document prior to the previous permit expiring.

Children born out-of-country to Canadian Citizens will take the eligibility criteria of the parent upon return to the Province.



4.0 PORTABILITY

4.1 Minimum Waiting Period

A person is eligible for New Brunswick Medicare coverage on the first day of the third month following the month permanent residency has been established. The three month waiting period is legislated under New Brunswick's *Medical Services Payment Act*. Refer to section 3.1 of this submission for exceptions.

4.2 Coverage during Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, *Regulation 84–20*, sub-sections 3(4) and 3(5).

Medicare coverage may be extended upon request in the case of temporary absences to:

- › students in full-time attendance at an university or other approved educational institution outside New Brunswick;
- › residents temporarily working in another jurisdiction; and
- › residents whose employment requires them to travel outside the province.

Students

Those in full-time attendance at a university or other approved educational institution, who leave the province to further their education in another province, will be granted coverage for a 12 month period that is renewable, provided the following terms are met:

- › Medicare is contacted once every 12 months;
- › permanent residency is not established outside New Brunswick; and
- › health insurance coverage is not received elsewhere.

Residents

Residents temporarily employed in another province or territory are granted coverage for up to 12 months, provided the following terms are met:

- › permanent residency is not established outside New Brunswick; and
- › health insurance coverage is not received elsewhere.

New Brunswick has formal agreements for reciprocal billing arrangements of insured hospital services with all provinces and territories. In addition, New Brunswick has reciprocal agreements with all provinces, except Quebec, for the provision of insured physician services. Services provided by Quebec physicians to New Brunswick residents are paid at Quebec rates provided the service delivered is insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any claims submitted directly by a patient are reimbursed to the patient.

4.3 Coverage during Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act, Regulation 84–20*, subsections 3(4) and 3(5).

Eligibility for New Brunswick residents temporarily absent outside of Canada is determined in accordance with the *Medical Services Payment Act*.

Residents temporarily employed outside Canada are granted coverage for 182 days. This may be extended up to 12 months within a three year period upon approval from the Director of Medicare Eligibility and Claims. Exceptions to this are mobile and contract workers.

Coverage for any absence over 212 days for vacation purposes requires approval from the Director of Medicare Eligibility and Claims. This approval can only be for up to 12 months in duration and will only be granted once every three years.

New Brunswick residents exceeding the 12 month extension have to reapply for New Brunswick Medicare upon their return to the province. In this instance, cases are reviewed on a case by case basis. Depending on the circumstances, some cases may be eligible for first day coverage while others who have been away from the province slightly beyond the 12 month period may be given a grace period.

Insured residents who receive insured emergency services out-of-country are eligible to be reimbursed \$100 per day for in-patient stays and \$50 per out-patient visit. The insured resident is reimbursed for physician services associated with the emergency treatment at New Brunswick rates. The difference in rates is the patient's responsibility.

Mobile Workers

Mobile Workers are residents whose employment requires them to travel outside the province (e.g., pilots). The following guidelines must be met to receive Mobile Worker designation.

- › applications must be in writing;

- › documentation is required as proof of Mobile Worker status (e.g., letter from employer or contract confirming that frequent travel is necessary outside the province:
- › a letter from the resident detailing their permanent residence as New Brunswick and the frequency of their return to the province;
- › a copy of their New Brunswick driver's license;
- › if working outside Canada, a copy of resident's immigration documents that allow them to work outside the country; and
- › the worker must return to New Brunswick during their off-time.

Mobile Worker status is assigned for a maximum of two years, after which the resident must reapply and submit documentation to confirm a continuation of Mobile Worker status.

Contract Workers

Any New Brunswick resident accepting a contract out-of-country must supply the following information and documentation:

- › a letter of request from the New Brunswick resident with their signature, detailing their absence, Medicare number, address, departure and return dates, destination, forwarding address, and reason for absence; and
- › a copy of a contractual agreement between employee and employer indicating start and end dates of employment.

Contract Worker status is assigned up to a maximum of two years. Any further requests for contract worker status must be forwarded to the Director of Medicare Eligibility and Claims for approval on an individual basis.

Students

Those in full-time attendance at a university or other approved educational institution in another country will be granted coverage for a 12 month period that is renewable, provided they comply with the following:

- › proof of enrollment must be provided from the educational institution on an annual basis;
- › Medicare must be contacted once every 12 months;
- › permanent residency cannot be established outside New Brunswick; and
- › health insurance coverage cannot be received elsewhere.

4.4 Prior Approval Requirement

Medicare may cover out-of-country services that are not available in Canada on a pre-approval basis only. Residents may opt to seek non-emergency out-of-country services; however, they are responsible for assuming the total cost.

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided the following requirements are met:

- › the required service or equivalent, or an alternate service must not be available in Canada;
- › the service must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (guide to United States hospitals, health care systems, networks, alliances, health organizations, agencies and providers);
- › the service must be rendered by a medical doctor; and
- › the service must be an accepted method of treatment recognized by the medical community and be regarded by the medical community as scientifically proven in Canada. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. A physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation from a Canadian specialist or specialists.

A beneficiary who disagrees with a decision made by Medicare regarding their case or the case of an immediate family member can appeal to the Insured Services Appeal Committee. Beneficiary appeals can include decisions about eligibility, refusal of a claim payment for entitled services or the amount paid on a claim. The Committee includes members from the general public. It meets three to four times a year based on the number of cases. It reviews each case and presents recommendations to the Minister of Health who makes the final decision regarding an appeal.

Out-of-country insured services that are not available in Canada, are non-experimental, and receive prior approval are paid in full. Often the amount payable is negotiated with the provider by Global Medical Management on the province's behalf.

Haemodialysis is exempt from the out-of-country coverage policy. Patients are required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the current inter-provincial rate per session.

Prior approval is also required to refer patients to psychiatric hospitals and addiction centres outside the province (but within Canada) because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received by Medicare from the Addiction Services or Mental Health branches of the Department.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

New Brunswick's health care system delivers equitable, quality care to the public it serves. New Brunswick does not permit user fees for insured health services as defined by the *Canada Health Act*. New Brunswick uses a robust "comment based" approach to identifying individual citizens' concerns on a wide range of health issues. In a typical month in the 2018–2019 fiscal year the

Department of Health received, logged, and responded to 100–150 concerns from individual New Brunswickers on issues including access to primary or specialized care, pharmaceutical approvals, access to services in a citizen's language of choice, wait times for specific services, the structure of specific programs, etc. The Department's web page provides several mechanisms to make such comments, including mailing addresses, e-mail addresses, telephone numbers, and a web-based message service. No concerns respecting extra-billing and user charges were received in the 2018–2019 fiscal year.

Access in a resident's official language of choice is not a limiting factor, regardless of where a resident receives services in the province.

Improving access to primary care and acute care is an ongoing focus within New Brunswick's health system. To support this focus, Government announced a number of investments in 2018–2019 that will further improve access to health services. They include:

- › Investing an ongoing estimated \$16M annually to add 25 new specialists to the New Brunswick health system, with the intent to reduce wait times. This supplemented a prior announcement of adding 25 new family physicians, to improve accessibility;
- › A \$6.4M investment in expanding "Flexible Assertive Community Treatment Teams" to provide multidisciplinary support to individuals dealing with significant mental health issues; and
- › The release of the "New Brunswick Palliative Care Framework," and investments in hospice construction and hospice care in Fredericton, Saint John, Moncton, and Miramichi.

5.2 Physician Compensation

Payments to physicians and dentists are governed under the *Medical Services Payment Act, Regulations 84–20, 93–143 and 2002–53*.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary and sessional, alternate payment mechanisms or Family Medicine New Brunswick that may include a blended system.

5.3 Payments to Hospitals

The legislative authorities governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Service Act*, which governs the financing of hospitals. The *Regional Health Authorities Act* provides for delivery and administration of health services in defined geographic areas within the province.

The Department mainly distributes available funding to New Brunswick's regional health authorities (RHA) through a Current Service Level approach. The funding base of the RHA from the previous year is the starting point, to which approved salary increases and a global inflator for non-wage items are added. This applies to all clinical services provided by hospital facilities, as well as support services (e.g., administration, food services, etc.).

Funding for Service New Brunswick (SNB), a shared services agency that manages the information technology, materials management, laundry and clinical engineering components of the hospital facilities in New Brunswick, is also based on the Current Service Level approach.

Any requests for funding for new programs or services are submitted to the Deputy Minister of Health for approval. Funding for approved new programs or services is based on requirements identified through discussions between Department of Health and RHA staff. These amounts are added to the RHA funding base once there is agreement on the funding requirements.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

New Brunswick recognizes the federal role regarding its contributions under the Canada Health Transfer in public documentation presented through legislative and administrative processes. Federal transfers are identified in the Main Estimates document and in the Public Accounts of New Brunswick. Both documents are published annually by the New Brunswick government.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	750,691	754,522	761,157	767,562	775,093

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	61	62	62	62	64
3. Payments for insured health services (\$)	1,876,686,329	1,666,482,214	1,704,602,299	1,778,140,499	1,933,194,385

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)¹	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	4,797	4,972	4,552	4,524	4,517
7. Total payments, in-patient (\$)	51,379,027	52,181,789	46,528,311	50,506,502	47,646,790
8. Total number of claims, out-patient	52,050	53,344	50,434	49,939	50,858
9. Total payments, out-patient (\$)	18,669,203	20,046,048	20,857,748	21,199,404	21,711,066

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	5
11. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	12,555
12. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	16
13. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	37,319

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	not applicable	not applicable	not applicable	not applicable	101
15. Total payments in-patient (\$)	not applicable	not applicable	not applicable	not applicable	68,869
16. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	624
17. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	245,165

¹ There are no private for-profit facilities providing health insured services operating in New Brunswick.

² Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians ³	1,631	1,652	1,666	1,742	1,734
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$) ⁴	581,071,156	589,156,558	598,757,372	616,104,222	637,821,346
22. Total payments for services provided by physicians paid through fee-for-service (\$)	328,951,360	362,601,062	373,715,908	381,321,118	393,236,955

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	215,167	247,273	226,812	225,177	218,578
24. Total payments (\$)	20,746,216	24,675,343	23,067,671	22,061,956	22,167,200

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not applicable	not applicable	not applicable	not applicable	547
26. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	25,142

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not applicable	not applicable	not applicable	not applicable	2,955
28. Total payments (\$)	not applicable	not applicable	not applicable	not applicable	296,008

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists ⁵	10	9	11	13	10
30. Number of opted-out dentists ⁶	not applicable	not applicable	not applicable	not applicable	not applicable
31. Number of non-participating dentists ⁶	not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of services provided	1,719	1,607	1,623	1,788	1,601
33. Total payments (\$)	319,051	273,686	343,764	379,857	314,903

³ These are the number of physicians with an active physician status on March 31st of each year.

⁴ The total payment for all payment methods.

⁵ These are the number of dentists and oral maxillofacial surgeons (OMS) participating in New Brunswick's Medical Services Plan during a fiscal year. Routine dental services are not covered by New Brunswick Medicare therefore few dentists and OMSs are registered—only some emergency dental services done in hospital are covered by the Medical Services Plan.

⁶ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years—In general, NB Medicare does not keep track of dentists in the province.

QUEBEC



1.0 PUBLIC ADMINISTRATION

1.1 Health Insurance Plan and Public Authority

Quebec's hospital insurance plan, the Régime d'assurance hospitalisation du Québec, is administered by the Ministère de la Santé et des Services sociaux (MSSS) [the Quebec Department of Health and Social Services].

Quebec's health and drug insurance plans are administered by the Régie de l'assurance maladie du Québec (the Régie), a public body established by the provincial government which reports to the Minister of Health and Social Services.

1.2 Reporting Relationships

The *Public Administration Act* (R.S.Q., c. A-6.01) sets forth government criteria for preparing reports on the planning and performance of public authorities, including the MSSS and the Régie.

1.3 Audit of Accounts

The Quebec Hospital Insurance Plan and the Quebec Health and Drug Insurance Plans are administered by the public authorities on a non-profit basis. All books and accounts are audited by the auditor general of the province.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured inpatient services include the following:

- › standard ward accommodation and meals;
- › necessary nursing services;
- › routine surgical supplies;
- › diagnostic services;
- › use of operating rooms, delivery rooms and anaesthetic facilities;
- › medication;
- › prosthetic and orthotic devices that can be integrated with the human body;
- › biological products and related preparations;
- › use of radiotherapy and physiotherapy facilities; and
- › services delivered by hospital staff.

Outpatient services include the following:

- › clinical services for psychiatric care;
- › electroshock, insulin and behaviour therapies;
- › emergency care;
- › minor surgery (day surgery);
- › radiotherapy;
- › diagnostic services;
- › physiotherapy;
- › occupational therapy;
- › inhalation therapy, audiology, speech therapy and orthoptic services; and
- › other services or examinations required under Quebec legislation.

Other insured services are:

- › mechanical, hormonal or chemical contraception services;
- › surgical sterilization services (including tubal ligation or vasectomy);
- › reanastomosis of the fallopian tubes or vas deferens; and
- › extraction of a tooth or root when the patient's health status makes hospital services necessary.

The Ministère de la Santé et des Services sociaux (MSSS) administers a free ambulance transportation program for persons aged 65 and older, in accordance with the parameters described in the Quebec policy on user transportation.

In addition to basic insured health services, the Régie de l'assurance maladie du Québec (the Régie) also covers:

- › optometric services for people who are under age 18 or 65 and over and for last-resort financial assistance recipients;
- › dental care for children age 10 and under and last-resort financial assistance recipients; and
- › acrylic dental prostheses for last-resort financial assistance recipients.¹

¹ Services covered for recipients of last-resort financial assistance for 12 months or more.

It also covers, for Quebec residents within the meaning of the *Health Insurance Act* (R.S.Q. c. A-29) who meet the eligibility criteria for each program:

- › prostheses;
- › orthotics;
- › orthopedic appliances;
- › walking and posture aids;
- › hearing aids;
- › assistive listening devices; and
- › visual aids.

This coverage applies only to aids and appliances covered in the Regulations. Financial aid is granted for external breast prostheses, ocular prostheses, devices provided to ostomies, and compression clothing for people with lymphedema.

With regard to drug insurance, since January 1, 1997, the Régie has covered, in addition to recipients of last-resort financial assistance and persons aged 65 and over, Quebec residents who otherwise would not have access to a private drug insurance plan. In 2018–2019, the public drug insurance plan covered \$3.6 million for insured persons.

2.2 Insured Physician Services

Services insured under this plan include medical and surgical services that are provided by physicians participating in the plan and are medically necessary.

Also included are:

- › family planning services set forth by legislation;
- › artificial insemination services; and
- › services required for the purpose of fertility preservation set forth by legislation which are provided by a participating physician.

2.3 Insured Surgical-Dental Services

Services insured under this plan include surgery performed by dental surgeons and specialists in oral and maxillofacial surgery, in a prescribed hospital centre or university institution.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- › plastic surgery for purely cosmetic purposes;
- › accommodation in a private or semi-private room at the patient's request;
- › television;
- › telephone;

- › drugs and biological products ordered after discharge from hospital; and
- › services to which the patient is entitled under the *Act respecting industrial accidents and occupational diseases* or other federal or provincial legislation.

The following services are not insured:

- › any examination or service not related to a process of curing or preventing illness;
- › psychoanalysis of any kind, unless such service is delivered in a facility maintained by an institution authorized for such purpose by the Minister of Health and Social Services (the Minister);
- › any service provided solely for aesthetic purposes;
- › any refractive surgery, except where there is documented failure in respect of corrective lenses and contact lenses for astigmatism of more than 3.00 diopters or anisometropia of more than 5.00 diopters, any consultation by telecommunication or by correspondence, with the exception of telehealth services within the meaning of the *Act respecting health services and social services*;
- › any service delivered by a professional to his or her spouse or children;
- › any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than one who has received an insured service, except in certain cases;
- › any visit made for the sole purpose of obtaining the renewal of a prescription; any examination, vaccination, immunization or injection where the service is provided to a group or for certain purposes;
- › any service delivered by a professional on the basis of an agreement or contract with an employer, association or body;
- › any adjustment of eyeglasses or contact lenses;
- › any surgical extraction of a tooth or dental fragment performed by a physician, unless such service is provided in a hospital centre in certain cases;
- › all acupuncture procedures;
- › injection of sclerosing substances and the examination performed at that time;
- › mammography used for detection purposes, unless this service is required by medical prescription in a place designated by the Minister to a recipient 35 years of age or older, provided that the person has not been so examined for one year;
- › thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in humans, unless these services are delivered in a hospital centre;
- › ultrasonography, unless this service is delivered in a hospital centre or by a radiologist or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose;

- › optical tomography of the eyeball and confocal scanning laser ophthalmoscopy of the optic nerve, unless these services are delivered in a facility maintained by an institution that operates a hospital or are delivered in association with the delivery, by intravitreal injection, of an antiangiogenic drug for the treatment of certain pathologies;
- › any radiological or anaesthetic service provided by a physician if required for providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of radiology, if required by a person other than a physician or dentist;
- › any sex-reassignment surgery, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose;
- › any services that are not related to pathology and that are delivered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim booklet, for colour blindness or a refractive error, in order to provide or renew a prescription for eyeglasses or contact lenses; and
- › any assisted reproduction services, with the exception of artificial insemination, including ovarian stimulation services within the meaning of the Act.



3.0 UNIVERSALITY

3.1 Eligibility

Registration with the Hospital Insurance Plan is not required. Registration with the Régie de l'assurance maladie du Québec (RAMQ) is sufficient to establish an individual's eligibility. Any individual residing or staying in Quebec as defined in the *Health Insurance Act* must be registered with RAMQ to be eligible for hospital services.

A person whose eligibility has been denied or who is dissatisfied with a decision of the RAMQ may request a review of the decision. The request for a review must be submitted to the RAMQ in a written notice setting out the reasons for the request. The request must be submitted within the six-month period following the date when the requester was informed of the decision.

As a last resort, within 60 days of being notified of the decision, a person may contest before the Tribunal administratif du Québec the decision for which the person has requested a review.

3.2 Other Categories of Individuals

Inmates in federal penitentiaries are not covered by the Quebec Health Insurance Plan.

Certain categories of residents, notably permanent residents under the *Immigration Act* and persons returning to live in Canada, become eligible under the plan following a waiting period of up to three months. Persons from another country receiving last-resort financial assistance benefits are eligible upon registration.

Canadian Forces personnel and their family members posted to Quebec from another Canadian province or territory who have status permitting them to settle there are eligible on the date of their arrival. Those who have not acquired Quebec resident status, and inmates of federal penitentiaries, become insured the day they are discharged or released.

Immediate coverage is provided for certain seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the Ministère de l'Éducation [the Quebec Department of Education], persons from outside Canada who are eligible under an agreement or accord reached with a country or an international organization, and refugees.

Persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for a period of more than six months may be eligible for the plan following a waiting period of up to three months.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Persons settling in Quebec after moving from another province of Canada are entitled to coverage under the Quebec Health Insurance Plan when they cease to be entitled to benefits from their province of origin, provided they register with the Régie de l'assurance maladie du Québec (the Régie) and meet certain conditions.

4.2 Coverage During Temporary Absences from Quebec

If living outside Quebec in another province or territory for 183 days or more and provided they so notify the Régie, students and full-time unpaid trainees may retain their status as residents of Quebec:

- › students for a maximum of four consecutive calendar years; and
- › full-time unpaid trainees for a maximum of two consecutive calendar years.

This is also the case for persons living outside Quebec who are temporarily employed or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons who are directly employed or working on contract outside Quebec for a company or corporate body with its headquarters or a place of business in Quebec to which they report directly, or who are employed by the federal government and posted outside Quebec, also retain their status as a resident of the province. The same is true of persons who remain outside the province for 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years.

Insured persons who leave Quebec to live in another province or territory in Canada remain eligible for health insurance for up to three months after their departure, but their eligibility for the Quebec drug plan ends on the day of their departure.

However, coverage for insured persons who leave Quebec to permanently move abroad terminates the day of their departure.

4.3 Reimbursement of Professional Services Received outside Quebec

The costs of insured services provided by health professionals to an insured person in another province or territory of Canada are reimbursed for the amount actually paid or at the rate that would have been paid by the Régie for such services in Quebec, whichever is lower. Exceptionally, for the Outaouais region, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa medical specialists at the Ontario fee rate for specialized services that are not available in the Outaouais region. This agreement came into effect on November 1, 1989. The Régie covers the amount it would have paid for the same services in Quebec. The Centre intégré de services de santé et de services sociaux de l'Outaouais [Outaouais integrated health and social services centre] pays the difference between the cost invoiced by Ontario and the amount initially reimbursed by the Régie. A similar agreement was signed in December 1991 between the Centre de santé Témiscaming [Témiscaming Health Centre] and the North Bay Regional Health Centre.

The service provided must be an insured service within the meaning of the Act. Services that are experimental in nature are not reimbursed.

4.4 Reimbursement of Hospital Services Received in Canada

Costs for hospital services provided to an insured person in another province or territory of Canada are paid in accordance with the terms and conditions of the Hospital Reciprocal Billing Agreement regarding hospital insurance agreed to by the provinces and territories of Canada. These costs are paid either at the established per diem for hospitalization in a standard ward or in intensive care proposed by the host province and approved by all the provinces and territories or, in cases of outpatient services or expensive procedures, at the approved interprovincial rates. Services that are excluded from interprovincial agreements but covered under the provincial program are reimbursed at the rate in force.

4.5 Reimbursement of Hospital Services outside Canada

During a temporary stay outside Canada, the Régie reimburses the full cost of emergency hospital services and 75 per cent of the cost in other cases to students, unpaid trainees, Quebec government employees posted abroad and employees of non-profit organizations working in international aid or co-operation programs recognized by the Minister of Health and Social Services (the Minister). However, when such persons go on holiday outside their place of study, training or work, this coverage is no longer in force, and regular coverage for hospital services applies.

Residents of Quebec who are working or studying abroad are covered by the plan in effect in that country when the stay falls under a social security agreement reached between the Minister and the country in question.

For residents who are not in one of the above situations and receive insured services in a hospital outside Canada, the Régie reimburses the cost of such services, when they become necessary due to an emergency or sudden illness, to a maximum of: \$100 CAD per day if the patient was hospitalized, including for day surgery, or to a maximum of \$50 CAD per day for outpatient services. However, hemodialysis treatments are covered to a maximum of \$220 CAD per treatment. The services must be rendered in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments.

4.6 Prior Approval Requirement

To receive full reimbursement for professional and hospital services elsewhere in Canada or in another country not covered under an agreement, a written request signed by two physicians with expertise in the field of the pathology of the person on whose behalf the request is made must first be sent to the Régie. The request must be accompanied by a summary of the insured person's medical file, describe the specialized services required by the insured person, attest to the unavailability of the said services in Quebec or Canada, and contain information about the treating physician and the name and address of the hospital where the services are to be provided. Following an evaluation of the request by the Régie, authorization to receive the services is either given or denied. No authorization will be given if the service is available in Quebec or if it is an experimental service.

A person whose request has been denied or who is dissatisfied with a decision of the Régie de l'assurance maladie du Québec (RAMQ) may request a review of the decision. The request for a review must be submitted to the RAMQ in a written notice setting out the reasons for the request. The request must be submitted within the six-month period following the date when the requester was informed of the decision.

As a last resort, within 60 days of being notified of the decision, a person may contest before the Tribunal administrative du Québec the decision for which the person has requested a review.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Everyone has the right to receive adequate health care services without any kind of discrimination. In Quebec, the *Health Insurance Act* does not allow user fees to be imposed. It also prohibits any person from demanding or receiving any payment from a person for incidental fees related to an insured service, except in cases prescribed by regulation and the conditions mentioned therein. If anyone thinks that the person has been incorrectly billed fees, the person may request reimbursement from the Régie de l'assurance maladie du Québec (the Régie), which will determine whether any amounts have been unjustifiably paid. If appropriate, the Régie

will reimburse the insured person and will recover the amount reimbursed from the health-care professional or the clinic involved. It is also possible to reimburse insured persons who have not made reimbursement requests if the Régie finds that fees have been charged to them illegally.

A situation that appears to be illegal with respect to fees charged to an insured person may also be reported to the Régie which, after verification, will follow up appropriately. These follow-ups may include an inspection or an investigation of the clinics or the professionals involved. Residents who have reason to believe that they have been subject to patient charges can contact the Régie at: www.ramq.gouv.qc.ca/fr/citoyens/assurance-maladie/soins/Pages/remboursement.aspx

Improving access to health and social services for the population is a government priority. In order to achieve this objective, Quebec has undertaken a transformation of the Health and Social Services Network (the network) and its governance in 2015.

For most health and social services regions, this transformation has established an integrated health and social services centre or an integrated university health and social services centre which generally encompasses all of the health missions.

In more detail, as of March 31, 2019, the health and social services network had 142 institutions: 51 public and 91 private. These institutions administer 1,580 facilities or physical spaces providing health and social services to the Quebec population.

The 51 public institutions are administered by 34 president-CEOs or CEOs. They include Integrated Health and Social Services Centres (CISSS) and Integrated University Health and Social Services Centres (CIUSSS), hereafter referred to as integrated centres, as well as grouped institutions and other institutions that have been neither grouped nor merged.

As of April 1, 2015, each of the 22 integrated centres is the result of the merger of all or some of the public institutions in a given health and social services region, as the case may be, with the health and social services agency. Nine of the 22 integrated centres call themselves “centre intégré universitaire de santé et de services sociaux” because they are located in a health and social services region in which a university offers a complete predoctoral program of study in medicine or because they operate a centre designated as a university institute in the field of social services.

For their part, the 29 remaining public institutions are distributed as follows:

- › Five University Hospital Centres (CHU), one University Institute (IU) and one institution which are not attached to an integrated centre but to the Ministère de la Santé et des Services sociaux (MSSS), and which offer specialized or ultra-specialized services beyond the boundaries of their health and social service region, namely:
 - › CHU de Québec—Université Laval;
 - › Quebec Heart and Lung Institute—Université Laval;
 - › Centre hospitalier de l’Université de Montréal;

- › McGill University Health Centre;
- › Centre hospitalier universitaire Ste-Justine;
- › Montréal Heart Institute;
- › Institut national de psychiatrie légale Philippe-Pinel;
- › Five public institutions not targeted or affected by the Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies (chapter O-7.2) under the LMRSSS that serve a Northern or Aboriginal population; and
- › 17 public institutions attached to an integrated centre. These institutions were not merged with other institutions under the LMRSSS but are administered by the board of the integrated centre to which they are attached.

In addition, as of March 31, 2019, Quebec had 42 public and five private facilities under agreement with a hospital centre (CH) mission providing diagnostic services and general and specialized medical care in the physical health (CHSGS) and mental health (CHPSY) sectors. As of that date, there were 21,072 beds with a CH mission, i.e., 19,943 general and specialized care beds and 1,129 psychiatric care beds.

According to the most recent available data:

- › From April 1, 2017, to March 31, 2018, Quebec hospital institutions had 834,697 short-term care admissions and 368,634 admissions for day surgery. These admissions accounted for 6,930,635 patient days.
- › From April 1, 2018 to March 31, 2019, there were 833,258 short-term care admissions and 373,684 day surgery admissions. These admissions accounted for 6,899,467 patient days.

In conclusion, Quebec also has four integrated university health networks (réseaux universitaires intégrés de santé or RUISS) which promote co-operation, complementarity and integration of the care, teaching and research missions of the health facilities and universities with which they are affiliated. In addition to the services provided by public facilities, the population also has access to the services of private facilities which offer accommodation, long-term care and other services.

Since 2002, Family Medicine Groups (GMF) have served as flagships for the organization of front-line health care and services in Quebec. GMF promote teamwork, collaboration among professions, institutional responsibility to the population, and the development of trust and close collaboration between patients and clinicians. Review of the GMF management framework led to the creation of the Programme ministériel de financement et de soutien professionnel [departmental funding and professional support program] (The program). The Program came into force on November 16, 2015. It offers financial and professional support tailored to the realities of clinicians and the needs of patients. It has introduced equitable, patient-centred funding, additional professional support (in addition to nursing personnel, social workers,

pharmacists and other health professionals), a more balanced service offer, less burdensome administrative procedures, and mandatory use of electronic health records. These features have the voluntary support of physicians and the benefit of a team funding structure. The core of the model continues to be the registration of patients with a group physician and a service offering that allows registered patients to take advantage of accessible services. The elementary structure of the GMF ensures that registered patients have reasonable and timely access, as is demonstrated by the addition of a measurement of patients' attendance at the GMF in which they are registered. The Program updates terms of funding and resource allocation, and is designed to be more flexible to implement. It relies on the professional commitment of clinical communities to provide accessible, continuous and quality services. As of March 31, 2019, Quebec had 342 accredited GMF in the province. As of the same date, there were 51 GMF networks (of which 35 were former network clinics).

5.2 Physician Compensation

Physicians are remunerated in accordance with the negotiated fee schedule. The Minister may enter into an agreement with the organizations representing any class of health professional.

The *Health Insurance Act* (A-29) governs the compensation of health professionals (physicians, dentists, optometrists and pharmacists). While the majority of physicians practise within the provincial plan, Quebec allows two other options:

- › professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and
- › non-participating professionals who practise outside the plan, with no reimbursement from the Régie going to either them or their patients.

To become a non-participant, a health professional must notify the Régie by registered or certified mail. The non-participation takes effect the thirtieth (30th) day from the date of mailing, and re-enrollment takes effect the eighth (8th) day following the date of mailing of the notice (Regulation respecting the application of the *Health Insurance Act*, s. 29).

There are various modes of remuneration:

- › **Fee for service:** Compensation according to the service rates set out in the compensation agreements for each specialty.
- › **Mixed:** Include half-day and full-day rates or daily compensation and fee supplements.
- › **Lump sum fees:** Include hourly and half-day rates, as well as daily compensation.
- › **Salary:** Salary = specialists / fixed fees = general practitioners. These two modes of compensation are based on a work week whose number of hours may vary.
- › **Establishment laboratory service:** This rate governs the practice of laboratory medicine, which includes the disciplines of biomedicine, nuclear medicine and diagnostic radiology.

- › **Lump sum:** Lump sum compensation is based on a given amount paid periodically or annually to family physicians (general practitioners) for the care and medical management of a patient, as well as a supplement for the volume of patients registered and the lump sum for family practice.
- › **Bonuses (incentive measures):** Bonuses increase the hourly rate or fixed fees. These include responsibility bonuses, occupational health bonuses and those related to the frontline service delivery support schedule.
- › **Special measures (incentive measures):** Some measures are aimed at encouraging physicians to practise and remain in underserved areas (e.g., isolation allowances).
- › **Establishment laboratory service:** this mode governs the rate for the practice of laboratory medicine, which includes the disciplines of biomedicine, nuclear medicine and diagnostic radiology. The physician enters a billing period, the services provided and the number of times said services were rendered.

According to the most recent data available, in 2018–2019 the Régie paid an estimated \$7.8 billion for professional services provided to Quebec residents. Professional services (including reimbursements to insured persons and payments to professionals) received outside Quebec were estimated at \$44.9 million.

The Régie is responsible for enforcing health-care professional compensation agreements and for controlling compensation paid to health-care professionals. It has established a framework that enables it to enhance its controls on the basis of the risks identified, in order to ensure that the compensation paid to health-care professionals complies with the terms and conditions in the agreements negotiated. The Régie has various control measures as follows:

Awareness-Raising Mechanisms

The Régie issues notifications to the Quebec Department of Health and Social Services with respect to issues and risks associated with controlling the payment of health-care professionals on the basis of the agreements negotiated. Thus, based on its analyses, the Régie's findings may result in the issuance of notifications on different issues even if they apply more to medical practice or the organization of services.

Systematic Controls

These measures are aimed at the overall billing of health-care professionals or agreement situations. The controls are carried out manually, by computer, by taking samples, or by monitoring. Systematic controls may be followed by specific controls if the Régie deems it necessary to do an in-depth analysis of a situation with a professional or a limited group of professionals.

Specific Controls (inspections, investigations, service audits performed)

These measures are aimed at the billings of a professional or a limited group of professionals for whom practices have been identified as at risk of being non-compliant or potentially abusive or fraudulent. A specific audit may also be initiated following a complaint or a tip.

The Régie recovers the amounts that have been inappropriately paid by means of a compensation or recovery mechanism.

The Régie has a monitoring mechanism to ensure that professionals with noncompliant, abusive or fraudulent billings are subject to monitoring.

5.3 Payments to Hospitals

The Minister of Health and Social Services funds hospitals through payments directly related to the cost of insured services provided.

The payments made in 2018–2019 to institutions operating as hospital centres for insured health services provided to residents of Quebec totalled over \$13.6 billion. Payments to hospital centres in other provinces or outside Canada for hospital services totalled approximately \$232.75 million.

ONTARIO



Ontario has one of the largest and most complex publicly-funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care¹, Ontario's health care system was supported by over \$61 billion (including capital) in spending during 2018–2019.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Ontario Health Care and Health Care Planning

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by the Ministry of Health (MOH). OHIP was established in 1972 and is continued under the *Health Insurance Act* (HIA), Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided to Ontario residents (as defined in the HIA) in hospitals and health facilities, and by physicians and other health care practitioners.

The MOH provides services to the public through programs such as health insurance, drug benefits, assistive devices, forensic mental health and supportive housing, long-term care, home care, community and public health, and health promotion and disease prevention. It also regulates hospitals and nursing homes, medical laboratories and specimen collection centres, and coordinates emergency health services.

Local Health Integration Networks (LHIN) were established under the *Local Health System Integration Act, 2006* (LHSIA). Since April 1, 2007, the LHIN have served as Ontario's regional health authorities and have had responsibility for funding, planning and integrating health care services at the local level. This included services delivered by hospitals, community care access centres, long-term care homes, community health centres, community support service agencies, and mental health and addictions agencies.

In 2017, the LHIN role was expanded to include the management and delivery of home and community care services. To support their expanded mandate, the roles and responsibilities of the former 14 community care access centres were transferred to the LHIN.

On February 26, 2019, Ontario announced its long-term plan to build a modern and sustainable health care system that starts and ends with the patient. Ontario is creating an integrated public health care system by coordinating the work of existing provincial health agencies and programs. Ontario will have one single health agency—Ontario Health—to oversee health care delivery,

¹ On June 20, 2019, Ontario announced changes to its Cabinet that included the creation of the Ministry of Health and the Ministry of Long-Term Care. As such, the Ministry of Health and Long-Term Care will be referred to as the Ministry of Health (MOH) throughout this report.

improve clinical guidance and provide support for providers to ensure better quality care for patients.

Some provincial agencies will transition to the new agency in phases, including:

- › Cancer Care Ontario;
- › Health Quality Ontario;
- › eHealth Ontario;
- › Trillium Gift of Life Network;
- › Health Shared Services Ontario;
- › HealthForceOntario Marketing and Recruitment Agency; and
- › 14 Local Health Integration Networks.

The transformation will take place over a number of years. It will roll out in carefully planned phases to ensure patient care is not interrupted. The *People's Health Care Act* and the *Connecting Care Act* enabled these changes.

1.2 Reporting Relationship

The HIA stipulates that the Minister of Health is responsible for the administration and operation of OHIP, and is Ontario's public authority for the purposes of the *Canada Health Act*. The HIA sets out legislative reporting requirements for OHIP under s.9 where it states:

The Minister shall make a report annually to the Lieutenant Governor in Council upon the affairs of the Plan and the Minister shall lay the report before the Assembly if it is in session or, if not, at the next session.

The OHIP report provides background information about the program, information about application legislation, funding models, accountability measures, funding for services obtained out of Ontario and program expenditure information.

The OHIP Annual Report, covering the fiscal period 2014–2015, was tabled in the winter of 2018.

1.3 Audit of Accounts

Every year the Auditor General of Ontario reports on the results of their examination of government resources and administration. The Auditor General's report is tabled by the Speaker of the Legislative Assembly, usually in the fall, at which time it becomes available to the public. Audit reports on select areas of the MOH chosen for review by the Auditor General are included within this annual report, the last of which was released on December 5, 2018.

The MOH's accounts are published annually in the Public Accounts of Ontario. The 2018–2019 Public Accounts of Ontario were tabled and released on September 13, 2019.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured in-patient and out-patient hospital services in Ontario are prescribed under the *Health Insurance Act* (HIA), and *Regulation 552* under the Act.

Insured in-patient hospital services include medically required:

- › use of operating rooms, obstetrical delivery rooms and anaesthetic facilities including necessary equipment and supplies;
- › necessary nursing services;
- › laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;
- › drugs, biologicals and related preparations; and
- › accommodation and meals at the standard ward level.

Insured out-patient services include medically required:

- › laboratory, radiological and other diagnostic procedures, together with necessary interpretations;
- › use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- › use of diet counselling services;
- › use of the operating room and anaesthetic facilities;
- › surgical supplies;
- › necessary nursing service;
- › supply of drugs, biologicals, and related preparations (subject to some exceptions);
- › certain other specified services such as the provision of certain equipment, to hemophiliac patients for use at home; and
- › certain specified home-administered drugs.

Hospital services are not specifically listed in *Regulation 552* in the HIA; rather, the Regulation lists broad categories of services that include new medical and technological advances as they become accepted standards of practice.

Regulatory changes are approved by Cabinet and generally there is a public consultation process by way of Ontario's Regulatory Registry.

No regulation changes to insured hospital services were completed in fiscal year 2018–2019.

2.2 Insured Physician Services

Insured physician services are prescribed under the HIA and Regulations under the Act.

Under *Regulation 552* of the HIA, a service provided by a physician in Ontario is an insured service if it:

- › is medically necessary;
- › referred to in the Schedule of Benefits - Physician Services; and
- › rendered in such circumstances or under such conditions as specified in the Schedule of Benefits—Physician Services.

Physicians provide medical, surgical and diagnostic services, including primary health care services. Services are provided in a variety of settings, including: physician offices, community health centres, hospitals, mental health facilities, licensed independent health facilities, and long-term care homes.

In general terms, insured physician services include:

- › consultations and visits, for diagnosis and treatment of medical conditions;
- › maternity care;
- › anaesthesia;
- › immunizations; and
- › surgical procedures.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario, and be located in Ontario when rendering the service.

During 2018–2019, most physicians submitted claims for all insured services rendered to insured persons directly to the Ontario Health Insurance Plan (OHIP), and a small number of physicians billed the insured person. Physicians who do not bill OHIP directly are commonly referred to as having opted-out of the Plan. When a physician has opted-out of the Plan the physician bills the patient an amount not exceeding the amount payable for the service under the Schedule of Benefits—Physician Services (this was permitted on a ‘grandparented’ basis following proclamation of the *Commitment to the Future of Medicare Act* [CFMA] in 2004). The patient then recoups that amount from the Plan.

There were approximately 32,566 physicians who submitted claims to OHIP in 2018–2019. This figure includes physicians submitting both fee-for-service claims and physicians included in an alternative payment plan who submitted tracking or shadow-billed claims. In 2018–2019, there were 17 opted-out physicians in Ontario.

The Schedule of Benefits — Physician Services is regularly reviewed and revised to reflect current medical practice and new technologies. New services may be added, existing services revised, or obsolete services removed through regulatory amendment. This process involves consultation with the Ontario Medical Association (OMA) and may also require negotiation with the OMA under the Binding Arbitration Framework.

There were no changes to the Schedule in 2018–2019.

2.3 Insured Surgical-Dental Services

In accordance with the *Canada Health Act*, certain surgical-dental services are prescribed as insured services under *Regulation 552* in the HIA, and listed in the Schedule of Benefits—Dental Services. The Act authorizes OHIP to pay for a limited number of procedures when the procedure is medically necessary and the insured services are performed in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D, by a dental surgeon who has been appointed to the dental staff of the public hospital.

Generally, insured dental services include:

- › oral and maxillo-facial surgery that would normally be required to be performed in a hospital;
- › root resection and apical curettage procedures when performed in association with other insured dental procedures; and
- › dental extractions when performed in a hospital for the safety of high risk patients and if prior approval is obtained from the Ministry of Health (MOH).

With respect to insured surgical-dental services, the MOH consults with the Ontario Dental Association in making changes to the Schedule of Benefits - Dental Services.

In Ontario, in the fiscal year 2018–2019, 880 dentists had active billing numbers and 281 dentists billed OHIP. There were 599 dentists who had active billing numbers but did not bill OHIP. Following proclamation of the CFMA in 2004, dentists are required to submit claims for all insured surgical-dental services to OHIP, i.e. are prohibited from charging the patient for insured services. No dentists are 'opted-out' or exempt under 'grandparented' provisions.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include but are not limited to:

- › private or semi-private accommodation unless no ward room is available or if prescribed by a physician, oral maxillofacial surgeon or midwife due to a patient's condition;
- › telephones and televisions;
- › charges for certain private-duty nursing; and
- › provision of medications for patients to take home from hospital, with prescribed exceptions.

Section 24 of *Regulation 552* details some specified physician and supporting services that are not insured services.

Uninsured physician services may include:

- › services that are not medically necessary;
- › services not listed in the Schedule of Benefits — Physician Services; and
- › services that in the circumstances set out in section 24 of *Regulation 552* are uninsured. For example a service, including an annual health or annual physical examination, received wholly or partly for the production or completion of a document or transmission of information to a third party (e.g., insurance company, employer, Workplace Safety and Insurance Board (WSIB), etc.) may be uninsured.

Under section 24, treatment for a medical condition that is generally accepted within Ontario as experimental is also not insured.

Additionally, “add ons” to insured services that are considered non-medically necessary and optional upgrades to a basic insured service (e.g. upgraded cataract lenses, specialized testing for cataract surgery, fibreglass casts, etc.) are uninsured services for which a patient may be charged.

Dental services provided in dentists’ offices are not insured and payment is the responsibility of the individual patient. Dental services not specifically listed in the Dental Schedule are also not insured including such services as prosthetic restorations (fixed bridges and dentures) for the replacement of teeth, orthodontic treatment, fillings and crowns.

In an effort to uphold requirements under the *Canada Health Act* to prohibit extra-billing and user charges (EBUC) for insured health care services, Ontario’s CFMA provides authority to investigate and take action related to allegations of EBUC. Specifically, the CFMA makes it illegal:

- › for a physician or designated practitioner to charge, or accept any benefit, for rendering an insured service to an insured person in addition to the amount that is paid by OHIP (subject to a few specified exceptions). Such charges are unauthorized payments that are commonly called extra-billing;
- › for a physician or designated practitioner to accept payment or benefit for an insured service rendered to an insured person except from OHIP (subject to a few specified exceptions);
- › for any person or entity to charge or accept payment or other benefit for an insured service rendered to an insured person except as outlined above or as specified in the Regulations;
- › for any person or entity to pay, charge or accept payment or other benefit in exchange for conferring upon an insured person a preference in obtaining access to an insured service. Such payments and benefits for preferred access are commonly called queue-jumping; and,
- › for a physician, practitioner or hospital to make the provision of an insured service to an insured person conditional on a person’s choice not to pay a block or annual fee for the uninsured service (i.e., patients cannot be required to purchase uninsured services in the form of a block or annual fee in order to access insured services).

Under the *Independent Health Facilities Act* (IHFA), the MOH provides facility fee funding to cover overhead costs associated with the provision of insured services rendered in non-hospital facilities. Under this Act, facility fees are payable only by the Minister of Health, Cancer Care Ontario or a Local Health Integration Network and only to a licensed independent health facility, and charges to or receipt of a facility fee payment from a patient is an illegal facility fee.

The MOH reviews all possible violations of the CFMA and IHFA that come to its attention. Possible violations come to the MOH's attention from various sources such as patient complaints, the media, advertisements, health care providers and their staff and Members of Provincial Parliament. In some cases, the MOH may also review possible violations of the CFMA and IHFA on a proactive basis (i.e., without receiving a complaint). If it is found that a patient was charged an unauthorized payment, the MOH ensures that patients are reimbursed in accordance with provisions of the CFMA.

Providers and facilities are legally permitted to charge patients for uninsured services, either on a fee-for-service basis, or through a block or annual fee, which covers a group of uninsured services rendered by a physician, practitioner or hospital over a specified time period.

The MOH does not regulate charges by physicians for uninsured services, or for services rendered to uninsured persons nor does the MOH set prices for uninsured services.

The College of Physicians and Surgeons of Ontario (CPSO), the body governing the practice of medicine in Ontario, is responsible for regulating charges by physicians for uninsured services, including block fees. The MOH's interest in block fees is to ensure that they do not create a barrier to accessing insured services, do not include charges for insured services, do not confer preferential access to insured services, or constitute illegal facility fees contrary to Ontario law. However, the ministry does not regulate the amount charged for block fees or the types of uninsured services that may or may not be included in block fees.

The CPSO has established guidelines with respect to charging patients for uninsured services, and is responsible for investigating complaints against physicians, such as for excessive fees. It is professional misconduct under the *Medicine Act* for physicians to charge a fee that is excessive in relation to the services performed. The MOH directs patients who have complaints regarding charges for uninsured services to the CPSO.



3.0 UNIVERSALITY

3.1 Eligibility

Section 11 of the *Health Insurance Act* (HIA) specifies that every person who is a resident of Ontario is entitled to become an insured person under the Ontario Health Insurance Plan (OHIP) upon application. In order to be considered an Ontario resident, *Regulation 552* under the HIA, with a few exceptions that are noted in the Regulation, requires that a person must:

- › hold Canadian citizenship or an immigration status as prescribed in *Regulation 552*;
- › make his or her primary place of residence in Ontario;

- › subject to some limited exceptions, be physically present in Ontario for at least 153 days in any 12-month period; and
- › for most new and returning residents, be physically present in Ontario for 153 of the first 183 days following the date residence is established in Ontario. For example, a person cannot be away from the province for more than 30 days in the first six months of residency.

Individuals who are not eligible for OHIP coverage are those who do not meet the definition of a resident, such as tourists, visitors to the province and those who do not hold an immigration or other similar status as defined in the Regulation. Services that a person is entitled to receive under federal legislation are not insured services, for example, those provided to federal penitentiary inmates and Canadian Forces members. Services that a person is entitled to receive under the *Workplace Safety and Insurance Act* are also not insured services in Ontario.

When it is determined that a person is not eligible, or is no longer eligible, for OHIP coverage, a request may be made by the person to the Ministry of Health (MOH) to review the decision. Anyone may request that the Ministry of Health review the denial of their OHIP eligibility by making a request in writing to the OHIP Eligibility Review Committee. Those who are not satisfied with the decision regarding their OHIP eligibility may request an appeal of their case by the Health Services Appeal and Review Board.

The MOH is the sole payor for OHIP insured physician, hospital and hospital surgical-dental services. An eligible Ontario resident may not obtain any benefits from another insurance plan for the cost of any insured service that is covered by OHIP (with the exception of during the OHIP waiting period).

Persons who were previously ineligible for OHIP coverage but whose status and/or residency situation has changed may be eligible upon application, subject to the requirements of *Regulation 552*. There were 14, 231,376 valid and active health card users in Ontario as of March 31, 2019.

3.2 Other Categories of Individuals

The MOH provides health insurance coverage to a limited number of specified categories of residents of Ontario, other than Canadian citizens and permanent residents or landed immigrants.

These residents are required to provide acceptable original documentation to support their residence in Ontario and their identity in the same manner as Canadian citizens and permanent resident or landed immigrant applicants.

The individuals listed below who are residents in Ontario may be eligible for OHIP coverage in accordance with *Regulation 552* of the HIA. Individuals are required to apply in person to ServiceOntario, which has the government-wide mandate for the delivery of front-facing services to the residents of Ontario, including the issuance of the Ontario Photo Health Card.

Applicants for Permanent Residence: These are persons who have submitted an application for Permanent Resident status to Immigration, Refugees and Citizenship Canada (IRCC), and IRCC has confirmed that the person meets the eligibility requirements to apply for permanent residence in Canada and that the application has not yet been denied.

Protected Persons/Convention Refugees: These are persons who are determined to be Protected Persons/Convention Refugees under the terms of the federal *Immigration and Refugee Protection Act*. Members of this group are provided with immediate OHIP coverage.

Holders of Temporary Resident Permits: A Temporary Resident Permit is issued to an individual by IRCC when there are compelling reasons to admit an individual into Canada who would otherwise be inadmissible under the federal *Immigration and Refugee Protection Act*. Each Temporary Resident Permit has a case type or numerical designation on the permit that indicates the circumstances allowing the individual entry into Canada. Individuals who hold a permit with a case type of 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 or 80 (if for adoption) are eligible for OHIP coverage.

Foreign Clergy, Foreign Workers and their Accompanying Family Members: An eligible foreign clergy is a person who is sponsored by a religious organization or denomination if the member has finalized an agreement to minister to a religious congregation or group in Ontario for at least six months, as long as the member is legally entitled to stay in Canada.

A foreign worker is eligible for OHIP if the individual has been issued a Work Permit or other document by IRCC that permits the person to work in Canada, and if the person also has a formal agreement in place to work full-time for an employer in Ontario. The work permit or other document issued by IRCC, or a letter provided by the employer, must set out the employer's name, state the person's occupation with the employer, and state that the person will be working for the employer for no less than six consecutive months.

A spouse and/or dependent (under 22 years of age; or 22 years of age or older if dependent due to a mental or physical disability) of an eligible foreign clergy or an eligible foreign worker is also eligible for OHIP coverage as long as the spouse or dependent is legally entitled to stay in Canada.

Live-in Caregivers: Eligible live-in caregivers are persons who hold a valid Work Permit under the Live-in Caregiver Program (LCP) administered by the Government of Canada. The Work Permit for LCP workers does not have to list the three specific employment conditions required for all other foreign workers.

Applicants for Canadian Citizenship: These individuals are eligible for OHIP coverage if they have submitted an application for Canadian citizenship under section 5.1 of the federal *Citizenship Act*, even if the application has not yet been approved, provided that IRCC has confirmed that the person meets the eligibility requirements to apply for citizenship under that section and the application has not yet been denied.

Children Born Out-of-Country: A child born to an OHIP-eligible woman who was transferred from Ontario to receive insured health services that were pre-approved for payment by OHIP is eligible for immediate OHIP coverage provided that the mother was pregnant at the time of departure from Ontario.

Seasonal Agricultural Farm Workers: are persons who have a Work Permit issued under the Seasonal Agricultural Worker Program administered by the Government of Canada. Due to the special nature of their employment, migrant farm workers do not have to meet any other residency requirement and are provided with immediate OHIP coverage.

3.3 Premiums

No premiums are required to obtain OHIP coverage. There is an Ontario Health Premium that is collected through the provincial income tax system but it is not connected to OHIP registration or eligibility in any way. Responsibility for the administration of the Ontario Health Premium lies with the Ontario Ministry of Finance.



4.0 PORTABILITY

4.1 Minimum Waiting Period

In accordance with section 5 of *Regulation 552* under the *Health Insurance Act* (HIA), individuals who move to Ontario are typically entitled to Ontario Health Insurance Plan (OHIP) coverage three months after establishing residency in the province unless listed as an exception in sections 6, 6.1, 6.2, or 6.3 of *Regulation 552*, or subsection 11(2.1) of the HIA.

Assessment of whether or not an individual is subject to the waiting period occurs at the time of their application for OHIP coverage. Examples of those who are exempt from the three month waiting period include newborn babies, eligible military family members, and insured residents from another province or territory who move to Ontario and immediately become residents of an approved long-term care home in Ontario.

In accordance with *Regulation 552* under the HIA and as provided for in the Interprovincial Agreement on Eligibility and Portability, persons who permanently move to Ontario from another Canadian province or territory where they are insured will typically be eligible for OHIP coverage after the last day of the second full month following the date residency is established, in other words, an interprovincial waiting period.

4.2 Coverage during Temporary Absences in Canada

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability (EPA), as per section 1.6 of *Regulation 552*, and in accordance with the EPA, an insured person who leaves Ontario temporarily to travel within Canada, without establishing residency in another province or territory, may continue to be covered by OHIP for a period of up to 12 months.

An insured person who temporarily seeks or accepts employment in another province or territory may continue to be covered by OHIP for a period of up to 12 months. If the individual plans to remain outside Ontario beyond the 12 month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

As per section 1.8 of *Regulation 552*, and in accordance with the EPA, insured students who are temporarily absent from Ontario, but remain within Canada, may be eligible for continuous health insurance coverage for the duration of their full-time studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide the Ministry of Health (MOH) with documentation or information from their educational institution confirming registration as a full-time student. Insured family members (spouses and dependents) of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

Also, in accordance with section 1.6 and 1.8 of *Regulation 552* of the HIA, most insured residents who want to travel, work or study outside Ontario, but within Canada, and maintain OHIP coverage, must have resided in Ontario for at least 153 days in the last 12 month period immediately prior to departure from Ontario.

Payments for insured out-of-province services are prescribed under sections 28, 28.0.1, 28.0.2, and 29 of *Regulation 552* of the HIA. Insured residents who are temporarily outside of Ontario can use their valid Ontario health card to obtain insured physician (except in Quebec) and hospital services generally at no direct cost.

Ontario participates in Reciprocal Hospital Billing Agreements with all other provinces and territories for payment of insured in-patient and out-patient hospital services. For the 2018–2019 fiscal year, rates were set and approved by the Interprovincial Health Insurance Agreements Coordinating Committee. Payment for in-patient services depends on the hospital's approved in-patient per diem rate. Payment for out-patient services is at the standard approved out-patient rate.

Ontario is also party to the Reciprocal Medical Billing Agreements with all other provinces and territories, except Quebec (which does not participate in reciprocal medical billing). Ontario residents who have been directly billed for insured physician or hospital services in another province or territory can submit their receipts to MOH for reimbursement. Reimbursement of insured physician services is at the rates payable in the Ontario Schedule of Benefits for Physician Services or the amount billed, whichever is less. Reimbursement of insured hospital services is at the established rates or the amount billed, whichever is less.

Out-of-Province (Within Canada)

Out-of-province (but within Canada) genetic tests or other laboratory tests performed outside of a publicly funded hospital require prior approval of funding in accordance with Section 28.0.2 of *Regulation 552*. In addition, certain medical services that require prior approval of funding in Ontario (as prescribed in the Schedule of Benefits for Physician Services for services including breast reduction and panniculectomy) must be prior approved if the service is sought in another province or territory.

4.3 Coverage during Temporary Absences Outside Canada

Residents may be temporarily outside of Canada for a total of 212 days in any 12 month period and still maintain OHIP coverage as long as their primary place of residence remains Ontario.

Extended Absences:

Health insurance coverage for insured Ontario residents during extended absences (longer than 212 days) outside Canada is governed by *Regulation 552* of the HIA.

The MOH requests that residents apply to MOH to confirm this coverage before their departure and provide documents explaining the reason for their absence.

In accordance with regulations and MOH policy, most applicants must also have been residents in Ontario for at least 153 days in each of the two consecutive 12 month periods before their expected date of departure.

The length of time that a person can receive continuous Ontario health insurance coverage during an extended absence outside Canada varies depending on the reason for the absence as follows:

REASONS AND LENGTHS OF TIME A PERSON CAN RECEIVE CONTINUOUS ONTARIO HEALTH INSURANCE COVERAGE DURING AN EXTENDED ABSENCE

REASON	OHIP COVERAGE
Study	Duration of full-time academic studies (unlimited)
Work	Five-year terms (specific residency requirements must be met for two years between absences)
Charitable Worker	Five-year terms (specific residency requirements must be met for two years between absences)
Vacation/Other	Two-year terms (specific residency requirements must be met for five years between absences)
Spouses and dependents may also qualify for continuous OHIP coverage while accompanying the primary applicant on an extended absence outside Canada.	

Out-of-Country Coverage for Ontario Residents who are Temporarily Absent

OHIP provides limited coverage for health care costs incurred by eligible Ontarians who are temporarily absent from Canada, such as for travelling, working and studying.

Regulation 552 under the HIA sets out eligibility criteria and payment authority for funding for these services.

The provisions under this program provide reimbursement at very limited rates for medical treatment required to treat illnesses, diseases, conditions or injuries that are acute, unexpected, arose outside of Canada and require immediate treatment.

OHIP will reimburse patients at the following rates:

- › in-patient hospital expenses at \$200/\$400 CAD per day for standard in-patient care/intensive in-patient care;
- › emergency out-patient hospital services eligible for OHIP coverage are paid up to a maximum of \$50 CAD per day or the amount billed – whichever is less (excluding services that include dialysis which is payable at \$210 CAD per day); and
- › physician services are reimbursed at the rates listed in the Ontario Physician Schedule of Benefits or the amount billed, whichever is less.

These provisions are intended and designed to provide a very limited amount of funding for the medical treatment of insured residents of Ontario if they incur an unexpected illness, disease, condition or injury while they are outside of Canada and not if the illness, disease, condition or injury arises before the patient leaves Canada, or if it is not acute or unexpected, no payment can be made.

4.4 Prior Approval Requirement

As set out in *Regulation 552* under the HIA, payment for non-emergency health services provided outside of Canada requires written prior approval from the General Manager of OHIP before the services are rendered.

With written prior approval, full funding for out-of-country medical services is paid directly to out-of-country hospitals, health facilities and physicians as well as laboratories for medically necessary insured services that are not performed in Ontario or, with the exception of laboratory services, for services that cannot be obtained in Ontario without medically significant delay.

In accordance with the requirements of *Regulation 552* under the HIA, the requested out-of-country medical services are eligible for funding as insured services only if they are:

- › performed at an licensed hospital or health facility as defined in the Regulation; and
- › generally accepted by the medical profession in Ontario as appropriate for a person in the same medical circumstances as the insured person; and
- › medically necessary, and either:
 - › not performed in Ontario by an identical or equivalent procedure, or
 - › performed in Ontario but the insured person must travel outside of Canada to avoid delay that would result in either death or medically significant irreversible tissue damage; and
 - › not experimental or for the purposes of research or a survey.

Requests for prior approval of funding require written confirmation from a physician who is a specialist in the type of services for which prior approval has been requested to confirm that the regulatory criteria for the funding of out-of-country medical services are met. This requirement does not apply to emergency services or services that are within a general practitioner's scope of practice.

There are also other specified requirements in section 28.4 of *Regulation 552* depending on the nature of the service for which funding is requested.

Funding requirements for non-emergency genetic tests and laboratory tests performed outside Canada are described in section 28.5 of *Regulation 552* of the HIA.

In the case of a denial of funding, the referring Ontario physician and the patient are advised that the decision may be reviewed if new medical information is submitted for consideration. Internal reviews may be requested as often as needed, provided new additional supporting medical documentation is submitted. In addition, the patient may appeal an out-of-country funding decision to the Health Services Appeal and Review Board.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Funding for all insured hospital, physician, and designated practitioner services provided to insured Ontario residents is in accordance with the *Health Insurance Act* (HIA) and Regulations. Access to insured services without charges is protected under Part II of the *Commitment to the Future of Medicare Act* (CFMA), “Health Services Accessibility.” The CFMA prohibits extra-billing by including a provision that prohibits any physician or designated practitioner from charging or accepting payment or other benefit for rendering an insured service to an insured person for more than the amount that is paid by the Ontario Health Insurance Plan (OHIP). The CFMA also prohibits a physician or designated practitioner from accepting payment or benefit for an insured service rendered to an insured person except from OHIP (subject to a few specified exceptions) and generally prohibits any person or entity to charge or accept payment or other benefit for an insured service rendered to an insured person except as outlined above or as specified in the regulations.

The CFMA further prohibits queue-jumping through a provision that prohibits any person or entity from paying, charging, or accepting payment or other benefit in exchange for conferring upon an insured person a preference in obtaining access to an insured service. In addition, the CFMA prohibits physicians, practitioners and hospitals from refusing to provide an insured service if an insured person chooses not to pay a “block” or “annual” fee for uninsured services.

The Ministry of Health (MOH) reviews all possible contraventions of the CFMA that come to its attention. For situations in which it is determined that an unauthorized payment has occurred, the MOH takes steps to ensure that the amount is repaid to the payee.

For complaints regarding charges for insured services, the CFMA program of the ministry can be reached at 1-888-662-6613 or by email at: protectpublichealthcare@ontario.ca.

Health Card Validation (HCV) assists health care providers with access to information requested for claims payment. HCV allows the provider to determine the point-in-time status of a patient’s Ontario health number (and version code) indicating eligibility or ineligibility for provincially funded health care services, thereby reducing claim rejects. A health care provider may subscribe

for validation services if they have a valid and active billing number as assigned by the MOH. If patients require access to insured services and do not have a valid health card in their possession, upon obtaining patient consent, the provider may obtain the necessary information by utilizing the accelerated health number release service provided by ServiceOntario's Health Number Look Up service which is offered 24 hours a day, 365 days per year to physicians or hospitals registered for this service.

Acute care priority services are designated, highly specialized, hospital-based services that deal with life-threatening conditions such as organ transplants, cancer surgery and treatments, and neuro services. These services are often high-cost and are rapidly growing, which has made access a concern. Generally, these services are managed provincially, on an ongoing basis by continually monitoring demand and adjusting funding as needed.

Acute care priority services include:

- › selected cardiovascular services;
- › selected cancer services;
- › chronic kidney disease services;
- › critical care services; and
- › organ and tissue donation and transplantation.

Primary Health Care: The various primary health care physician compensation models encourage access to comprehensive primary health care services for Ontario as a whole, as well as for targeted population groups and remote underserved communities.

Interprofessional Care Models: Family Health Teams (FHT) are independent, non-profit organizations that provide interdisciplinary team-based primary health care; they are staffed by providers such as nurse practitioners, nurses, social workers and dietitians. Physician groups that can affiliate with and participate in FHTs are funded by one of three compensation options: Blended Capitation (such as FHN or FHO), Complement Based Models (RNPGA or other specialized agreements) and BSM (for community sponsored FHTs). FHT are located across Ontario, in both urban and rural settings, ranging in size, structure, scope and governance.

Nurse Practitioner-Led Clinics (NPLCs) have been created throughout Ontario to provide comprehensive, accessible and coordinated family health care services by targeting Ontarians who have difficulty accessing primary care. NPLCs are contributing to a number of local and provincial health care priorities by providing faster access to care through same day and next day appointments and collaborating with other community partners to improve quality and better coordinate care for their patients.

Community Health Centres (CHCs) are models of primary health care delivery that play a key role delivering primary health care services to priority populations across Ontario and support the province's overarching efforts to transform primary care. CHCs are not-for-profit community

governed organizations with a primary focus to improve the health and well-being of populations who have traditionally faced barriers accessing health services, including those who are low income, new immigrants, those with complex mental health issues and individuals who do not have health insurance. CHCs are mandated to deliver comprehensive primary health care services, health promotion, and disease prevention services to individuals and families. CHCs develop partnerships that focus on broader health and social issues, such as inadequate housing, literacy, pollution and other social determinants of health.

Aboriginal Health Access Centres (AHACs) are Aboriginal-led, primary health care organizations that provide a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services to First Nations, Métis and Inuit Communities. AHACs are closely modelled after Ontario's Community Health Centres and provide the mechanisms to improve the health and well-being of communities in Ontario facing various barriers in accessing health care. AHACs serve as a key contributor to Ontario's commitment to improve and expand access to comprehensive primary care by providing clinical care services, integrated chronic disease prevention and management, family focused maternal/child health care and addictions counselling and mental health care.

Health Care Connect (HCC): HCC refers Ontarians who are seeking a primary health care provider (family doctor or nurse practitioner) to a provider who is accepting new patients in their community. Insured persons without a primary health care provider who register with HCC may be referred to a family doctor or a nurse practitioner if there is a participating provider who is accepting new patients in their community. HCC is voluntary for both patients and providers and there is no guarantee that a referral will be made for each program registrant.

During 2018–2019, MOH continued to administer various initiatives to improve access to health care services across the province. Ontario's physician supply has stabilized due to past medical school expansion and ongoing evidence-informed planning, and the province is working to enhance the retention and distribution of physicians through measures, such as:

- › supporting rural and remote clinical education opportunities for medical students;
- › supporting Remote First Nations medical resident training positions to address First Nations primary health care in northern Ontario;
- › supporting the Northern Ontario School of Medicine;
- › supporting training and assessment programs for International Medical Graduates and other qualified physicians who do not meet certain requirements for practice in Ontario; and
- › supporting the HealthForceOntario Marketing and Recruitment Agency to help recruit and retain health care professionals in Ontario communities that need them.

There are a number of existing initiatives to improve access across Ontario, including but not limited to the Northern and Rural Recruitment and Retention Initiative, the Northern Physician Retention Initiative, and the Northern Health Travel Grant Program.

Northern and Rural Recruitment and Retention Initiative (NRRRI): The NRRRI supports the recruitment and retention of physicians in rural and northern communities. The NRRRI provides financial recruitment incentives to physicians who establish a fulltime practice in an eligible community. Community eligibility for the NRRRI is based on a Rurality Index for Ontario score of 40 or more. Also eligible are the five Northern Ontario Census Urban Referral Centre census metropolitan areas (Thunder Bay, Sudbury, North Bay, Sault Ste. Marie and Timmins).

Northern Physician Retention Initiative (NPRI): The NPRI provides physicians who have completed a minimum of four years of continuous full-time practice in Northern Ontario with a \$7,000 retention incentive paid at the end of each fiscal year in which they continue to practise full-time in Northern Ontario. NPRI supports retention of physicians in Northern Ontario and encourages them to maintain active hospital privileges. Northern Ontario is defined as the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Muskoka, Rainy River, Sudbury, Thunder Bay and Timiskaming.

Northern Health Travel Grant (NHTG) Program: The NHTG Program helps defray travel-related costs for residents of Northern Ontario who must travel long distances to access insured medical specialist services, or designated health care facility-based procedures that are not locally available, within a radius of 100 kilometres. In addition to travel grants based on kilometric rate, the program provides an accommodation allowance of \$100-\$550 (dependent on the number of lodging nights) per eligible treatment trip to patients whose one-way road distance to a specialist is at least 200 kilometers. In 2017–2018, a \$9.9 million enhancement was introduced to move from a \$100 flat rate accommodation allowance to a maximum of \$550, dependent on the number of medically necessary lodging nights. The NHTG Program also promotes using specialist services located in Northern Ontario, which encourages more specialists to practice and remain in the north.

5.2 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Many physician payments are provided through fee-for-service arrangements. Fee-for-service remuneration is based on the Schedule of Benefits - Physician Services under the HIA. Other physician payment models include Primary Health Care Models (such as blended capitation models), Alternate Payment Plans, and funding arrangements for physicians in Academic Health Science Centres. Physicians that belong to these other payment models may also bill fee-for-service when providing services that are outside of the scope of these models.

The MOH undertakes payment accountability activities to ensure physicians receive the payment to which they are entitled. Pre-payment activities include monitoring and system controls, such as automated payment rules in the OHIP fee-for-service claims payment system.

Post-payment activities include payment reviews, education and audit. If payments for inappropriate claims are identified, the MOH works with the physician to resolve the issue. The MOH may also use remedies in contract provisions or the HIA. Audits include a formal

review process to seek recovery of payment. Post-payment reviews are identified through monitoring such as data analytics, as a result of concerns reported to the MOH, such as through the fraud hotline or other mechanisms.

In 2015–2016, 97 per cent of General Practitioners received fee-for-service payments from OHIP, but fewer than 30 per cent of them were paid solely on a fee-for-service basis. The majority (70 per cent) of primary care physicians in Ontario received funding through one of the primary health models: Comprehensive Care (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Community Health Centres (CHC), Rural and Northern Physician Group Agreement (RNPAG), Group Health Centre (GHC), Blended Salary Model (BSM), and specialized agreements.

The MOH negotiates physician compensation with the Ontario Medical Association (OMA) in accordance with the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement. In 2017, the MOH and the OMA successfully negotiated a Binding Arbitration Framework, an agreement that governs the process for PSA negotiations, mediation, and arbitration.

On February 19, 2019, a board of arbitration released its award establishing the parameters for physician compensation for the period of April 1, 2017, to March 31, 2021.

5.3 Payments to Hospitals

Ontario hospitals are funded through a combination of global funding and Patient-Based Funding—which provides funding on a spectrum between activity-based, and performance-based approaches.

Since April 1, 2012, Ontario shifted hospital funding from a predominantly global budget system towards a patient-based funding (PBF) system. PBF ensures that patients get the right care, at the right place, at the right time, and at the right price. PBF offers an integrated approach to health system funding and puts the patient at the centre through adopting a ‘funding follows the patient’ principle.

For purposes of funding, publicly funded hospitals are classified based on whether they receive funding through the Growth and Efficiency Model or not. In addition, hospitals are further classified based on whether they provide specialized care (e.g. teaching, pediatric) or by their size (e.g. large, medium).

Stand-alone psychiatric and small-sized hospitals do not receive PBF funding. Instead, they rely primarily on global budgets for their operational funding.

Hospital Funding Sources

Global funding: Non-targeted base funding that is carried over year-to-year. This funding is not tied to the delivery of specific procedures.

Growth and Efficiency Model (GEM) (Formerly Health-Based Allocation Model [HBAM]):

This is an evidence-based funding formula that uses clinical and financial information to redistribute about \$5.135 billion annually among all modeled hospitals, based on the number of patients treated and the complexity of their care. The model also takes into account the efficiency of hospitals.

In 2019–2020, the redistribution of HBAM was suspended, pending development of a long-term plan that considers a consolidated approach to address growth in services.

In 2019–2020, the Growth and Efficiency Model (GEM) was introduced. GEM was used to allocate incremental growth funding, rather than re-distributing existing funds.

Quality Based Procedures (QBP): QBP are episodes of care (e.g. hip/knee replacement surgery, stroke) for which evidence-based best practices have been defined and providers are compensated for providing the services included in the episode based on an established price.

Funding is allocated by assigning a number of cases (volumes) and a provincial price that is specific to identified surgical or medical procedures. The provincial price is adjusted to reflect patient cohort differences at each hospital using a measure of acuity, known as the Case Mix Index (CMI).

The funding amount for QBP is based on historical utilization, population growth projections and other risk factors and is intended to address the demands of a growing and aging population.

Bundled Care: Like QBP, Bundled Care funding is allocated by an assigned number of cases and a price. However, a Bundled QBP encompasses services that cross providers, specifically including hospital and post-acute community care like home care. Bundled QBP provide a single payment for an episode of care across multiple settings and providers, like hip/knee replacement surgery and post-surgical rehabilitation.

Funding is allocated to a Bundle Holder (a health service provider) who is responsible for partnering with and transferring funds to other service providers for surgical care and/or post-acute rehabilitation, providing a more integrated service from the time patients enter hospital for surgery to their recovery at home and in the community. Bundle Holders must ensure that patients are receiving the full scope of care in an integrated pathway, regardless of where the patient lives.

Bundled care is being implemented for hip and knee replacement surgery and chronic kidney disease, and being tested in other clinical areas.

Priority Programs and Services: Funding for life-saving procedures and specialized services (i.e. cardiovascular, neurosurgical, bariatric, critical care) as well as maternal/newborn health programs.

Funding amounts are determined using a number of data points, including: historical utilization information, changes in the population of interest for the catchment area, and direct discussions with the hospitals and Local Health Integration Networks (LHIN), regarding their respective projections.

Post Construction Operating Plan (PCOP): PCOP funding provides operating funds to hospitals for clinical service and space expansions incurred after the completion of an approved capital project.

Post Construction Operating Plan funding may be provided for service volume increases, one-time start up and transition costs, equipment amortization and/or incremental facility costs.

Wait Times: Allocated to support additional diagnostic imaging (e.g. Magnetic Resonance Imaging [MRI] & Computerized Axial Tomography [CT] Hours) and select surgical procedures (price per procedure). Funding allocation is determined based on prior year performance, current capacity and wait lists.

Pay for Results (P4R): Provides annual one-time performance-related funding incentives to hospitals with high volume Emergency Departments with over 30,000 annual visits.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health Transfer in its Public Accounts of Ontario 2018–2019.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st ¹	13,545,565	13,723,465	13,829,743	14,042,917	14,231,376

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number ²	145	143	143	141	141
3. Payments for insured health services (\$) ³	16,377,339,000	16,387,182,900	16,784,015,574	17,356,176,130	18,024,589,979

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services ⁴	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services (\$) ⁴	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	7,087	7,160	6,337	6,473	6,230
7. Total payments, in-patient (\$)	65,048,142	66,194,339	61,781,960	61,748,658	59,696,706
8. Total number of claims, out-patient	136,778	129,182	120,710	119,325	122,863
9. Total payments, out-patient (\$)	42,332,365	42,834,485	43,097,597	43,821,288	46,325,610

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA⁵

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient ⁷	not applicable	not applicable	not applicable	not applicable	738
11. Total payments in-patient (\$) ⁷	not applicable	not applicable	not applicable	not applicable	42.0M
12. Total number of claims out-patient ⁷	not applicable	not applicable	not applicable	not applicable	See note 5
13. Total payments out-patient (\$) ⁷	not applicable	not applicable	not applicable	not applicable	See note 5

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient ^{6,7}	not applicable	not applicable	not applicable	not applicable	4,343
15. Total payments in-patient (\$) ^{6,7}	not applicable	not applicable	not applicable	not applicable	3,936,420
16. Total number of claims out-patient ^{6,7}	not applicable	not applicable	not applicable	not applicable	13,693
17. Total payments out-patient (\$) ^{6,7}	not applicable	not applicable	not applicable	not applicable	1,393,745

¹ These estimates represent the number of Valid and Active Health Cards (have current eligibility and resident has incurred a claim in the last 7 years).

² Number represents all publicly funded hospitals excluding specialty psychiatric hospitals. Specialty psychiatric hospitals are excluded in order to conform to Canada Health Act Annual Report requirements. The 2017–2018 count has changed due to the amalgamation process of two hospitals during FY 2017–2018.

³ Amount represents funding for all public and private hospitals excluding specialty psychiatric hospitals. Fiscal years 2014–2015 to 2016–2017 are based on Public Accounts.

⁴ Data are not collected in a single system in MOHLTC. Further, the MOHLTC is unable to categorize providers/facilities as “for-profit” as MOHLTC does not have financial statements detailing service providers’ disbursement of revenues from the Ministry.

⁵ Indicators 10 & 11 include both in-patient and out-patient for insured hospital and physician services provided outside Canada.

⁶ Data pertains to hospital services to out-of-country travellers for emergency services that are acute, unexpected, arose outside of Canada and require immediate treatment.

⁷ Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	29,380	30,177	30,893	31,718	32,566
19. Number of opted-out physicians	24	21	20	19	17
20. Number of non-participating physicians ⁸	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$) ⁹	11,823,825,604	11,918,882,881	12,113,803,206	13,199,726,871	13,024,319,815
22. Total payments for services provided by physicians paid through fee-for-service (\$)	7,784,933,027	7,803,728,926	8,028,037,940	8,206,912,437	8,469,716,136

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	623,076	589,688	585,353	539,598	573,828
24. Total payments (\$)	31,360,835	29,524,980	30,851,717	28,646,930	30,818,175

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services ^{7,11}	not applicable	not applicable	not applicable	not applicable	See note 5
26. Total payments (\$) ^{7,11}	not applicable	not applicable	not applicable	not applicable	See note 5

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services ^{7,11}	not applicable	not applicable	not applicable	not applicable	80,534
28. Total payments (\$) ^{7,11}	not applicable	not applicable	not applicable	not applicable	2,750,057

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	275	278	281	276	280
30. Number of opted-out dentists ¹⁰	not applicable	not applicable	not applicable	not applicable	not applicable
31. Number of non-participating dentists ¹⁰	not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of services provided	96,258	99,570	98,823	105,438	106,109
33. Total payments (\$)	12,040,331	12,442,618	13,124,123	12,981,062	13,131,908

⁸ Ontario has no non-participating physicians, only opted-out physicians who are reported under item #20.

⁹ Total payments includes payments made to Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, Academic Health Science Centres, the Hospital On Call Program and Health Care Connect. Services and payments related to Other Practitioner Programs, Out-of-Country/ Out-of-Province Programs, Nurse Practitioners, Interprofessional Shared Care, NP Led Clinics, ECHO & Chronic Pain, Fertility Services, Family Health Teams and Community Labs are excluded.

¹⁰ Data pertains to physician services for out-of-country travellers for emergency services that are acute, unexpected, arose outside of Canada and require immediate treatment.

¹¹ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

MANITOBA



Manitoba Health, Seniors and Active Living (MHSAL) provides leadership and support to protect, promote and preserve the health of all Manitobans. MHSAL continues efforts to improve access, service delivery, capacity, innovation, sustainability and improve the health status of Manitobans while reducing health disparities. The roles and responsibilities of the department include policy, program and standards development; fiscal and program accountability; and evaluation. In addition, some direct services continue to be provided through Selkirk Mental Health Centre, Cadham Provincial Laboratory, public health inspections, and provincial nursing stations.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by Manitoba Health, Seniors and Active Living (MHSAL) under the *Health Services Insurance Act*, R.S.M. 1987, c. H35.

The MHSIP is administered under this Act, and insures the costs of hospital, personal care, and medical and other health services referred to in acts of the legislature or related regulations.

The Minister of Health, Seniors and Active Living (the Minister) is responsible for administering and operating the MHSIP. The Minister may also enter into contracts and agreements with any person or group that he or she considers necessary for the purposes of the Act.

The Minister may also make grants to any person or group for the purposes of the Act on such terms and conditions that are considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

There were no legislative amendments to the Act or the Regulations in the 2018–2019 fiscal year that affected the public administration of the MHSIP.

1.2 Reporting Relationship

Section 6 of the *Health Services Insurance Act* requires the Minister to have audited financial statements of the MHSIP showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to prepare an annual report, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it, if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the *Health Services Insurance Act* requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the MHSIP annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2018–2019 fiscal year and is contained in the [Manitoba Health, Seniors and Active Living Annual Report](#).



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Sections 46 and 47 of the *Health Services Insurance Act*, as well as the *Hospital Services Insurance and Administration Regulation* (M.R. 48/93), provide for insured hospital services.

As of March 31, 2019, there were 96 facilities providing insured hospital services to both in- and out-patients. Hospitals are designated by the *Hospitals Designation Regulation* (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in-patient and out-patient hospital services include:

- › accommodation and meals at the standard ward level;
- › necessary nursing services;
- › laboratory, radiological and other diagnostic procedures;
- › drugs, biologics and related preparations;
- › routine medical and surgical supplies;
- › use of operating room, case room and anaesthetic facilities; and
- › use of radiotherapy, physiotherapy, occupational and speech therapy facilities where available.

The Regulation states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The regional health authorities and Manitoba Health, Seniors and Active Living (MHSAL) monitor compliance.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Medical Services Insurance Regulation* (M.R. 49/93) made under the *Health Services Insurance Act*.

Physicians providing insured services in Manitoba must be lawfully entitled to practice medicine in Manitoba, and be registered and licensed under the *Medical Act*. As of April 30, 2019, there were 2,982 physicians registered in Manitoba, with 2,755 participating in the Manitoba Health Services Insurance Plan.

A physician, by giving notice to the Minister of Health, Seniors and Active Living (the Minister) in writing, may elect to collect the fees other than from the Minister for medical services rendered to insured persons, in accordance with section 91 of the Act and section 5 of the *Medical Services Insurance Regulation*. The election to opt out of the health care insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. No physicians opted-out of the medical plan in 2018–2019.

The range of physician services insured by MHSAL is listed in the *Payment for Insured Medical Services Regulation* (M.R. 95/96). Coverage is provided for all medically required personal health care services that are not excluded under the *Excluded Services Regulation* (M.R. 46/93) of the Act, rendered to an insured person by a physician.

During fiscal year 2018–2019, a number of new insured services were added to a revised fee schedule. [The Physician's Manual](#) can be found on the Health, Seniors and Active Living website.

The process for a medical service to be added to the list of those covered by MHSAL is that physicians must put forward a proposal to their specific section of Doctors Manitoba. Doctors Manitoba will negotiate the item, including the fee, with MHSAL. MHSAL may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the *Hospital Services Insurance and Administration Regulation* (M.R. 48/93) under the *Health Services Insurance Act*. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to, or collect from, an insured person a fee in excess of the benefits payable under the Act or Regulations. No providers of dental services opted-out in 2018–2019.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA negotiates the item and fee with MHSAL.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The *Excluded Services Regulation* (M.R. 46/93) made under the *Health Services Insurance Act* sets out those services that are not insured. These include:

- › examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties;
- › group immunization or other group services except where authorized by MHSAL;
- › services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependents;
- › preparation of records, reports, certificates, communications and testimony in court;
- › mileage or travelling time;
- › services provided by psychologists, chiropodists and other practitioners not provided for in the legislation;
- › tattoo removal;
- › contact lens fitting;
- › reversal of sterilization procedures; and
- › psychoanalysis.

The *Hospital Services Insurance and Administration Regulation* states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The regional health authorities and MHSAL monitor compliance.

All Manitoba residents have equitable access to services. Third parties such as private insurers or the Workers Compensation Board do not receive priority access to services through additional payment. Manitoba has no formalized process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows regional health authorities and MHSAL to monitor usage and service concerns.

To de-insure services covered by MHSAL, the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2018–2019.



3.0 UNIVERSALITY

3.1 Eligibility

The *Health Services Insurance Act* defines the eligibility of Manitoba residents for coverage under the provincial health care insurance plan.

Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, makes his or her home in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a temporary resident permit under the *Immigration and Refugee Protection Act* (Canada), unless the Minister of Health, Seniors and Active Living (the Minister) determines otherwise, or is a visitor, transient or tourist.

The *Residency and Registration Regulation* (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have a work permit of 12 months or more under the *Immigration and Refugee Protection Act* (Canada). Additionally, section 8.1.1 of the *Residency and Registration Regulation* extends deemed residency to temporary foreign workers (and their dependents) in the province to provide agricultural services on the basis of a work permit, regardless of the duration of their work permit.

The *Residency and Registration Regulation*, section 6, defines Manitoba's waiting period as follows:

"A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

Section 6 of the *Residency and Registration Regulation* stipulates that there is no waiting period for dependents of members of the Canadian Armed Forces.

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan (MHSIP) excludes residents covered under any federal plan, including the following federal statutes:

- › *Aeronautics Act*;
- › *Civilian War-related Benefits Act*;
- › *Government Employees Compensation Act*;
- › *Merchant Seaman Compensation Act*;
- › *National Defence Act*;
- › *Pension Act*;
- › *Veteran's Rehabilitation Act*; and
- › Federal inmates or those covered under legislation of any other jurisdiction (*Excluded Services Regulations* subsection 2[2]).

These residents become eligible for health services insurance coverage upon discharge from the Canadian Forces, or in the case of an inmate of a penitentiary, upon discharge if the inmate has no resident dependents. Upon change of status, these persons have one month to register with Manitoba Health, Seniors and Active Living (MHSAL) (*Residency and Registration Regulation* (M.R. 54/93, subsection 2[3])).

RCMP members are insured persons in Manitoba and are eligible for benefits under the MHSIP.

The process of issuing health insurance cards requires that individuals inform and provide documentation to MHSAL that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months in a calendar year. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health, Seniors and Active Living will provide a registration card for the individual and all qualifying dependents.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependent. The six-digit number may be shared by all members of a family including a spouse and dependents. A nine-digit Personal Health Identification Number is used for payment of all medical service claims and hospital services.

As of June 1, 2018, there were 1,370,642 residents registered with the Manitoba Health Services Insurance Plan.

There is no provision for a resident to opt out of the Manitoba Health Services Insurance Plan.

3.2 Other Categories of Individuals

The *Residency and Registration Regulation* (M.R. 54/93, sub-section 8[1]) requires that temporary workers possess a work permit issued by Immigration, Refugees and Citizenship Canada for at least 12 consecutive months, be physically present in Manitoba for six months in a calendar year, and be legally entitled to be in Canada before receiving MHSIP coverage.

Section 8.1.1 of the *Residency and Registration Regulation* extends deemed residency to temporary foreign workers (and their dependents) in the province to provide agricultural services on the basis of a work permit, regardless of the duration of their work permit.



4.0 PORTABILITY

4.1 Minimum Waiting Period

The *Residency and Registration Regulation* (M.R. 54/93, section 6) identifies the waiting period for insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arriving in Manitoba is entitled to benefits on the first day of the third month following the month of arrival.

4.2 Coverage during Temporary Absences in Canada

The *Residency and Registration Regulation* (M.R. 54/93 section 7[1]) defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their fulltime enrollment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient, high-cost procedures and out-patient services are based on national rates agreed to by provincial and territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical physician services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for physician medical services received in Quebec are submitted by the patient or physician to Manitoba Health, Seniors and Active Living (MHSAL) for payment at host province rates.

4.3 Coverage during Temporary Absences Outside Canada

The *Residency and Registration Regulation* (M.R. 54/93, sub-section 7[1]) defines the rules for portability of health insurance during temporary absences from Canada.

Section 7(1)(g) of the *Residency and Registration Regulation* extends the period during which a person may be temporarily absent from Manitoba for the purpose of residing outside of Canada from six months to a maximum of seven months in a 12-month period.

Residents on full-time employment contracts outside Canada will receive health services insurance coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Individuals serving as humanitarian aid workers or missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by MHSAL for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by MHSAL for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Manitoba residents receiving coverage under the provincial health insurance plan who receive medical and hospital services outside of Canada are eligible to be reimbursed at the rates set out in the *Medical Services Insurance Regulation* and the *Hospital Services Insurance and Administration Regulation*. Emergency doctors' services outside of Canada are reimbursed at a rate equal to what a Manitoba doctor would receive for a similar service. Emergency hospital care is paid on an average daily rate established by MHSAL.

4.4 Prior Approval Requirement

Prior approval is not required for procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval by MHSAL is required for high cost items or procedures that are not included in the reciprocal agreements.

In order to be eligible for reimbursement, all non-emergency hospital and medical care provided outside Canada requires prior approval from MHSAL. Manitobans requiring medically necessary medical and/or hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for reimbursement of costs incurred outside of Canada, pursuant to the *Medical Services Insurance Regulation*, by providing MHSAL with a recommendation from a specialist stating that the patient requires a specific, medically necessary service.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Manitoba Health, Seniors and Active Living (MHSAL) ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the *Surgical Facilities Regulation* (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

The *Health Services Insurance Act* and The *Private Hospitals Act* include definitions and other provisions to ensure:

- › that no charges can be made to individuals who receive insured surgical services, or to anyone else on that person's behalf; and
- › that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

The *Accessibility for Manitobans Act* includes definitions and principles to ensure accessibility by preventing and removing barriers that disable people with respect to receiving health care services including:

- › accommodation;
- › the built environment, including facilities, building, structures and premises
- › the delivery and receipt of goods, services and information; and
- › a prescribed activity or undertaking.

In the event that a Manitoba resident feels that they have been inappropriately charged for a service that is insured under the provincial health insurance plan (i.e., a potential incidence of extra-billing or a user charge), the resident is encouraged to contact Manitoba to report this occurrence at the following coordinates:

Manitoba Health Seniors and Active Living

300 Carlton Street
Winnipeg, MB R3B 3M9
1-800-392-1207

Inquiries are made by the Insured Benefits Branch of Manitoba Health, Seniors and Active Living into the specifics of the fee(s) charged to assess whether the service provided was an insured service, and any required further action. Generally, contact from MHSAL to the medical service provider, advising that the provider must reimburse the patient and submit a claim to MHSAL, is sufficient to address the concern. Further incidents on the part of the same service provider may result in an investigation by MHSAL's Audit and Investigation Unit. Concerns regarding the professional conduct of medical service providers are referred to the appropriate regulatory agency.

Manitoba Health, Seniors and Active Living remains committed to the principles of Medicare and improving the health status of all Manitobans. In 2018–2019, Manitoba continued to support these commitments through a number of activities including the following:

System Transformation

As recommended in the KPMG Health System Sustainability and Innovation Review, the government of Manitoba announced the creation of a Transformation Management Office in order to guide the integration of structural and organizational reform of the health system between government, regional health authorities and health-care facilities to ensure fiscal sustainability while addressing wait times. The government is now focused on the implementation of the review's recommendations to ensure the realization of sustainable benefits over the 2018–2019 year and moving forward.

Additionally, Shared Health Manitoba, a new provincial health organization announced in 2017–2018, continues to focus on patient-centred planning to ensure consistent standards across the province for the provision of care. Input was sought from over 10 provincial clinical teams comprised of health-care providers with varied professional backgrounds and experience across rural, urban and northern Manitoba communities with the objective of developing of a multi-year clinical and preventive services plan for Manitoba.

The province also continued its focused efforts on the implementation of the provincial mental health and addictions strategy by aligning the needs identified in the Improving Access and Coordination of Mental Health and Addictions Services: A Provincial Strategy for all Manitobans report (the Virgo report) with the provincial clinical services plan, to ensure alignment with the broader health care system—a key recommendation within the Virgo report.

Additionally, Manitoba continued to implement the patient centred medical home model through two complementary and aligned initiatives—MyHealth Teams and Home Clinic. The goal of these is to improve access and demonstrate achievement of quality primary care standards for Manitobans. Adoption rate of home clinics remained high, representing approximately 70 per cent of all primary care providers. As a result of these initiatives, matching Manitobans to a new family physicians or Nurse Practitioners remained at 80 per cent within 30 days. Both initiatives remain aligned with the broader provincial preventive and clinical services plan.

Facilities

As an ongoing component of Healthcare System Transformation, a Provincial Information and Communication Technology (ICT) Governance model was integrated within Shared Health Manitoba with the intent of ensuring that a more equitable and provincial perspective was taken when considering investments focused on improving and where possible enhancing access and quality of services.

Manitoba Health facilitated a process with Manitoba eHealth and Manitoba Jobs and the Economy - Business Transformation and Technology to supports greater integration and standardization with Manitoba's digital healthcare system with the intent of improving access and equity of quality care across the province.

Manitoba established expectations and conditions to enable adoption of a portfolio based management approach for the prioritization and progression of ICT investments needed to support provincial health care applications and shared services across Manitoba.

Manitoba secured and sustained government funding to support the execution of the provincial strategic ICT capital plan which resulted in annual investments totaling \$33.3 million in ICT infrastructure. Manitoba further advanced \$33.9 million in annually prioritized projects developed in conjunction with clinical service providers, health care delivery organizations and decision-makers with the intent ensuring that healthcare practitioners and decision makers can share information across the province and across the whole continuum of a patient's care.

Manitoba continued to support the delivery of electronic data interchange and information sharing between government, Manitoba eHealth, regional health authorities, health providers and other government departments and jurisdictions with the intent of supporting and advancing decision support and the effective management of health information which shape the improvement of access to healthcare services.

Manitoba oversaw and completed the upgrade of its Provincial Electronic Patient Record System. Emergency Department Information System and Provincial Laboratory Information System and with the intent of increasing system capacity and reliability in the delivery of direct acute patient care.

Manitoba developed and implemented a capital building plan which supported provincial population health objectives. Specifically, Manitoba continued its planning and implementation of the construction of up to 1200 personal care home beds across the province. Manitoba also assessed and prioritized fire safety retrofit projects (sprinkler systems and related fire safety equipment) with the intent of ensuring the continued access to healthcare services when and if required.

Manitoba initiated the development of a comprehensive healthcare system asset management proposal with the intent of adopting a best practice approach to proactively and sustainably manage current and future infrastructure challenges.

Manitoba capital investments which improved or expanded access to insured services during the 2018–2019 fiscal year included the following:

- › Powerview—Pine Falls Health Complex—Primary Health Care and Traditional Healing Centre
- › Selkirk Regional Health Centre
- › St. Rose du Lac Primary Health Centre
- › Morden/Tabor Personal Care Home
- › Notre Dame de Lourdes Health Centre
- › Grace General Hospital Emergency Department Redevelopment

In addition to the major projects completed and initiated across the province, an additional one hundred twenty-two infrastructure renewal and comprehensive maintenance projects were approved and advanced with specific intent of enhancing and/or sustaining insured services.

Health Professionals

In 2018–2019, the province provided funding for the following complement of medical and nursing professionals registered to practice in Manitoba:

- › 1,480 Specialist Physicians
- › 1,422 General Practitioners
- › 99 Physician Assistants
- › 239 Nurse Practitioners
- › 13,522 Registered Nurses
- › 1,069 Registered Psychiatric Nurses
- › 3,616 Licensed Practical Nurses

The transition to the *Regulated Health Professions Act* (RHPA) continues to be a significant undertaking for the province. The RHPA came into effect in January 2014 to ensure all regulated health professions are governed by consistent, uniform regulations with enhanced focus on patient safety and accountability. The legislation includes a list of activities and procedures called reserved acts, that regulated health professionals may be authorized to perform when providing health care based on their competence and training.

The RHPA sets out consistent rules and processes for governance, registration, complaints and discipline, as well as regulation and bylaw making authority. To date audiologists and speech language pathologists, physicians and surgeons, and registered nurses have transitioned to self-regulation under the RHPA. Most recently, a transitional council was established to guide implementation of a college of paramedics as part of the move to paramedic self-regulation in Manitoba. The transition of other health professions to the RHPA will continue to be a focus for the province, as it will have a significant long-term impact on the provincial health workforce.

In 2018–2019 the province provided funding to increase the number of medical and nursing professionals registered in Manitoba as follows:

- › Specialist Physicians increased by 32 (from 1,448 to 1,480)
- › General Practitioners increased by 46 (from 1,376 to 1,422)
- › Nurse Practitioners increased by 35 (from 204 to 239)
- › Registered Psychiatric Nurses increased by 6 (from 1,063 to 1,069)
- › Licensed Practical Nurses increased by 112 (from 3,504 to 3,616)

The number of Registered Nurses decreased by 186 (from 13,708 to 13,522) and Physician Assistants (unchanged at 99) did not increase.

5.2 Physician Compensation

Manitoba continues to employ the following methods of payment for physicians:

- › fee-for-service;
- › contract;
- › blended; and
- › sessional.

The *Health Services Insurance Act* governs remuneration to physicians for insured services. There were no amendments to the *Health Services Insurance Act* related to physician compensation during the 2018–2019 fiscal year.

Fee-for-service remains the primary method of payment for physician services. Alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive non fee-for-service compensation, including through a salary (employment relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods where appropriate. As well, physicians may receive sessional payments for providing medical services on a time based arrangement, as well as stipends for on-call and other responsibilities.

In 2018–2019 MHSAL, in collaboration with Shared Health, represented Manitoba in its negotiations with Manitoba physicians. The physicians are typically represented by Doctors Manitoba with some exceptions, such as oncologists engaged by CancerCare Manitoba.

Doctors Manitoba and Manitoba reached a four-year agreement in July of 2019, to renew the physician Master Agreement. The new physician Master Agreement took effect on April 1, 2019, and will expire on March 31, 2023.

The Manitoba Physician's Manual lists all of the fee tariff descriptions, rates, rules of application and the dispute resolution process in relation to fee-for-service payments to physicians. This document is the Schedule of Benefits payable to physicians on behalf of insured persons in Manitoba pursuant to the *Medical Services Insurance Regulation* under the *Health Services Insurance Act*.

All fee-for-service claims must be submitted electronically. The submission of paper claims is permitted on a limited basis and only with the prior approval of MHSAL. Fee-for-service claims must be received within six months of the date upon which the physician rendered the service.

5.3 Payments to Hospitals

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operating agreements between regional health authorities and the operators of hospitals and personal care homes, defined as “health corporations” under the Act.

Pursuant to the provisions of division 3.1, regional health authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that:

- › enables the health services to be provided by the health corporation;
- › enables the funding to be provided by the regional health authority for the health services;
- › sets out the terms of the agreement; and
- › includes a dispute resolution process and remedies for breaches.

If the parties cannot reach an agreement, the Act enables them to request that the Minister appoint a mediator to help them resolve outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute. The Minister's resolution is binding on the parties.

There are three regional health authorities which have hospitals operated by health corporations in their health regions. The regional health authorities have required agreements with health corporations that enable the regional health authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities. In all other regions, the hospitals are operated by the *Regional Health Authorities Act*. The allocation of resources by regional health authorities for providing hospital services is approved by MHSAL through the approval of regional health plans, which the regional health authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that regional health authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the regional health authorities. In relation to those hospitals that are not owned and operated by a regional health authority, the regional health authority is required to pay each hospital in accordance with any agreement reached between the regional health authority and the hospital operator.

No legislative amendments to the Act or the Regulations in 2018–2019 had an effect on payments to hospitals.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Manitoba regularly recognizes the federal role regarding the contributions provided under the Canada Health Transfer in public documents. Federal transfers are identified in the Estimates of Expenditures and Revenue (Manitoba Budget) document and in the Public Accounts of Manitoba. Both documents are published annually by the Manitoba government.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	1,317,861	1,320,343	1,339,308	1,369,673	1,370,642 ¹

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	96	96	96	96	96
3. Payments for insured health services (\$)	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0 ²	0 ²	0 ²	0 ²	0 ²
5. Payments to private for-profit facilities for insured health services (\$)	0 ²	0 ²	0 ²	0 ²	0 ²

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	2,829	2,507	2,458	2,569	2,491
7. Total payments, in-patient (\$)	25,458,440	27,875,311	28,194,575	31,845,644	33,989,616
8. Total number of claims, out-patient	32,083	30,485	30,412	30,843	31,401
9. Total payments, out-patient (\$)	11,010,715	10,542,720	11,535,541	12,579,590	12,742,040

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not available	not available	not available	not available	not available
11. Total payments in-patient (\$)	not available	not available	not available	not available	not available
12. Total number of claims out-patient	not available	not available	not available	not available	not available
13. Total payments out-patient (\$)	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient ³	614	616	589	613	567
15. Total payments in-patient (\$) ³	1,697,912	5,162,892	3,148,170	3,160,654	1,930,540
16. Total number of claims out-patient ³	12,028	1,982	10,842	11,615	10,542
17. Total payments out-patient (\$) ³	3,344,999	3,790,531	3,652,283	4,463,261	6,790,798

¹ Population as of June 1st, 2018.² Beginning in 2014–2015, HSAL no longer has arrangements with private for-profit facilities. These facilities are accessible through Regional Health Authorities. This is reflected retrospectively in a revised figure for 2014–2015.³ The claims in our data system cannot be separated into pre-approved or non pre-approved, therefore, the numbers reflect the total claims and payments as reported for previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	2,510	2,533	2,660	2,709	2,755
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	not applicable	not applicable	not applicable	not applicable	not applicable
21. Total payments for services provided by physicians paid through all payment methods (\$)	1,134,521,000	1,204,757,000	1,283,742,000	1,252,850,000	1,339,598,000
22. Total payments for services provided by physicians paid through fee-for-service (\$)	742,136,000	784,398,000	867,122,000	845,522,000	901,784,000

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	244,903	263,393	254,395	273,056	271,009
24. Total payments (\$)	11,963,709	12,545,113	13,062,681	13,818,753	13,898,168

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services ³	not available	not available	not available	not available	not available
26. Total payments (\$) ³	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services ³	7,785	7,995	6,641	6,867	5,888
28. Total payments (\$) ³	1,048,275	1,269,879	1,042,755	788,816	768,212

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	190	207	227	222	247
30. Number of opted-out dentists ⁴	not applicable	not applicable	not available	0	0
31. Number of non-participating dentists ⁴	not applicable	not applicable	not available	515	495
32. Number of services provided	6,397	6,561	7,249	7,415	7,081
33. Total payments (\$)	2,083,453	1,531,281	1,851,615	2,047,349	1,872,000

⁴ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

SASKATCHEWAN



Saskatchewan's Ministry of Health focuses on our patient first agenda, where we concentrate on better health, better care, better value, and better teams for Saskatchewan people. The Ministry continually explores innovative approaches to meet the needs and respect the values of patients and families in planning and delivering care.

Saskatchewan's transition from 12 regional health authorities to a single provincial health authority in 2017 was driven by the commitment to improve frontline patient care for Saskatchewan people. The province continues to standardize processes and policies to better coordinate health services across the province and help ensure patients receive high-quality, timely health care, regardless of where they live in Saskatchewan.

Saskatchewan's health care delivery system includes the Saskatchewan Cancer Agency, eHealth Saskatchewan, 3S Health (Shared Services Saskatchewan), the Athabasca Health Authority, affiliated health care organizations, and a diverse group of professionals, many of whom are in private practice. There are 28 self-regulated health professions in the province, which are overseen by 26 regulatory bodies, and the health system as a whole employs an estimated 46,000 people who provide a broad range of services.

The Ministry will continue to provide effective strategic oversight to the Saskatchewan Health Authority and the Saskatchewan Cancer Agency and encourages leadership from boards, management, and health professionals at all levels.

The Ministry continues partnerships with local, regional, provincial, national and international organizations, as those partnerships are fundamental to providing all Saskatchewan residents with access to quality health care services.

Visit the [Saskatchewan website](#) for more information about Ministry programs and services.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of the *Health Administration Act* authorizes that the Saskatchewan Minister of Health (the Minister) may:

- › pay part of, or the whole of, the cost of providing health services for any persons or classes of person who may be designated by the Lieutenant Governor-in-Council;
- › make grants or loans, or provide subsidies to the provincial health authority, health care organizations or municipalities for providing and operating health services or public health services;

- › pay part of, or the whole of, the cost of providing health services in Saskatchewan in which those services are considered by the Minister to be required;
- › make grants or provide subsidies to any health agency that the Minister considers necessary; and
- › make grants or provide subsidies to stimulate and develop public health research, and to conduct surveys and studies in the area of public health.

Sections 8 and 9 of the *Saskatchewan Medical Care Insurance Act* provide the authority for the Minister to establish and administer a plan of medical care insurance for residents. The *Provincial Health Authority Act*, implemented in 2017, provided the authority to amalgamate the 12 regional health authorities to a single health authority.

Sections 3 and 9 of the *Cancer Agency Act* provide the authority for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Saskatchewan Ministry of Health, provincial health authority, and the Saskatchewan Cancer Agency are outlined in the *Health Administration Act*, the *Provincial Health Authority Act* and the *Cancer Agency Act*.

1.2 Reporting Relationship

The Ministry is directly accountable, and regularly reports, to the Minister on the funding, and administering the funds, for insured physician, surgical-dental and hospital services.

Section 36 of the *Saskatchewan Medical Care Insurance Act* requires that the Minister submit an annual report concerning the medical care insurance plan to the Legislative Assembly.

The *Provincial Health Authority Act* requires that the provincial health authority submit to the Minister:

- › a report on the activities of the provincial health authority; and
- › a detailed, audited set of financial statements.

Pursuant to legislation, these reports and corresponding statements are then provided by the Minister to the Legislative Assembly.

Section 7-4 of the *Provincial Health Authority Act* requires that the provincial health authority and the Cancer Agency submit to the Minister any reports that the Minister may request from time to time. The provincial health authority and the Cancer Agency are required to submit various financial documents and a health service plan to the Ministry.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government ministries and agencies, including the Ministry. The audit of the Ministry includes a review of Ministry payments including, but not limited to, payments made to the Saskatchewan Health Authority (SHA), the Saskatchewan Cancer Agency, and physicians and dental surgeons for insured physician and surgical-dental services.

Section 7-7 of the *Provincial Health Authority Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by the SHA and the Saskatchewan Cancer Agency, audit the accounts of the SHA or the Saskatchewan Cancer Agency at least once in every fiscal year. The SHA and the Saskatchewan Cancer Agency must annually submit to the Minister a detailed, audited set of financial statements.

The most recent audits were for the year ending March 31, 2019. The SHA and Saskatchewan Cancer Agency each table annual reports in the Saskatchewan Legislature each year which include their audited financial statements. The Government of Saskatchewan tables its audited financial statements (Public Accounts) in the Legislature each year as well. The reports are available to the public directly from each entity and are available on their websites.

The Office of the Provincial Auditor for Saskatchewan provides independent assurance (audit reports) and advice on the Government's management of and accountability practices for the public resources entrusted to it. They inform the Legislative Assembly about the reliability of the Government's financial and operational information, the Government's compliance with legislative authorities and the adequacy of the Government's management of public resources. Their reports are available on the [Provincial Auditor of Saskatchewan site](#).



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Section 2-7 of the *Provincial Health Authority Act* gives the Saskatchewan Minister of Health (the Minister) the authority to provide funding to the provincial health authority or a health care organization for the purpose of the Act.

Section 2-9 of the Act permits the Minister to designate facilities including hospitals, special care homes and health centres. Section 2-10 allows the Minister to prescribe standards for delivering services in those facilities in the provincial health authority, and health care organizations that have entered into service agreements with the provincial health authority.

The Act sets out the accountability requirements for the provincial health authority and health care organizations. These requirements include, for example, submitting annual financial and health service plans for ministerial approval (section 7-2), the Minister's approval for general bylaws and practitioner bylaws of the provincial health authority, Cancer Agency or affiliates (section 6-3[1]), and reporting critical incidents (section 8-2). The Minister also has the authority to establish a provincial surgical registry to help manage surgical wait times (section 2-11). The Minister retains authority to inquire into matters (section 8-3), appoint a public administrator if necessary (section 8-4), and approve general and staff practitioner by-laws (sections 6-1 to 6-3).

Funding for hospitals is included in the funding provided to the provincial health authority.

A comprehensive range of insured services is provided by hospitals. These may include:

- › public ward accommodation;
- › necessary nursing services;
- › the use of operating room and case room facilities;
- › required medical and surgical materials and appliances;
- › x-ray, laboratory, radiological and other diagnostic procedures;
- › radio-therapy facilities;
- › anaesthetic agents and the use of anaesthesia equipment;
- › physiotherapeutic procedures;
- › all drugs, biological and related preparations required for hospitalized patients; and
- › services rendered by individuals who receive remuneration from the hospital.

Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals, so people know what they can expect at each hospital. While not all hospitals will offer the same kinds of services, reliability and predictability means:

- › it is widely understood which services each hospital offers; and
- › these services will be provided on a continuous basis, subject to the availability of appropriate health providers.

The provincial health authority has the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs, available health providers and financial resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, which takes into account such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. Typically the provincial health authority initiates the process and, depending on the specific service request, it could include consultations involving several branches within the Ministry of Health as well as external stakeholder groups such as service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of the *Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. All insured fee items for physicians can be found in the [Physician Payment Schedule](#). As of March 31, 2019, there were 2,600 physicians licensed to practise in the province and eligible to participate in the

Medical Care Insurance Plan. Of these, 1,340 (51.5 per cent) were family practitioners and 1,260 (48.5 per cent) were specialists. Physicians may choose to not participate in the Medical Services Plan (known in Saskatchewan legislation as opting-out), but if doing so, they must fully opt out of all insured physician services. As per legislation the non-participating physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2019, there were no non-participating physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Saskatchewan Ministry of Health, and are listed in the Physician Payment Schedule of the *Saskatchewan Medical Care Insurance Payment Regulations* (1994) of the *Saskatchewan Medical Care Insurance Act*.

A process of formal discussion and negotiation between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service, or a change is made to an existing physician service, the changes are reflected in the Physician Payment Schedule. A regulatory amendment to the *Saskatchewan Medical Care Insurance Payment Regulations* is required to provide the authority to pay updated rates to physicians and new insured services.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Medical Services Plan.

2.3 Insured Surgical-Dental Services

Dentists may choose to not participate in the Medical Services Plan (known in Saskatchewan legislation as opting out), but if doing so, they must opt out of all insured surgical-dental services. The non-participating dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

There were no non-participating dentists in Saskatchewan as of March 31, 2018.

Insured surgical-dental services are limited to:

- › oral or maxillofacial surgery and adjunctive services if provision for payment for the service is included in the dentist payment schedule;
- › orthodontic service or nasoalveolar molding treatment services for the care of cleft palate where the beneficiary receiving the service is referred to the dentist by a physician or another dentist;

- › the extraction of any teeth necessary to be performed before the provision of heart surgery services, services for chronic renal disease, stem cell transplant services, head or neck cancer services or services for total joint replacement by prosthesis, or resulting from cancer radiation treatment, where:
 - i. the beneficiary is referred to the dentist by a specialist in the field of practice in which the services lie;
 - ii. the specialist recommends that payment be made for the service; and
 - iii. the minister approves the payment.

In addition, all dental anaesthetic for beneficiaries under age 14 is publicly funded.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion, consultation and negotiation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service. Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

As of March 31, 2019, there were approximately 518 practicing dentists and dental surgeons located in all major centres in Saskatchewan. Eighty-eight provided services insured under the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

- › in-patient and out-patient hospital services provided for reasons other than medical necessity;
- › services prescribed to be an “uninsured service” in legislation;
- › the extra cost of private and semi-private hospital accommodation not ordered by a physician;
- › physiotherapy and occupational therapy services not provided by or under contract with the provincial health authority;
- › services provided by health facilities other than hospitals unless through an agreement with the provincial health authority and licensed under the *Patient Choice Medical Imaging Act* or the *Health Facilities Licensing Act*;
- › non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- › non-medically required elective physician services;
- › surgical-dental services that are not medically necessary; and
- › services received under other public programs including the *Workers’ Compensation Act*, the federal Department of Veteran Affairs and the *Mental Health Services Act*.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. There are no charges allowed in Saskatchewan for insured hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary and/or not deemed to be an insured service. Compliance is monitored through consultations with the provincial health authority, physicians and dentists, as well as via complaints from members of the public.

Insured hospital services are typically de-insured by the government if they were determined to be no longer medically necessary and/or clinically appropriate. The process involves discussions among stakeholders, practitioners, and officials from the Saskatchewan Ministry of Health.

Insured physician services could be de-insured if they were determined not to be medically required and/or clinically appropriate. The process involves consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Insured surgical-dental services could be de-insured if they were determined not to be medically necessary and/or clinically appropriate. The process involves discussion and consultation with the dental surgeons of the province, and is managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.



3.0 UNIVERSALITY

3.1 Eligibility

The *Saskatchewan Medical Care Insurance Act* (sections 2 and 12) and the *Medical Care Insurance Beneficiary and Administration Regulations* define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage.

While the Regulations set out classes of beneficiaries exempt from insured services under the Act, it is possible for individual residents to request that the Health Registry not issue a provincial health card in certain cases (e.g., for religious reasons).

Eligibility is limited to residents. A “resident” means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor-in-Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students, and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not covered under Saskatchewan's Medical Services Plan:

- › members of the Canadian Forces, federal inmates, refugee claimants, visitors to the province; and
- › persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- › discharged members of the Canadian Forces, if stationed in or resident in Saskatchewan on their discharge date;
- › released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- › refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

Individuals who are not successful when applying for a provincial health card may appeal the decision by submitting to Health Registries - eHealth Saskatchewan, a Saskatchewan Health Services Card Application—Appeal Form.

The number of persons registered for health services in Saskatchewan on June 30, 2018, was 1,196, 842.

3.2 Other Categories of Individuals

Other categories of individuals who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, study permit or Minister's permit issued by Immigration, Refugees and Citizenship Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status or with a study or work permit, Minister's permit or permanent resident or landed immigrant record.



4.0 PORTABILITY

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 Coverage during Temporary Absences in Canada

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of the *Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada.

Residents of Saskatchewan are able to maintain health coverage during a period of temporary absence, conditional upon the registrant's intent to return to Saskatchewan residency.

- › Residents of Saskatchewan are required to be physically present in the province for a minimum 5 months over a 12 month period.
- › Residents of Saskatchewan who are temporarily absent from the province for 7 months or more are required to submit a request for extended absence as follows:
 - › education: for the duration of studies at a recognized educational facility (confirmation by the facility of full-time student status and expected graduation date are required);
 - › employment of up to 12 months in Canada; and
 - › vacation and travel of up to 12 months.

In 2015–2016, Saskatchewan amended the *Medical Care Insurance Beneficiary and Administration Regulations* to increase the amount of time residents are allowed to be out-of-province while still maintaining their health care benefits. Residents are now able to maintain health coverage after spending a maximum of seven months outside of Saskatchewan. Residents were only allowed to be absent for a maximum of six months over any 12 month period before their health benefits were discontinued. The new policy took effect January 1, 2016.

Section 6.6 of the *Health Administration Act* provides the authority for paying in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of the *Saskatchewan Medical Care Insurance Payment Regulations* (1994) provides payment for physician services to Saskatchewan beneficiaries temporarily residing outside the province but within Canada.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services. Quebec does not participate in reciprocal billing of physician services.

4.3 Coverage during Temporary Absences Outside Canada

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of the *Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Residents of Saskatchewan are able to maintain health coverage during a period of temporary absence, conditional upon the registrant's intent to return to Saskatchewan residency.

- › Residents of Saskatchewan are required to be physically present in the province for a minimum of 5 months over a 12 month period.
- › Residents who are temporarily absent from the province for 7 months or more are required to submit a request for extended absence as follows:
 - › education: for the duration of studies at a recognized educational facility (confirmation by the facility of full-time student status and expected graduation date are required);
 - › employment of up to 24 months outside of Canada; and
 - › vacation and travel of up to 12 months.

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* provides open-ended temporary absence coverage for persons whose principal place of residence is in Saskatchewan, but who are not able to satisfy the annual six months physical presence requirement because the nature of their employment requires travel from place to place outside Canada (e.g., cruise line workers).

Section 6.6 of the *Health Administration Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of \$100 per in-patient and \$50 per out-patient visit per day.

4.4 Prior Approval Requirement

Out-of-Province

The Saskatchewan Ministry of Health covers most hospital and medical out-of-province care received by its residents in Canada through reciprocal billing arrangements. These arrangements mean that residents do not need prior approval and may not be billed for most hospital and medical services received within the publicly funded health care system in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered. Prior approval is required for the following services provided out-of-province:

- › alcohol and drug, mental health, rehabilitation, problem gambling services, home care, certain rehabilitative services and services not eligible to be billed reciprocally.

Prior approval from the Saskatchewan Ministry of Health must be obtained by the patient's specialist.

Out-of-Country

If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval for coverage from the Medical Services Plan of the Saskatchewan Ministry of Health. The Saskatchewan Cancer Agency is consulted for out-of-country cancer treatment requests. If approved, the Saskatchewan Ministry of Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

In Saskatchewan, the Health Services Review Committee (HSRC) is an arms-length panel that reviews government decisions made on requests for out-of-province and out-of-country medical coverage, ensuring legislation, policy, and guidelines are followed appropriately.

The Ministry of Health informs eligible applicants of their right to request a review by the HSRC upon denial of their out-of-province or out-of-country coverage request. A person can request a review by the HSRC only if the coverage request was for out-of-province insured medical health services, elective out-of-country insured medical services (physician and hospital care) or community care programs (mental health, alcohol and drug, problem gambling, and rehabilitative services).

If a case is ineligible for HSRC or if HSRC upholds the Saskatchewan Ministry of Health's coverage decision, a person may contact the Provincial Ombudsman for another review.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons, and user charges by hospitals for insured health services are not allowed in Saskatchewan.

Pursuant to section 18 (1.1) of the *Saskatchewan Medical Care Insurance Act*, no physician or other person who provides an insured service to a beneficiary shall demand or accept payment for that service in an amount that he knows exceeds the payment to be made for that service prescribed in the *Saskatchewan Medical Care Insurance Regulations*.

With regards to extra-billing and user charges, compliance is monitored through consultations with the provincial health authority, physicians and dentists, as well as complaints from members of the public. The Saskatchewan Ministry of Health's General Inquiry contact information is as follows:

Saskatchewan Ministry of Health
1-800-667-7766
info@health.gov.sk.ca

When requests are made by a beneficiary to reimburse monies paid directly to a physician for insured physician services that are extra-billing charges, correspondence is sent to the beneficiary (copying the physician) advising them of Section 18 (1.1) of the *Saskatchewan Medical Care Insurance Payment Act* that a physician must accept the negotiated rate as payment in full for insured services provided to a beneficiary. Once they have received payment from Medical Services Plan for the eligible service(s), reimbursement for any difference in the amount charged by the practitioner and the amount paid by Medical Services should be collected directly from the practitioner. If further complaint is made, the beneficiary is directed to address complaints to the Saskatchewan College of Physicians and Surgeons.

In addition, a private third-party facility must obtain a health facility license to provide certain insured services (e.g., surgical services) on behalf of the publicly funded health system. The *Health Facilities Licensing Act* (HFLA) authorizes and prescribes the conditions under which a health facility license may be issued to a private facility. The HFLA stipulates that a licensee may not charge or permit any other person to charge any fee to any beneficiary for any insured health service as defined under the HFLA.

Legislation prescribes that the Saskatchewan Minister of Health may amend, suspend or cancel a license if, in the opinion of the Minister, the licensee has failed to comply with the above clause.

Persons who have a complaint of an extra-billing and user charge may also raise the concern with the College of Physicians and Surgeons of Saskatchewan. The College has in their bylaws 7.1 Code of Ethics that includes:

- › treat all patients with respect;
- › do not exploit them for personal advantage.

Contravention of, or failure to comply with, the Code of Ethics is unbecoming, improper, unprofessional or discreditable conduct for the purposes of the *Medical Care Insurance Act*.

The health system continues to strengthen coordination, communication, and referral guidelines to better coordinate services to ensure patients have timely access to the most appropriate specialist and diagnostic services. By reducing the wait time for a consult with a specialist or diagnostic services (such as MRI and CTs), patients will be able to access treatment sooner.

Other Programs and Initiatives to Improve Access

The Family Physician Comprehensive Care Program is intended to support recruitment and retention of family physicians by recognizing those physicians who provide a full range of services to their patients and the continuity of care that result from these comprehensive services.

Leveraging Immediate Non-Urgent Knowledge (LINK) is a provincial telephone consultation service that allows primary care providers to consult with a specialist about serious and/or complex non-urgent patient health concerns. LINK helps patients get answers to their health concerns sooner, prevents unnecessary referrals and supports better referrals to the right specialist when required.

5.2 Physician Compensation

Section 6 of the *Saskatchewan Medical Care Insurance Payment Regulations* (1994) outlines the obligation of the Minister of Health to make payments for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salary, and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services. Total expenditures for in-province physician services and programs in 2018–2019 amounted to \$1.072 billion: \$556.8 million for fee-for-service billings; \$32.7 million for Specialist Emergency Coverage Programs; and \$358.7 million in non-fee-for-service expenditures. There was also an additional \$123.6 million for the Clinical Services Fund and other Saskatchewan Medical Association and bursary programs.

Saskatchewan physicians do not charge block fees.

5.3 Payments to Hospitals

Funding to the Saskatchewan Health Authority (SHA) is based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. The SHA is given a global budget and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes. The SHA may receive additional funds for providing specialized hospital programs (e.g., renal dialysis, specialized medical imaging services, specialized respiratory services, and surgical services).

Payments to the SHA for delivering services are made pursuant to section 2-7 of the *Provincial Health Authority Act*. The legislation provides the authority for the Minister of Health to make grants to the SHA and health care organizations for the purposes of the Act, and to arrange for providing services in any area of Saskatchewan if it is in the public interest to do so.

The SHA provides an annual report on the aggregate financial results of its operations.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Federal contributions provided through the Canada Health Transfer are publicly acknowledged by the Government of Saskatchewan in:

- › the Ministry of Health's 2018–2019 Annual Report;
- › the 2018–2019 Provincial Budget and related documents;
- › the 2017–2018 Public Accounts; and
- › the Quarterly and Mid-Year Financial Reports.

These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged in news releases and issue papers, and in speeches and remarks made at various conferences, meetings and public policy forums.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	1,152,330	1,154,257	1,176,932	1,199,429	1,196,842 ¹

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	66	66	66	66	66
3. Payments for insured health services (\$)	1,889,855,000	1,943,748,000	1,976,162,750	1,968,702,500 ²	2,067,238,750 ²

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	4	5	5	6	6
5. Payments to private for-profit facilities for insured health services (\$)	not available	not available	not available ³	not available ³	not available ³

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY⁴

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	4,113	4,923	4,376	4,277	4,174
7. Total payments, in-patient (\$)	42,834,000	67,838,500	49,817,000	54,776,000	64,494,900
8. Total number of claims, out-patient	66,006	77,250	68,995	71,933	72,192
9. Total payments, out-patient (\$)	24,130,100	28,739,900	27,218,000	28,957,000	29,364,100

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	3	7	5	2	7
11. Total payments in-patient (\$)	2,700,800	1,096,600	933,300	37,900	3,078,800
12. Total number of claims out-patient	72	176	52	53	218
13. Total payments out-patient (\$)	411,000	1,066,600	405,900	269,600	2,055,800

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	396	344	335	308	317
15. Total payments in-patient (\$)	1,829,100	203,100	116,700	248,800	193,800
16. Total number of claims out-patient	1,404	1,403	1,285	1,191	1,244
17. Total payments out-patient (\$)	69,200	69,700	62,200	58,700	69,400

¹ Saskatchewan's numbers as of June 30, 2018.

² As reported by the Saskatchewan Health Authority in their annual audited financial statements.

- Includes acute care services, specialized hospital services, and in-hospital specialist services.
- Does not include in-patient mental health or addiction treatment services.
- Does not include payments to Saskatchewan Cancer Agency for out-patient chemotherapy and radiation.
- Physician compensation is included under the appropriate functional areas.

³ CT and MRI services are not considered insured services in Saskatchewan within the meaning of the *Saskatchewan Medical Care Insurance Act*. Private facilities providing surgical, MRI and CT services may receive payments for these services under contract with the provincial health authority. The Ministry of Health does not directly provide payments to these facilities.

⁴ Data for prior years has been re-stated to reflect total number of hospital cases rather than claims as a single hospitalization can result in numerous claims.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	2,224	2,375	2,491	2,560 ⁵	2,600
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$)	898,584,963	941,409,025	982,568,484	997,950,125	1,009,110,700
22. Total payments for services provided by physicians paid through fee-for-service (\$)	507,079,008	535,162,606	557,334,395	561,557,167 ⁶	556,831,300 ⁶

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	714,648	753,736	785,072	740,342	757,219
24. Total payments (\$)	37,220,270	40,339,800	42,855,888	41,691,900 ⁵	42,976,000

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA⁷

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not available	not available	not available	not available	596
26. Total payments (\$)	not available	not available	not available	not available	500,368

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not available	not available	not available	not available	4,906
28. Total payments (\$)	not available	not available	not available	not available	274,585

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	79	79	78	78	88
30. Number of opted-out dentists ⁸	not available	not available	0	0	0
31. Number of non-participating dentists ⁸	not available	not available	0	0	0
32. Number of services provided	17,346	18,777	13,139	11,550	10,916
33. Total payments (\$)	1,870,512	2,146,101	1,688,771	1,516,900	1,529,800

⁵ Number has been re-stated.⁶ Figure is composed of fee-for-service billing and funding for the Emergency Rural Coverage Program which is paid through the fee-for-service program.⁷ Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.⁸ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

ALBERTA



The Minister of Health, the Department of Health (Alberta Health) and the Regional Health Authority (Alberta Health Services) play key roles in Alberta's health care system. All persons and entities work together to provide safe, consistent and universally accessible, publicly funded health care services for Albertans.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Alberta Health administers and operates the Alberta Health Care Insurance Plan (AHCIP), in accordance with the *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* (AHCIA) has governed the operation of the AHCIP. Alberta Health sets policy and direction to achieve a sustainable and accountable health system to promote and protect the health of Albertans. Section 3 of the AHCIA enables the AHCIP and designates the Alberta Minister of Health (the Minister), as the public authority responsible for the administration and operation of the AHCIP. During 2018–2019, amendments were made to the AHCIA to address the Alberta Medical Association's representation rights.

1.2 Reporting Relationship

The Alberta Minister of Health is accountable for the AHCIP. The *Fiscal Planning and Transparency Act* provides a framework for government budgeting and fiscal planning. The Minister is required to prepare an annual report. The 2018–2019 Annual Report of the Ministry of Health was released to the public on June 28, 2019.

1.3 Audit of Accounts

The Auditor General of Alberta is an independent office responsible for conducting annual financial audits and other audits pertaining to the government's management of public resources. In accordance with Alberta's *Auditor General Act*, audit reports are tabled with the Legislative Assembly. The Auditor General's opinion on the audit of the province's consolidated financial statements, which includes the financial transactions and other information of the Ministry of Health, was published on June 28, 2019 in the Government of Alberta's 2018–2019 annual report. The report indicated that the consolidated financial statements present fairly, in all material respects, the financial position and results of operations for the year that ended March 31, 2019.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

In Alberta, Alberta Health Services (AHS) is the entity responsible to the Minister of Health for ensuring the provision of insured hospital services. The *Hospitals Act*, the *Hospitalization Benefits Regulation* (AR 244/1990), the *Health Care Protection Act* (HCPA), and the *Health Care Protection Regulation* (AR 208/2000), govern the provision of insured services by hospitals or designated non-hospital surgical facilities. During 2018–2019, no amendments were made to the legislation regarding insured hospital services. A directory of approved hospitals in Alberta is available at <https://open.alberta.ca/publications/hospital-services-in-alberta>.

The publicly funded services provided by approved hospitals in Alberta include all of the hospital services listed in the *Canada Health Act*. The insured hospital services range from advanced levels of diagnostic and treatment services for in-patients and out-patients, to routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are established in the *Hospitalization Benefits Regulation*. The Regulation is available on the site of the Alberta Queen's Printer at www.qp.alberta.ca.

The list of insured services included in the Regulations is intended to be both comprehensive and generic, thereby limiting the need for routine review and updating. No new services were added during 2018–2019 to the insured hospital services covered by the Alberta Health Care Insurance Plan (AHCIP).

2.2 Insured Physician Services

The *Alberta Health Care Insurance Act* (AHCIA) governs the payment to physicians for insured physician services under section 6. Only physicians who meet the requirements stated in the AHCIA are permitted to make a claim for payment of benefits for providing insured services under the AHCIP.

Alberta had 10,326 physicians participating under the AHCIP as of March 31, 2019. Within this, 8,545 physicians were paid exclusively under fee-for-service, 911 were compensated solely through an Alternative Relationship Plan, and the remaining 870 physicians received compensation from both fee-for-service and through an Alternative Relationship Plan. As of March 31, 2019, there were two non-participating physicians in the province.

Before being registered with the AHCIP, a physician must complete the appropriate registration forms and include a copy of his or her licence issued by the College of Physicians and Surgeons of Alberta.

Under section 8 of the AHCIA, all physicians are deemed to participate in the AHCIP. Under section 8(2), a physician may choose to not participate in the AHCIP by taking the following actions at least 180 days prior to the effective date of not participating: a) notifying the Minister of Health in writing indicating the effective date of not participating, b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the physician practises, and c) posting a notice of the proposed non-participation in a part of the physician's office to which patients have access.

Legal requirements are set out in section 8(3) of the AHCIA for a physician who has not previously practised in Alberta. Under section 8(3) the physician may choose to not participate in the AHCIP prior to commencing practice by: (a) notifying the Minister in writing indicating the date on which the physician will commence non-participating practice, and (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the physician intends to practise.

By not participating in the AHCIP, a physician agrees that, commencing on the effective date, they will not participate in the publicly funded health system. This means that the physician cannot make a claim from the AHCIP for payment for providing what would otherwise be insured health services and the patient cannot seek reimbursement for any amounts paid by the patient for receiving health services from the non-participating physician.

Section 12 of the *Alberta Health Care Insurance Regulation* (AR 76/2006) lists services that are not considered basic or extended health services. The *Medical Benefits Regulation* (AR 84/2006) establishes the benefits payable for insured medical services provided to a resident of Alberta. Descriptions of those services are set out in the Schedule of Medical Benefits available at www.alberta.ca/fees-health-professionals.aspx.

The Ministry of Health is committed to having a Schedule of Medical Benefits that supports continuous improvement and is responsive to health reform. The medical community is continuously consulted and health services codes are created to ensure the schedule reflects the current standard of practice within Alberta. There is no public consultation. All changes to the benefit schedule require the approval of the Minister of Health.

During 2018–2019, no health services were added to the schedule; however, new health services codes were added (for medical assistance in dying, operations on cranial and peripheral nerves, bariatric surgery, sequestrectomy, and hernia repair). Previously, payments to physicians for these health services were made using existing health services codes. Therefore, these new codes do not reflect new services, but were made to more accurately reflect the services being provided.

2.3 Insured Surgical-Dental Services

In Alberta, a small number of medically necessary oral surgical and dental procedures are insured. These are listed in the Schedule of Oral and Maxillofacial Surgery Benefits available at <https://open.alberta.ca/publications/schedule-of-dental-benefits>.

The majority of dental procedures that can be billed to the AHCIP can only be performed by a dentist certified as an oral and maxillofacial surgeon who meets the requirements stated in the AHCIA. Insured dental-surgical services must be performed in either a public hospital or a designated non-hospital surgical facility. Major surgical services, as described in section 2(2)(b) of the HCPA, may only be provided in a public hospital. As of March 31, 2019, there were 226 dentists participating under the AHCIP for eligible dental procedures and no dentists were opted-out of the AHCIP. Routine dental care is not covered by the AHCIP.

Although there is no formal agreement with dentists, the Ministry of Health meets with members of the Alberta Dental Association and College to discuss changes to the Schedule of Oral and Maxillofacial Surgery Benefits. There is no public consultation. All changes to the benefit schedule require the approval of the Minister of Health.

Under section 7 of the AHCI, all dentists are deemed to participate in the AHCIP. Under section 7(2), a dentist may choose to opt out of the AHCIP by taking the following actions at least 30 days prior to the effective date of opting out: (a) notifying the Minister in writing indicating the effective date of not participating; (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the dentist practises; and, (c) posting a notice of the proposed non-participation in a part of the dentist's office to which patients have access. Legal requirements are set out in section 7(3) of the AHCI for a dentist who has not previously practised in Alberta. Under section 7(3), the dentist may choose to not participate in the AHCIP prior to commencing practice by (a) notifying the Minister in writing indicating the date on which the dentist will commence non-participating practice, and (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the dentist intends to practise.

By choosing to not participate in the AHCIP, a dentist agrees that, commencing on the effective date, they will not participate in the publicly funded health system. This means that the dentist cannot make a claim from the AHCIP for payment for providing what would otherwise be publicly funded surgical-dental services and the patient cannot seek reimbursement for any amounts paid by the patient for receiving surgical-dental services from the non-participating dentist.

2.4 Uninsured Hospital, Physician, and Surgical-Dental Services

Section 12 of the *Alberta Health Care Insurance Regulation* lists services that are not considered basic or extended health services unless otherwise approved by the Minister of Health. Section 4(2) and section 5(2) of the *Oral and Maxillofacial Surgery Benefits Regulation* (AR 86/2006) indicate no benefits are payable for oral and maxillofacial surgery services provided to an Alberta resident in another province or territory of Canada or outside of Canada if they are not insured services in Alberta. Section 4(2) of the *Hospitalization Benefits Regulation* available at www.qp.alberta.ca, provides a list of hospital services that are not considered to be insured.

Services not covered by the AHCIP include:

- › cosmetic surgery;
- › ambulance services;
- › prescription drugs;
- › routine dental care;
- › routine eye examinations for residents 19 to 64 years of age; and
- › third party medical services, such as medicals for employment, insurance and sports.

The Preferred Accommodation and Non-Standard Goods or Services Policy describes the Government of Alberta's expectations of AHS and guides the provision of preferred accommodation and enhanced or non-standard goods and services. This policy framework requires AHS to provide 30 days advance notice to the Minister of Health's designate regarding the categories of preferred accommodation offered and the charges associated with each category. AHS is also required to provide 30 days advance notice to the Minister of Health's designate regarding any goods or services that will be provided as non-standard goods or services. AHS must also provide information about the associated charge for these goods or services, and when applicable, the criteria or clinical indications that may qualify patients to receive it as a standard good or service. Alberta's policy for Preferred Accommodation and Non-Standard Goods or Services is available at <https://open.alberta.ca/publications/preferred-accommodation-and-non-standard-goods-or-services>.

Health services that are deleted from the Schedule of Medical Benefits are those services that the medical community has identified as obsolete. The process to engage the medical community is completed through consultation with the Alberta Medical Association and AHS. The Alberta Medical Association acts as the representative for each physician section. AHS is engaged in this decision process in order to understand how changes may impact current service delivery models or the health system at a macro level.

No services were de-insured in 2018–2019. However, 21 health services codes were deleted as they were incorporated into other health service codes.



3.0 UNIVERSALITY

3.1 Eligibility

Under the terms of the Alberta Health Care Insurance Act (AHCIA), Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan (AHCIP). A resident is defined as a person who is lawfully entitled to be or to remain in Canada, who makes the province their home and is ordinarily present in Alberta, and any other person deemed by the regulations to be a resident. The term “resident” does not include a tourist, transient or visitor to Alberta.

Persons moving permanently to Alberta from outside Canada are eligible for coverage if they have permanent resident status, are returning landed immigrants, or are returning Canadian citizens. Persons residing in Alberta on an approved Canada entry document may also be eligible for coverage under the AHCIP, and their eligibility is reviewed on a case-by-case basis.

A resident is not entitled to AHCIP coverage if the resident is a member of the Canadian Armed Forces or a person serving a term in a federal penitentiary as defined in the *Corrections and Conditional Release Act*. These residents receive health care coverage from the federal government. Spouses or partners and dependants of these residents are provided with AHCIP coverage if they are Alberta residents.

The AHCIP will cover individuals released within Alberta from the Canadian Armed Forces or federal penitentiaries, effective the date of release, if notified within three months. If individuals are released in another part of Canada, they are eligible for coverage on the first day of the third month after becoming a resident of Alberta.

In order to access insured services under the AHCIP, Alberta residents are required to register themselves and their eligible dependants. Family members are registered on the same account. Persons moving to Alberta should apply for coverage within three months of arrival or effective dates may be affected. For persons moving to Alberta from within Canada, their registration is effective on the first day of the third month after they become an Alberta resident. For persons moving to Alberta from outside Canada, their registration is effective the day they become an Alberta resident. The process for registering Albertans requires registrants to provide documentation that proves their identity, legal entitlement to be in Canada, and Alberta residency.

When a cancellation or denial of AHCIP coverage is questioned, an individual may contact the AHCIP by phone, e-mail, or mail to discuss the issue. If it cannot be resolved by front-line staff, it is escalated to a supervisor, then a manager, if needed. The manager will conduct a thorough investigation and send a letter with reasons for the decision, as it relates to legislation.

Individuals can choose not to participate in the AHCIP by filing a “Declaration of Election to Opt Out” at any time for themselves and their dependants. Coverage is cancelled for 36 months or until the declaration is revoked by the individual. A new declaration is required every 36 months of non-participation.

As of March 31, 2019, there were 4,700,840 Alberta residents registered with the AHCIP and 143 Alberta residents who were non-participants.

3.2 Other Categories of Individuals

Under the *Alberta Health Care Insurance Regulation*, a person may be deemed a resident for the purpose of AHCIP coverage if they are residing in Alberta to work, study, or are the spouse or partner or dependant of someone who is here to work or study. A Canada Entry Document such as a Work Permit, Study Permit or Visitor Record (that limits length of stay) is required as proof of their legal entitlement to be, and remain, in Canada. Deemed residents must intend on residing in Alberta for 12 months or more. There were 70,879 people covered by the AHCIP under these conditions as of March 31, 2019.

Individuals who hold a Study Permit that does not indicate a school in Alberta are required to provide proof of registration from the accredited school they are attending. Open or employer-specific work permits must be valid for six months or more. Employer-specific work permits must state the individual is employed by a company operating in Alberta. With the exception of clergy, athletes or members of the British army, individuals with a Visitor Record must be the spouse, partner or dependant of an eligible resident or deemed resident.

Individuals whose Canada Entry Document has the remark ‘does not confirm resident status’, are not eligible for AHCIP coverage. Landed immigrants who have a landed status document or proof of Permanent Resident Status and Convention Refugees who have a positive Notice of Decision letter are eligible for AHCIP coverage. Refugee claimants are not eligible.

Children of non-entitled residents (e.g., residents on a Visitor Record, with expired permits, or refugee claimants) who are born in Canada and meet residency requirements are eligible for AHCIP coverage. Children born to Canadian citizens who are temporarily absent from Alberta (and have maintained their coverage) are also eligible. However, documentation may be required.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Under the Alberta Health Care Insurance Plan (AHCIP), generally, persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following the date they establish residency in Alberta.

4.2 Coverage during Temporary Absences in Canada

The AHCIP provides coverage under the *Alberta Health Care Insurance Regulation* for eligible Alberta residents who temporarily leave Alberta for other parts of Canada. A person is considered temporarily absent from Alberta if the person stays in another province or territory for a period that will not exceed 12 consecutive months and where the person intends to return to and maintain permanent residence in Alberta on the conclusion of their stay outside Alberta.

Individuals who are routinely absent from Alberta every year normally must spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy the Ministry of Health of their permanent and principal place of residence within the province. Individuals may also remain eligible for coverage if, on a recurring basis, they are absent from Alberta for up to 212 days in a 12-month period for the purpose of vacation.

Alberta participates in interprovincial hospital and medical reciprocal billing agreements. All provinces and territories, except Quebec, participate in medical reciprocal agreements. These agreements were established to minimize complex billing processes and to help ensure timely payments to physicians and hospitals when they provide services to residents from other provinces or territories. Under the agreements, where an eligible Albertan receives an insured physician service or hospital service in another participating province or territory, Alberta will reimburse for the insured service provided at the host province's or territory's rates for medical services and the applicable rate for hospital services.

In 2018–2019, no amendments were made to the legislation regarding portability within Canada. More information on coverage during temporary absences outside Alberta is available at www.alberta.ca/ahcip-absence-from-alberta.aspx.

Section 16 of the *Hospitalization Benefits Regulation* addresses payment for hospital services obtained outside of Alberta but within Canada. Section 4 of the *Medical Benefits Regulation* addresses payment of physician services obtained outside of Alberta but within Canada. These sections were not amended in 2018–2019.

4.3 Coverage during Temporary Absences Outside Canada

The AHCIP provides coverage under the *Alberta Health Care Insurance Regulation* to eligible Alberta residents who are temporarily absent from Canada. A person is considered to be temporarily absent from Alberta if the person stays outside Canada for a period that will not exceed six consecutive months, and the person intends to return to and maintain permanent residence in Alberta on the conclusion of their stay outside Alberta.

Individuals who are routinely absent from Alberta every year normally must spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Exceptions may be considered by the Ministry of Health depending on the individual circumstance. Individuals may also remain eligible for coverage if, on a recurring basis, they are absent from Alberta for up to 212 days in a 12-month period for the purpose of vacation.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for 24 to 48 consecutive months. Students attending an accredited educational institute outside Canada on a full-time basis are entitled to coverage for the duration of their studies providing they intend to reside in Alberta at the conclusion of their studies.

The maximum amount payable for out-of-country in-patient hospital services is \$100 CAD per day (not including day of discharge). The maximum hospital out-patient visit rate is \$50 CAD, with a limit of one visit per day. The only exception is haemodialysis received as an out-patient, which is paid at a maximum of \$496 CAD per visit, with a limit of one visit per day. Physician and dental specialist or oral surgeon services are paid according to Alberta rates. Funding may also be available through the Out-of-Country Health Services Committee. The committee evaluates requests made by Alberta physicians or dentists for eligible Alberta residents to be considered for funding of insured services covered under the AHCIP that are not available in Canada. More information on coverage during temporary absences outside Canada is available at www.alberta.ca/ahcip-absence-from-alberta.aspx.

Section 16 of the *Hospitalization Benefits Regulation* also addresses payment for goods and services provided by hospitals or approved facilities outside of Canada. Section 5 of the *Medical Benefits Regulation* addresses payment of physician services obtained outside Canada. These sections were not amended in 2018–2019.

4.4 Prior Approval Requirement

Prior approval is not required for elective (non-emergency) insured services in another Canadian province or territory. Prior application is required for elective services received out-of-country and approval may only be given through the Out-of-Country Health Services Committee for

insured services that are medically required, are not experimental, and are not available in Alberta or elsewhere in Canada.

Decisions made by the committee can be appealed. Appeals may be submitted by the Alberta physician or dentist who submitted the application for the Alberta resident or by the Alberta resident. The Out-of-Country Health Services Appeal Panel was established under the *Alberta Health Care Insurance Act*, and continues under the *Out-of-Country Health Services Regulation* (AR 78/2006). The Appeal Panel reviews the application, the committee decision, and determines whether to vary, confirm, or overturn the committee's decision under appeal.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

The Government of Alberta is committed to meeting the health care needs of all Albertans. To ensure Albertans have the best possible access to primary health care services, the Alberta Ministry of Health funds Primary Care Networks (PCNs). PCNs support inter-disciplinary teams made up of family physicians and other health care professionals who work with Alberta Health Services (AHS) to coordinate the delivery of primary health care services for their patients. Each PCN has the flexibility to develop programs and provide services to meet the specific needs of patients. Access to health care services can be limited by geography, hours of operation, and wait times. As of March 31, 2019 there were 41 PCNs operating in Alberta. More than 3.7 million Albertans were enrolled in a PCN. A total of 4,533 primary care providers (including family physicians, general practitioners, pediatricians, and nurse practitioners), and the full-time equivalent of 1,210 other health care providers were registered providers in PCNs.

Section 9 of the *Alberta Health Care Insurance Act* (AHCIA) prohibits extra-billing by opted-in physicians or dentists (i.e., physicians and dentist participating in the Alberta Health Care Insurance Plan (AHCIP). No physician or dentist who participates in the AHCIP and who provides insured services to a resident with coverage under the AHCIP is allowed to charge or collect from any person an amount in addition to the benefits payable by the Minister of Health for those insured services.

Section 11 of the AHCIA prohibits any person from charging or collecting from any person the following payments, where the amount is in addition to the benefits payable by the Minister of Health for the insured service:

- (a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is participating in the AHCIP; or
- (b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is participating in the AHCIP.

When an individual questions extra-billing or user charges, they may contact AHCIP staff by phone, e-mail, fax, or mail as follows:

ALBERTA HEALTH

Attention: Alberta Health Care Insurance Plan
PO Box 1360, Stn Main
Edmonton, AB T5J 2N3

Phone: Edmonton: 780-427-1432;
Toll free in Alberta: 310-0000 then 780-427-1432

Fax: 780-422-0102

E-mail: health.ahcipmail@gov.ab.ca

(This email address is for general information or non-personal questions regarding the AHCIP)

If the matter cannot be resolved with the health practitioner through communication or education, it may proceed to a compliance review.

The Ministry of Health monitors and enforces compliance with the AHCA through a dedicated compliance unit. Compliance reviews assess billing compliance, identify recoveries of inappropriately paid funds, and can lead to education on billing. These reviews are conducted under section 18 of the AHCA. If a compliance review uncovers evidence of non-compliance with sections 9 or 11 of the AHCA, then sections 9, 11, 12, 13 and 14 set out the fines and other steps that may be taken by the Minister of Health.

Health infrastructure is important in ensuring current and future health care needs are met. The Ministries of Health and Infrastructure share the responsibility for planning and management of the Health Capital Plan and projects. The Ministry of Health is responsible for setting strategic directions and implementing health policy, legislation, standards and providing global operating funding to AHS. AHS identifies and prioritizes health service needs requiring capital development. The Government of Alberta supports health infrastructure by funding capital development and the Infrastructure Maintenance Program. The Ministry of Infrastructure is responsible for the design, construction and delivery of major health capital projects throughout the province. Health legislation also stipulates the requirements for the purchase and disposition of assets and properties and the general provisions for health infrastructure.

Budget 2018 included \$5.3 billion over five years for health facilities and equipment, including \$700 million for capital maintenance and renewal. In 2018–2019, a redeveloped maternity care unit at the Peter Lougheed Centre in Calgary and a new wing at the Medicine Hat Regional Hospital were opened. Progress continued on a number of other infrastructure projects to improve access to health services, including the Calgary Cancer Centre and Grande Prairie Regional Hospital.

Access to specialists was improved in 2018–2019 through expansion of eReferral, which uses existing information from Alberta Netcare (the province's electronic health record of Alberta patients' health information) to track referrals for specialist appointments in real time. During 2018–2019, 21 additional specialties were added to eReferral, bringing the total to 29, including breast and lung cancer, and hip and knee replacement. Using eReferral's advice request function, additional primary care providers can now obtain advice on how best to treat their patients. In many cases, this eliminates the need to refer a patient to a specialist.

5.2 Physician Compensation

The AHCIA governs the eligibility and payment to physicians for providing insured medical services to eligible Alberta residents. Physicians are compensated through the AHCIP on a volume-driven, fee-for-service basis or through the use of alternative compensation models such as Clinical Alternative Relationship Plans and the Academic Medicine and Health Services Program. Some primary care physicians are compensated through a Blended Capitation Model which blends fee-for-service and capitation payments.

Under the *Oral and Maxillofacial Surgery Benefits Regulation* (AR 86/2006), benefits are payable in accordance with the regulations under the AHCIA for oral and maxillofacial surgery services provided to a resident of Alberta by a dentist.

In Alberta, the College of Physicians and Surgeons of Alberta enforces standards of practice for charging for uninsured professional services (non-insured services under the AHCIA), which include rules related to block billing by physicians.

The Academic Medicine and Health Services Program has accountability and reporting expectations for physicians participating in the program, as well as for the Faculties of Medicine at both the University of Alberta and Calgary and AHS. Key performance themes include access, quality and safety, and specific indicators have been identified to measure performance within these themes on an annual basis.

Clinical Alternative Relationship Plans and the Academic Medicine and Health Services Program are used by specialists and family physicians and offer alternative compensation models or arrangements to the traditional fee-for-service payment system. Their purpose is to enhance physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction, and value for money. They also support innovative health care delivery, which will result in better health outcomes. The predictable funding provided through Clinical Alternative Relationship Plans and the Academic Medicine and Health Services Program enables physician groups to recruit new physicians to their programs and retain their services while in some cases providing additional funding to support service delivery.

The Government of Alberta and the Alberta Medical Association entered into the Alberta Medical Association Agreement in 2013, which was retroactive to April 1, 2011. In 2018, the Alberta Medical Association Agreement was amended and includes no increases to physician rates and prices paid for insured medical services. Certain financial terms in the Alberta Medical Association Agreement expire March 31, 2020.

To ensure accountability with the AHCI, the Ministry of Health conducts regular reviews of claims filed by physicians to assess their compliance within the AHCI. The Ministry of Health uses statistical and risk assessment methodologies to identify errors or issues in the claims that were paid under the AHCI. Compliance reviews can be initiated for a practitioner or group of practitioners to determine compliance with specific legislative or contractual requirements. Additionally, a compliance review may be triggered as a result of a specific complaint about a physician from an external party.

5.3 Payments to Hospitals

Alberta's public hospitals are operated by AHS or by faith-based voluntary organizations under service agreements with AHS. In Alberta, public hospitals are operated in accordance with the *Hospitals Act*. The *Health Care Protection Act* (HCPA) prohibits the operation of private hospitals.

The *Regional Health Authorities Act* governs the funding of AHS, Alberta's single regional health authority. The Ministry of Health funds AHS through base operating funds provided twice each month. AHS determines funding for individual hospitals and for designated non-hospital surgical facilities.

The HCPA governs the provision of insured and uninsured surgical services performed in public hospitals and non-hospital surgical facilities. The HCPA prohibits queue jumping. Specifically, no person shall give or accept any money or other valuable consideration, pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or provide an uninsured surgical service for the purpose of giving any person priority for the receipt of an insured surgical service. Access to insured surgical services is based on the medical needs of patients and determined by physicians and dentists.

The Minister of Health is required to approve any service agreement between operators of a non-hospital surgical facility and AHS in order for the facility to provide insured surgical services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta is also required.

According to the HCPA, ministerial approval for a proposed facility services agreement shall not be given unless the Minister of Health is satisfied:

- › that the provision of insured surgical services as contemplated under the proposed agreement would be consistent with the principles of the *Canada Health Act*;
- › that there is a current need and that there will likely be an ongoing need in the geographical area to be served for the provision of insured surgical services as contemplated under the proposed agreement;
- › that the provision of the insured surgical services as contemplated under the proposed agreement would not have an adverse impact on the publicly funded and publicly administered health system in Alberta;

- › that there is an expected public benefit in providing the insured surgical services as contemplated under the proposed agreement, considering factors such as (i) access to such services, (ii) quality of service, (iii) flexibility, (iv) the efficient use of existing capacity, and (v) cost effectiveness and other economic considerations;
- › that the health authority has an acceptable business plan in respect of the proposed agreement showing how the health authority will pay for the facility services to be provided;
- › that the proposed agreement indicates performance expectations and related performance measures for the insured surgical services and facility services to be provided; and,
- › that the proposed agreement contains provisions showing how physicians' compliance with the *Health Professions Act* (HPA) and regulations under the HPA, the bylaws of the College of Physicians and Surgeons of Alberta, the code of ethics and standards of practice adopted by the council of the College of Physicians, and Surgeons of Alberta under the HPA as they relate to conflict of interest and other ethical issues in respect of the operation of the facility, will be monitored.

Pursuant to the terms of any agreement between AHS and the operator of a non-hospital surgical facility, AHS agrees to pay a contracted "facility fee." This fee covers certain services specified under the HCPA that are medically necessary and are directly related to the provision of a surgical service at an approved surgical facility. Physicians who provide insured surgical services to patients within an accredited non-hospital surgical facility are paid on a fee-for-service basis through the AHCIP. These fees are the same regardless of whether the physician provides the insured service in a public hospital setting or in a non-hospital surgical facility.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Alberta publicly acknowledged the federal contribution provided through the Canada Health Transfer in the 2018–2019 Government of Alberta Annual Report.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	4,354,660	4,449,483	4,529,842	4,598,089	4,700,840

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	225	225	228	228	228
3. Payments for insured health services (\$)	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services (\$)	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY¹

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	6,297	6,787	7,059	6,668	6,484
7. Total payments, in-patient (\$)	42,466,396	48,651,644	48,492,921	46,468,281	48,297,039
8. Total number of claims, out-patient	127,995	135,369	147,350	135,149	130,737
9. Total payments, out-patient (\$)	37,809,358	43,000,306	50,582,365	47,508,204	48,132,671

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA^{1,2}

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims ³ in-patient (#)	3,679	4,216	3,855	4,014	3,672
11. Total payments ³ in-patient (\$)	359,377	407,398	372,724	389,741	349,087
12. Total number of claims ³ out-patient	4,440	5,008	4,945	4,709	4,402
13. Total payments ³ out-patient (\$)	419,295	479,625	458,265	459,683	394,654

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims ³ in-patient	not available	not available	not available	not available	not available
15. Total payments ³ in-patient (\$)	not available	not available	not available	not available	not available
16. Total number of claims ³ out-patient	not available	not available	not available	not available	not available
17. Total payments ³ out-patient (\$)	not available	not available	not available	not available	not available

¹ Data reported reflect claims processed up to three months after the close of the fiscal year. Any claims processed after this date are not reflected in the presented information.

² These data do not include claims/payments for Alberta residents who have received health services through the Out-of-Country Health Services Committee application process.

³ The claims in our data system cannot be separated into pre-approved or non pre-approved, therefore, the numbers reflect the total claims and payments as reported for previous years.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY⁴

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians ⁵	8,873	9,331	9,684	10,058	10,326
19. Number of opted-out physicians ⁷	0	0	0	0	0
20. Number of non-participating physicians	1	1	1	2	2
21. Total payments for services provided by physicians paid through all payment methods (\$)	not available	not available	not available	not available	not available
22. Total payments for services provided by physicians paid through fee-for-service (\$)	3,033,392,142	3,336,009,256	3,531,947,298	3,602,354,459	3,779,015,740

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	694,373	795,738	840,246	796,364	738,060
24. Total payments (\$)	32,203,224	34,639,878	37,906,996	35,943,674	35,826,012

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA⁸

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services ³	36,290	32,980	31,224	30,653	not available
26. Total payments (\$) ³	2,580,363	2,589,749	2,474,336	2,494,650	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services ³	not available	not available	not available	not available	not available
28. Total payments (\$) ³	not available	not available	not available	not available	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	221	215	217	232	226
30. Number of opted-out dentists ⁹	0	0	0	0	0
31. Number of non-participating dentists	0	0	0	0	0
32. Number of services provided	28,443	31,309	34,603	39,647	42,766
33. Total payments (\$)	8,208,000	9,185,042	9,756,738	11,402,793	12,616,145

⁴ Data for this section reflect claims processed up to three months after the close of the fiscal year. Any data pertaining to expenditures and physicians processed after this date are not reflected in the presented information.

⁵ The physician count includes physicians who are fee-for-service, in Alternative Relationship Plans or receive compensation from both fee-for-service and Alternative Relationship Plans.

⁶ 8,545 of these are paid under fee-for-service, 911 under an Alternative Relationship Plan and the remaining 870 received compensation from both fee-for-service and alternative relationship plans.

⁷ Alberta's legislation provides that all physicians are deemed to be participating in the Alberta Health Care Insurance Plan, unless they opt out in accordance with the procedure set out in section 8 of the *Alberta Health Care Insurance Act*.

⁸ These data do not include Alberta residents who have received health services through the Out-of-Country Health Services Committee application process. Additionally, following a methodology change in 2015–2016, there is a one-year lag from fiscal year end to date of payment for out-of-country data. This means data for out-of-country physician services are still being processed for 2018–2019.

⁹ Alberta's legislation provides that all dentists are deemed to be participating in the Alberta Health Care Insurance Plan, unless they opt out in accordance with the procedure set out in section 7 of the *Alberta Health Care Insurance Act*.

BRITISH COLUMBIA



British Columbia has a progressive and integrated health-care system that includes a health care insurance plan that provides publicly funded health-care services to residents of British Columbia in accordance with the guiding principles of the *Canada Health Act*. The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, and timely health-care services are available to all British Columbian residents.

To read more about British Columbia's publicly funded health system, please refer to the [Ministry of Health's 2018–2019—2020–2021 Service Plan](#).



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Ministry of Health sets goals and standards, and enters into performance agreements, for provincial health service delivery. The Ministry works with the six health authorities throughout the Province to provide quality, appropriate, and timely health services to British Columbians. Five regional health authorities deliver health care services to meet the needs of the population within their respective geographic regions. Completing the full continuum of health care services, a sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of province-wide health programs and services. The Ministry also works in partnership with the First Nations Health Authority to improve the health status of Indigenous Peoples in British Columbia.

The British Columbia Medical Services Plan (MSP), which is managed by the Medical Services Commission (MSC) on behalf of the Government of British Columbia, provides health-care coverage (including for diagnostic services) to beneficiaries and corresponding payments to medical and health-care practitioners.

MSP is administered pursuant to the *Medicare Protection Act* (MPA). The purpose of the MPA is to preserve a publicly managed and fiscally sustainable health-care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay. It expressly incorporates the principles of the *Canada Health Act*.

The MSC reports to the Minister of Health (the Minister), in accordance with the MPA. The function and legislative mandate of the MSC is prescribed to facilitate reasonable access to quality medical care, health-care, and prescribed diagnostic services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of British Columbia, three representatives from the British Columbia Medical Association (operating as the Doctors of BC), and three members from the public who have been jointly nominated by the Doctors of BC and the Government of British Columbia to represent beneficiaries.

General hospital services are publicly funded in British Columbia under the *Hospital Insurance Act* (section 8), the *Hospital Insurance Act Regulations* (Division 5) under the *Hospital Insurance Act*, the *Hospital Act* (section 4), and *Hospital District Act* (section 20).

Medically required laboratory services are publicly funded under the *Laboratory Services Act*. The Minister is responsible for all matters related to laboratory services (including the facility approval process), governance, accountability and provision of benefits for all laboratory services in the Province. Following the amalgamation of the BC Clinical Support Services Society with the Provincial Health Services Authority (PHSA) on June 29, 2018, the Agency for Pathology and Laboratory Medicine is a program under PHSA. The PHSA's mandate is to provide effective provincial oversight, which includes provincial planning, coordination, monitoring, evaluating, and reporting on province-wide results and health outcomes for publicly funded laboratory and pathology services.

1.2 Reporting Relationship

The Ministry provides information on the performance of British Columbia's publicly funded health-care system in its Annual Service Plan Report Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act*.

The MSC is accountable to the Government of British Columbia through the Minister; the [MSC Annual Report](#), which provides an annual accounting of the business of the MSC, its advisory committees and other delegated bodies, is published annually for the prior fiscal year.

Regional health authorities and the PHSA report to the Minister.

1.3 Audit of Accounts

The Ministry's accounts and financial transactions are subject to audit as follows:

- › Internal Audit and Advisory Services (IAAS), the government's internal auditor, determines the scope of the internal audits and timing of the audits. [IAAS reports](#) can be located [on the Government of British Columbia website](#).
- › The Office of the Auditor General (OAG) of British Columbia is responsible for conducting annual financial audits, as well as special audits and reports. The OAG reports its findings to the Legislative Assembly. The OAG initiates its own audits and determines the scope of its audits. The Select Standing Committee on Public Accounts of the Legislative Assembly reviews the recommendations of the OAG.

The [OAG's annual audit of the Ministry's accounts and financial transactions](#) are reflected in the OAG's overall review and opinion related to the BC Public Accounts, which can be found [on the Government of British Columbia website](#).

The [OAG's special audits and reports](#) can be located [on the Office of the Auditor General of British Columbia website](#).

1.4 Designated Agency

Since 2005, the Ministry has contracted with MAXIMUS Canada to deliver the administrative operations of MSP and PharmaCare (the Province's drug insurance plan), including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals. MAXIMUS Canada administers the Province's medical and drug insurance plans under the Health Insurance BC (HIBC) program. Policy and decision-making functions remain with the Ministry.

HIBC submits monthly reports to the Ministry regarding performance on service levels to the public and health-care providers.

HIBC processes payments for health-care services in accordance with payment schedules approved by the MSC.

MSP beneficiaries who are adults—and who do not meet the (primarily income-based) exceptions—are currently obligated to pay premiums. With respect to MSP premiums, Advanced Solutions (a DXC Technology Company) performs revenue management services, including account management, billing, remittance, and collection on behalf of the Province of British Columbia (Ministry of Finance) under the Revenue Services of British Columbia (RSBC) program. The Province remains responsible for and retains control of all government-administered collection actions.

HIBC and RSBC are required to comply with all applicable laws, including the:

- › *Ombudsperson Act*;
- › *Business Practices and Consumer Protection Act*;
- › *Financial Administration Act*; and
- › applicable privacy and freedom of information legislation (i.e., *Freedom of Information and Protection of Privacy Act*, the *Personal Information Protection Act* and the equivalent federal legislation, if applicable).

As of January 1, 2020, MSP premiums have been eliminated. The MPA was amended pursuant to the *Medicare Protection Amendment Act, 2019* to reflect this change. Premiums for periods of enrollment after January 1, 2020, will no longer be paid by beneficiaries.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Act* and *Hospital Act Regulations* provide authority for the Minister to designate facilities as hospitals and societies as hospital societies, to license private long-term care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* and the *Hospital Insurance Act Regulations* provide authority for the Minister to make payments to health authorities for the purpose of operating hospitals. They also outline who is entitled to receive publicly funded services and define the “general hospital services” that are to be provided as benefits.

Hospital services are publicly funded benefits when they are provided to a beneficiary in a public hospital, are medically required, and are recommended by the attending physician, midwife, nurse practitioner, or oral and maxillofacial surgeon. There is no scheduled or regular process to review publicly funded hospital services, as these services are intended to be inclusive.

When medically required, the following are provided to beneficiaries who are in-patients in a general hospital:

- › accommodation and meals at the standard or public ward level;
- › necessary nursing service;
- › laboratory and radiological procedures and the necessary interpretations, together with such other diagnostic procedures as are approved by the Minister in a particular hospital, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of illness, injury or disability;
- › drugs, biologicals and related preparations, when administered in a general hospital;
- › use of operating room, case room and anesthetic facilities, including necessary equipment and supplies;
- › routine surgical supplies;
- › use of radiotherapy facilities, where available;
- › use of physiotherapy facilities, where available.
- › services of a social worker;
- › other rehabilitation services, where available; and
- › other required services approved by the Minister that are provided by persons who receive remuneration from the hospital.

When medically required, the following are provided as benefits to out-patients who are beneficiaries:

- › emergency department services;
- › use of operating room facilities;
- › equipment and supplies used in medically necessary services provided to the beneficiary, including anesthetics, sterile supplies, dressings, casts, splints or immobilizers, and bandages;
- › meals required during diagnosis and treatment;

- › drugs and medications administered in a medically necessary service provided to the beneficiary; and
- › any service provided by an employee of the hospital that is approved by the Minister.

When medically required, the following diagnostic services—which are specified in the Medical and Health Care Services Regulation under the MPA—are provided as benefits to out-patients who are beneficiaries. Depending on the service, they may be at hospitals, or privately-owned facilities that the MSC has approved to provide the service:

- › diagnostic radiology;
- › diagnostic ultrasound;
- › computerized axial tomography (professional fee only);
- › nuclear medicine scanning;
- › polysomnography;
- › pulmonary function;
- › electromyography;
- › electroencephalography; and
- › electrocardiography.

Medically required in-patient and out-patient laboratory services are provided as benefits under the *Laboratory Services Act* (LSA).

Insured hospital services are provided to beneficiaries without charge, with a few exceptions. Exceptions include:

- › incremental charges for preferred (but not medically required) medical/surgical supplies;
- › nonstandard accommodation (when not medically required, and standard accommodation is available); and
- › daily fees for long-term care patients in extended care or general hospitals.

Some facilities providing long-term care services (in this case, the term “extended care” is sometimes used) are regulated under Part 2 of the *Hospital Act*. Health authorities and hospital societies are required to follow Home and Community Care policies to determine benefits in such cases.

2.2 Insured Physician Services

Unless specifically excluded, the following medical services are publicly funded as benefits under the MPA or the LSA:

- › Medically required services provided to beneficiaries (residents of British Columbia who are enrolled MSP in accordance with section 7 of the MPA) by a practitioner enrolled with the MSP; and

- › Medically required diagnostic services performed in an approved diagnostic facility under the supervision of an enrolled physician.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for publicly funded services, they must be enrolled with MSP. In the fiscal year 2018–2019, 11,588 physicians were enrolled with MSP and received payments through fee-for-service (FFS).

Practitioners in addition to physicians and dentists who may enroll and provide benefits under MSP include midwives, optometrists, osteopaths and supplementary benefit practitioners. The Supplementary Benefits Program assists premium assistance beneficiaries (see section 3.3 of this report), and others, to access the following services: acupuncture, massage therapy, physiotherapy, chiropractic, naturopathy, and podiatry (non-surgical services). The program contributes \$23.00 towards the cost of each patient visit to a maximum of ten visits per patient per annum summed across the six types of providers.

Practitioners enrolled in MSP may choose to be opted-in or opted-out. Opted-in practitioners are practitioners who are enrolled in MSP and who elect to bill MSP directly for MSP benefits provided to MSP beneficiaries. Except in certain very rare circumstances, an opted-in practitioner may not bill a patient directly for a benefit. Opted-out practitioners are enrolled in MSP and elect to bill patients directly for benefits. Enrolled practitioners wishing to opt out of MSP must give written notice to the MSC. In this case, patients may apply to MSP for reimbursement of the fee for benefits rendered. Under the MPA, an opted-out physician may not charge a patient more for a benefit than the prescribed MSP fee amount.

Under the Physician Master Agreement between the Government, MSC and Doctors of BC, modifications to the MSC Payment Schedule such as additions, deletions or fee changes are made by the MSC upon advice from Doctors of BC or the Government. To modify the payment schedule, the parties must submit proposals to the Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by the MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2018–2019, 51 net new physician services were added to the MSC Payment Schedule to reflect current practice standards including, for example, the introduction of a new Cardiology service for percutaneous left atrial appendage closure and 2 new Obstetric and Gynecology services for unilateral and bilateral laparoscopic sentinel lymph node biopsies.

Alternatively, 5 physician services were deleted from the MSC Payment Schedule in fiscal 2018–2019, including, for example, epilation of facial hair and axillo femoral bypass graft—unilateral.

Also, during fiscal year 2018–2019, 30 physician services were deleted from Orthopaedics and transferred to Neurosurgery.

2.3 Insured Surgical-Dental Services

In 2015, it was clarified that dental services provided in surgical facilities under contract with a health authority and listed in the Dental Payment Schedule are benefits under MSP.

In certain circumstances, in-patient or out-patient hospitalization is medically required for the safe and proper completion of surgical-dental services. In such cases, the surgical-dental procedure component is publicly funded if the service falls within the meaning of covered dental or orthodontic services by the Medical and Health Care Services Regulation under the MPA. The hospitalization component is funded by the health authority.

Publicly funded surgical-dental procedures include those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally, this would include oral surgery related to trauma, orthognathic surgery, medically required extractions, and surgical treatment of temporomandibular joint dysfunction. Additions or changes to the list of benefits are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes to the Dental Payment Schedule must be approved by the MSC.

Any general dentist in good standing with the British Columbia College of Dental Surgeons who is enrolled in MSP and has hospital privileges may provide surgical-dental benefits in a hospital or other approved facilities. There were 208 dentists enrolled with MSP in 2018–2019 (including general dentists, pediatric dental specialists, oral surgeons, oral medicine dental specialists, and orthodontists billing through MSP).

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Medical necessity is the criterion for public funding of hospital and medical services. Out-patient take-home drugs, and any drugs not clinically approved by the hospital, are excluded from coverage. Procedures not publicly funded under the *Hospital Insurance Act* and Hospital Insurance Act Regulations include:

- › services of medical personnel not employed or contracted by a hospital;
- › treatment for which WorkSafeBC, the Department of Veterans Affairs or any other agency is responsible; services or treatment that the Minister (or a person designated by the Minister) determines, on a review of the medical evidence, that the beneficiary does not require; and
- › excluded illnesses or conditions.

Non-publicly funded hospital services also include:

- › preferred accommodation at the patient's request when not medically required;
- › the incremental cost of preferred medical or surgical supplies/devices/services compared to that which is medically necessary;
- › televisions, telephones, and private nursing services; and
- › dental care that could safely be provided in a dental office, including prosthetic and orthodontic services.

Health authorities are required by Ministry policy to fund medically necessary transfers between acute care hospitals within British Columbia, but patients are required to pay a fee to partially off-set costs when an ambulance or contracted alternative service provider is used for transport in other situations.

Services not covered under MSP include:

- › those covered by the Workers' Compensation Act or by other federal or other provincial legislation;
- › provision of non-implanted prostheses;
- › orthotic devices;
- › proprietary or patent medicines;
- › medical examinations that are not medically required;
- › oral surgery rendered in a dentist's office;
- › telephone advice unrelated to publicly funded visits;
- › reversal of sterilization procedures (except when the sterilization was originally caused by trauma);
- › in-vitro fertilization;
- › medico-legal services; and
- › most cosmetic surgeries.

The MPA (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be a publicly funded benefit. Section 17 prevents extra-billing by prohibiting persons from being charged for or in relation to a benefit or for "materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit" provided by a practitioner who is enrolled in MSP.

In 2018–2019, the MPA was amended to strengthen requirements for beneficiaries to be notified of intended charges for services that would be benefits if rendered by a practitioner who is enrolled in MSP. If notice is not provided as required, a person is not liable to pay for the service unless the service was rendered in an emergency situation, making it impracticable to comply with the notice requirement.

The Ministry and the MSC respond to complaints of extra-billing made by patients and take appropriate actions to correct identified situations. In 2018–2019, the MPA was amended to provide that persons who charge for a service or matter relating to the rendering of the service must refund the person who was charged contrary to the MPA by an enrolled and opted in medical practitioner, or contrary to the notice requirement by a non-enrolled practitioner. Information regarding the extra-billing review process is available on the [Government of British Columbia site](#).

With respect to MSP, the MSC has authority to determine which services are benefits.



3.0 UNIVERSALITY

3.1 Eligibility

Section 7 of the *Medicare Protection Act* (MPA) sets out the MSP enrollment requirement for residents of BC (as defined in the MPA) to enroll in MSP. A person must be a resident of British Columbia to qualify for provincial health-care benefits.

Section 1 of the MPA defines a resident as a person who is either deemed to be a resident under regulation, or:

- › is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- › makes their home in British Columbia; and
- › is physically present in British Columbia for at least six months in a calendar year, or for a prescribed shorter period of time.

Deemed residents include individuals such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* (see section 3.2 of this report) among others, but this does not include a tourist or visitor to British Columbia.

Residents who do not want to participate in the Province's health-care plan may choose to opt out of the publicly funded program. Individuals are required to file an Election to Opt Out statement and submit that statement to MSC. A statement, once signed, is irrevocable and results in the resident being responsible for paying the entire cost of all hospital, medical and other health-care services he/she may receive during the 12-month opted-out period. Residents cannot opt out retroactively, and must reapply to opt out at the expiry of each 12-month period.

All residents are entitled to medically required hospital and medical care coverage. Those residents who are members of the Canadian Forces and those serving a term of imprisonment in a federal penitentiary as defined in the *Corrections and Conditional Release Act*, are eligible for federally funded health insurance. MSP provides first-day coverage to discharged members of the Canadian Forces and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

It is possible for a beneficiary's enrollment to be cancelled by order of the MSC, if MSC determines that the beneficiary was not eligible for enrollment or believes that the beneficiary has ceased to be a resident. Section 11 of the MPA requires that the beneficiary must be notified that they have a right to a hearing, prior to making an order cancelling a beneficiary's enrollment, and, if the beneficiary requests a hearing, the hearing is conducted by a delegate of the MSC—either in person or in writing. Decisions of the MSC or its delegates may be judicially reviewed by the Supreme Court of British Columbia.

The number of residents registered with MSP as of March 31, 2019, was 4,997,617.

3.2 Other Categories of Individuals

Holders of study permits and work permits, as well as applicants for permanent resident status who are the spouse or child of an eligible resident, are eligible for enrollment and benefits when they are deemed to be residents under the MPA in accordance with section 2 of the Medical and Health Care Services Regulation.

3.3 Premiums

The MPA and the Medical and Health Care Services Regulation currently provide authority for the MSC to collect premiums from beneficiaries.

Enrollment in MSP is mandatory (subject to an adult's right to opt out) and payment of premiums is ordinarily a requirement for coverage. Outstanding premium debt is not a barrier to receiving coverage.

The Medical Services Plan monthly premium rates for 2018–2019 fiscal year were \$37.50 for one adult and \$75 for two adults in a family. Additionally, there were no MSP premiums for children under the age of 19, or for dependent post-secondary students enrolled in full-time studies (this includes trade, technical or high schools). As announced by the Government of British Columbia, and further to amendments enacted through the *Medicare Protection Amendment Act, 2019*, MSP premiums will be eliminated for all beneficiaries effective January 1, 2020.

The Medical Services Plan has two programs that offer assistance with the payment of premiums based on financial need. Regular premium assistance has several levels of assistance and is based on a person's net income for the preceding tax year, combined with that of the person's spouse, if applicable, less MSP deductions. Premium assistance rates are no longer calculated to include children. The maximum income for premium assistance eligibility 2018–2019 was \$42,000 adjusted net income per year. The sum net income for premium assistance eligibility of a beneficiary and spouse when one spouse is in long-term care was \$54,000. The monthly premium rates that are paid by beneficiaries receiving premium assistance range from \$11.50 to \$32.50 for a single adult, and \$23 to \$65 for a family of two adults.

There are groups of specified beneficiaries, including those in receipt of assistance under the *Employment and Assistance Act* or *Employment and Assistance for Persons with Disabilities Act*, where there is no premium payable in accordance with section 10 of the Medical and Health Care Services Regulation.

For short-term periods, up to 100 per cent subsidy is offered under the temporary premium assistance program based on current, unexpected financial hardship. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or a holder of permanent resident (landed immigrant) status under the federal *Immigration and Refugee Protection Act*.

Given that MSP premiums will be eliminated effective January 1, 2020, premium assistance and temporary premium assistance programs will cease being effective as of that date.



4.0 PORTABILITY

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month in which residence is established, plus two additional months. For example, if an eligible person applies during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former provincial or territorial health insurance plan during the waiting period.

4.2 Coverage during Temporary Absences in Canada

Sections 3, 3.1, 4 and 5 of the Medical and Health Care Services Regulation set out the portability provisions for persons temporarily absent from British Columbia regarding publicly funded services.

In general terms, residents who spend part of every year outside British Columbia must be physically present in British Columbia at least six months in a calendar year, and continue to maintain their home in British Columbia, in order to retain coverage. As of January 1, 2013, longer term vacationers who are deemed residents may qualify for a total absence of up to seven months per calendar year for vacation purposes only, provided they give prior notice to MSC and continue to meet the other requirements, such as maintaining their home in British Columbia.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible to retain their medical coverage for up to 24 consecutive months provided they receive prior approval of the MSC and meet other requirements of section 4 of the Medical and Health Care Services Regulation. Approval is limited to once in five years for absences exceeding six months in a calendar year. When a beneficiary stays outside British Columbia longer than the approved period, there is a requirement to fulfill a waiting period upon re-establishing residence in the province before coverage can be renewed. Students and extended family of students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial/territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to British Columbia residents who are eligible for MSP coverage, upon presentation of a valid Personal Health Number or BC Services Card. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved for each hospital by the Assistant Deputy Ministers Policy Advisory Committee. For out-patient services, the payment is at the inter-provincial/territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled through inter-provincial/territorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be

handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from the BC Government.

British Columbia pays host provinces/territories approved hospital billing rates and outpatient rates. These rates are recommended by the Interprovincial Health Insurance Agreements Coordinating Committee and approved by provincial-territorial Deputy Ministers of Health.

4.3 Coverage during Temporary Absences Outside Canada

The provisions that define portability of health insurance during temporary absences outside Canada are: section 24 of the *Hospital Insurance Act*; Division 6 of the *Hospital Insurance Act Regulations*; sections 5.5 and 29 of the *Medicare Protection Act*; and sections 3–5 and 35 of the *Medical and Health Care Services Regulation*.

Residents who leave British Columbia temporarily to attend school or university are eligible for MSP coverage for the duration of their studies, provided they were physically present in Canada for 6 of the 12 months immediately preceding departure and are in full-time attendance at a recognized educational facility. Beneficiaries who have been studying outside British Columbia must return to the Province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe is encouraged to contact MSP.

In some circumstances, while temporarily outside the Province for work or vacation, an individual may be deemed an eligible resident during an 'extended absence' of up to 24 consecutive months once in a five-year period. To qualify, an individual must obtain prior approval for status as a resident during the absence, continue to maintain their home in British Columbia, be physically present in Canada for six of the 12 months immediately preceding departure, and have not been granted an extended absence in the previous five calendar years. In addition, they must not have taken advantage of the additional one-month absence available to vacationers during the year the extended absence begins, or during the calendar year prior to the start of the extended absence. In certain situations, if a person's employment requires them to routinely travel outside of British Columbia for more than six months per calendar year, they can apply to the MSC for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances may be deemed residents for up to an additional 12 months, if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person, and they are also residents or deemed residents.

British Columbia residents who are eligible for coverage while temporarily absent from British Columbia may receive reimbursement from MSP for out-of-country medical expenses. MSP provides coverage for out-of-country emergency physician services up to the British Columbia physician fee rates. Reimbursement for out-of-country emergency hospital services is limited to a maximum benefit of \$75.00 per day. Any excess cost is the responsibility of the beneficiary. Reimbursements are made in Canadian dollars.

4.4 Prior Approval Requirement

No prior approval is required for medically required procedures that are covered under interprovincial reciprocal agreements with other provinces and territories. Prior approval from the MSC is required for procedures that are excluded under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are:

- › surgery for alteration of appearance (cosmetic surgery);
- › gender reassignment surgery;
- › surgery for reversal of sterilization;
- › routine periodic health examinations such as routine eye examinations;
- › in-vitro fertilization;
- › artificial insemination;
- › acupuncture; acupressure;
- › transcutaneous electro-nerve stimulation;
- › moxibustion;
- › biofeedback;
- › hypnotherapy;
- › services to persons covered by other agencies (e.g., Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada);
- › services requested by a third party;
- › team conferences;
- › genetic screening and other genetic investigation, including DNA probes;
- › procedures still in the experimental/developmental phase; and
- › anesthetic services and surgical assistant services associated with all the foregoing.

All non-emergency procedures performed outside Canada require approval from the MSC before the procedure is performed, in order to be eligible for reimbursement under the publicly funded program. All such applications for reimbursement are to be submitted to the Ministry or its designate, Health Insurance BC. The beneficiary is notified of the decision in writing.

If a decision is made to deny the application for funding, the beneficiary may request an administrative review of the denial.

If, after the administrative review is concluded, the application for funding under MSP is denied again, the beneficiary may request a review of the decision. For out-of-country applications, the review is conducted by an MSC Review Panel. The panel consists of three members—one delegate representing the Ministry, one delegate representing the Doctors of BC, and one delegate representing the general public. This tripartite structure ensures that decisions affecting administration of the provincial health-care system reflect the best interest of all concerned. For out-of-province but inside Canada applications, the review is conducted by an advisory committee of the MSC.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Beneficiaries in British Columbia, as defined in section 1 of the MPA, are eligible for publicly funded health-care services as required. To ensure equal access to all regardless of income, section 18 also limits charges by non-enrolled medical practitioners in certain contexts. Similarly, section 15 of the *Laboratory Services Act* prohibits extra-billing to beneficiaries for medically required laboratory services provided at an approved laboratory facility, and sections 12 and 13 of the *Hospital Insurance Act* prohibits extra-billing for hospital services.

If a benefit is provided by an enrolled medical practitioner who has opted-out of MSP, any amount charged exceeding the amount allowed under the MPA is extra-billing and must be refunded. The MSC may apply for an injunction restraining a person from contravening the extra-billing provisions of the MPA.

Further, access to publicly funded services continues to be enhanced as follows:

- › The Alternative Payments Program funds regional health authorities to contract with or hire general practitioners (GPs) and/or specialists in order to deliver publicly funded clinical services.
- › The Ministry is moving towards an integrated system of patient care with interdisciplinary teams of health care providers to meet the health needs of communities and populations and increase access and attachment of patients. To support team-based care, the Ministry has implemented or expanded alternate compensation options:
 - › New Service Contracts for General Practitioners and Nurse Practitioners—Funding has been allocated to recruit up to 200 GPs and 200 NPs to work as part of team-based Primary Care Networks. A primary objective of this initiative is to increase patient attachment across the Province, and recruitment is targeted to GPs and NPs who do not currently have a patient panel. The three-year contract model provides income stability while the practitioner establishes his/her/their practice.
 - › Nurse in Primary Care Practice—This program enables the integration of nurses into interdisciplinary teams in family practices and expands a family practitioner's capacity to support a fully optimized scope of practice within the clinical setting.

- › Blended Capitation models such as Population-Based Funding—This funding model is to compensate primary care group practices that provide full scope family practice services for the longitudinal care of patients. Payments are based on the size and complexity of the practice’s registered patient panels. Capitation payments better provide flexibility for a practice to determine the best method and team member to provide the required services. Services to non-registered patients are paid under fee-for-service.
- › The Full-Service Family Practice Incentive Program continues to be expanded, as the Ministry and physicians continue to work together to develop incentives aimed at helping to support and sustain full-service family practice.
- › The Ministry provides funding through the Medical On-Call Availability Program to health authorities to enable them to contract with groups of physicians to provide “on-call” coverage necessary for hospitals to deliver emergency health-care services patients in a reliable, effective, and efficient manner.
- › The Ministry continues programs under the Physician Master Agreement (PMA) to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. An outline of these programs can be obtained on the [Government of British Columbia website](#).

Infrastructure and Capital Planning

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry maintains a long-term capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

5.2 Physician Compensation

The PMA is a formal agreement signed by the Government of British Columbia, the Doctors of BC, and the MSC. The three-year agreement (April 1, 2019 to March 31, 2022) supports ongoing efforts to recruit and retain physicians, while also improving access to GPs, specialists and care in rural and remote communities.

The Doctors of BC represent the interests of all physicians who receive payment for the medical services they provide to beneficiaries in relation to the PMA. The PMA establishes mechanisms that promote enhanced collaboration and accountabilities between the Province and Doctors of BC through various joint committees. It also provides a formal conflict management process at both the local and provincial levels, and language limiting physician service withdrawals. The role of health authorities in the planning and delivery of health-care services is reinforced in the PMA.

The PMA establishes the compensation and benefit structure for physicians who provide publicly funded medical services whether on fee-for-service, contract or population-based funding models (capitation). Through the PMA, the Province also provides targeted financial support for areas such as: rural programs; specialist services; full-service family practice; and shared care models involving GPs, specialists and other health-care professionals.

Physicians are registered by the College of Physicians and Surgeons of British Columbia, a body established under the *Health Professions Act*. The PMA provides processes for monitoring and managing the funding established by the MSC under section 25 of the MPA for publicly funded medical services provided by physicians on an FFS basis. Mechanisms for revisions to the MSC Payment Schedule and for the payment of physicians are detailed in the PMA.

Dentists are registered by the College of Dental Surgeons of British Columbia, which is also a body established under the *Health Professions Act*. The Province and the British Columbia Dental Association (BCDA) are in the process of negotiating a new Dentistry Master Agreement for the period from April 1, 2019 to March 31, 2021 that covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; pediatric dental services; and dental technical procedures. The provisions of the prior Master Agreement, which was put into effect April 1, 2014 and expired on March 31, 2019, remain in place until a new agreement has been negotiated. The Province and the BCDA collaborate through a Dentistry Liaison Committee.

Payment for medical services delivered in the Province is made through MSP to individual practitioners who submit claims under fee-for-service, to health authorities who contract and employ physicians for providing services to patients, and to health authorities and/or physician groups who provide patient services under the population-based funding model.

The MSC is authorized to monitor the billing and payment of claims in order to manage expenditures for medical and health-care benefits on behalf of MSP beneficiaries. The Ministry's Billing Integrity Program monitors, audits and investigates billing patterns and practices of medical and health-care practitioners to detect and deter inappropriate and incorrect billing of MSP claims to MSC. The Billing Integrity Program develops and analyzes practitioner's profiles, monitors trends, conducts audits, and, in accordance with the legislation and where appropriate, seeks recovery of inappropriately paid monies.

5.3 Payments to Hospitals

Funding for publicly funded hospital services is included within annual funding allocations to health authorities, as well as specifically targeted funding from time to time. This funding allocation is used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. Annual funding allocations to health authorities are determined as part of the Ministry's annual budget process in consultation with the Ministry of Finance and Treasury Board. The current year funding allocations and notional out-year allocations are conveyed to health authorities by means of annual funding letters.

The *Hospital Insurance Act* (including the *Hospital Insurance Act Regulations*) and the *Health Authorities Act* govern payments made by government to health authorities. These statutes establish the authority of the Minister to make payments to regional health authorities and the Provincial Health Services Authority, and specify in broad terms what services are publicly funded when provided within a hospital and in delivering regional and other healthcare services.

The British Columbia Tripartite Framework Agreement on First Nation Health Governance and other negotiated agreements provide the basis for the Ministry to provide funding to the First Nations Health Authority. Funding to support the Nisga'a Nation healthcare services and programs is provided to the Nisga'a Valley Health Authority under the terms of the 1999 Nisga'a Valley Health Board Transitional Funding Agreement.

The Ministry does not specifically fund hospitals directly; instead, health authorities are funded and provide operating budgets to hospitals within their region to deliver specified services. The exception to this is when funding provided to health authorities (again not directly to hospitals) is targeted for specific priority projects (e.g. to fund wages or to provide operating funding to support large hospital construction projects coming on stream). Since it is specifically targeted, it must be reported on separately.

Annual incremental funding is allocated to health authorities using the Ministry's Population Needs-Based Funding model and other funding allocation methodologies (targeted funding allocations directed to specific health authorities, e.g. for wage costs related to collective bargaining). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry, such as payments to physicians that occur through MSP and payments for prescription drugs that are covered under Pharmacare.

The accountability mechanisms associated with government funding for hospitals are part of several comprehensive documents that set expectations for health authorities. These include the annual funding letters, annual service plans, mandate letters, and annual bi-lateral agreements. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2018–2019, these documents included:

- › [Estimates, Fiscal Year Ending March 31, 2019](#);
- › [Budget and Fiscal Plan 2018/19 to 2020/21](#); and
- › [Public Accounts 2017/18–2018/19](#).

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	4,672,899	4,746,685	4,827,696	4,925,188	4,997,617

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number ¹	120	120	120	120	120
3. Payments for insured health services (\$) ²	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services (\$)	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	6,053	7,159	5,270	5,898	5,417
7. Total payments, in-patient (\$)	64,421,846	67,261,694	56,882,669	61,093,890	57,540,788
8. Total number of claims, out-patient	81,547	71,313	76,662	85,285	85,637
9. Total payments, out-patient (\$)	28,402,123	29,450,951	28,619,689	31,232,700	31,331,256

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	30	38	18	47	28
11. Total payments in-patient (\$)	2,534,422	4,396,030	6,486,370	4,451,966	3,635,035
12. Total number of claims out-patient	not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments out-patient (\$)	not applicable	not applicable	not applicable	not applicable	not applicable

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	2,241	2,380	1,982	1,743	2,092
15. Total payments in-patient (\$)	726,846	720,890	606,431	570,951	586,897
16. Total number of claims out-patient	3,713	3,189	2,601	1,904	2,867
17. Total payments out-patient (\$)	1,466,862	2,375,378	2,782,841	2,987,362	2,652,836

¹ As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

² BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: \$11.5 billion in 2016–2017, \$12.1 billion in 2017–2018 and \$12.7 billion in 2018–2019.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians ³	10,411	10,705	11,001	11,254	11,588
19. Number of opted-out physicians	2	2	2	2	2
20. Number of non-participating physicians	not available	not available	not available	not available	not available
21. Total payments for services provided by physicians paid through all payment methods (\$)	not available	not available	not available	not available	not available
22. Total payments for services provided by physicians paid through fee-for-service (\$)	2,829,342,371	2,907,582,518	3,023,409,095	3,097,014,152	3,232,180,832

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY⁴

Year	2014–2015	2015–2016	2016–2017	2017–2018 ⁵	2018–2019
23. Number of services	711,988	675,046	668,136	685,270	685,621
24. Total payments (\$)	37,312,545	36,090,357	35,532,618	35,788,808	36,896,106

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA⁴

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018 ⁵	2018–2019
25. Number of services	1,816	1,891	2,178	1,931	2,260
26. Total payments (\$)	2,962,440	3,711,796	4,989,144	5,268,867	6,915,394

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018 ⁵	2018–2019
27. Number of services	77,270	67,025	64,938	64,336	48,488
28. Total payments (\$)	4,320,855	3,522,394	3,388,615	4,268,886	3,099,450

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	214	207	192	200	208
30. Number of opted-out dentists ⁶	not available	not available	not available	not available	not available
31. Number of non-participating dentists ⁶	not available	not available	not available	not available	not available
32. Number of services provided	54,053	52,770	55,069	55,912	61,540
33. Total payments (\$)	8,417,735	8,232,622	8,308,740	8,471,681	9,604,988

³ The number of participating physicians in item 14 is for physicians who received payments through fee-for-service.

⁴ The amounts in items 23, 24, 25, 26 and 28 have been updated to include the most recent information on services and payments made each fiscal year based on the date of the service. The extraction of data has been applied consistently for each fiscal year. The data for 2017–2018 reflects dates of service April 1, 2017 to March 31, 2018, paid as of September 30, 2018.

⁵ Amount in 2017–2018 published CHAAR showed a clerical error correct total payments is \$35,788,808 as noted here.

⁶ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

YUKON



The Government of Yukon is committed to ensuring that Yukoners acquire the skills to live responsible, healthy and independent lives. The Minister of Health and Social Services is responsible for delivering all insured health care services with service delivery administered centrally by the Department of Health and Social Services (DHSS).

The Health Services Division of DHSS is responsible for a variety of health care, disease prevention, and treatment services which assist eligible Yukon residents in attaining maximum independence within their community. The Health Services Division oversees Insured Health Services, Community Health Services, Community Nursing, Communicable Disease Control, Health Promotion, Dental Health, and Environmental Health.

In 2018–2019, DHSS focused on developing more comprehensive and coordinated programs and services that met people's health needs, when and where services are required.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Insured Health and Hearing Services Branch (IHHS) is responsible for the delivery of health care benefits as set out in the *Health Care Insurance Plan Act* and *Hospital Insurance Services Act*. The overall objective of IHHS is to ensure access to, and portability of, insured physician and hospital services according to the provisions of these acts.

The Government of Yukon delivers insured health benefits according to the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). Both the YHCIP and YHISP are administered by the Director, Insured Health and Hearing Services. This position is a joint appointment by the Minister of Health and Social Services (the Minister) and the Commissioner of the Yukon Territory.

The *Health Care Insurance Plan Act*, section 3(2) and section 4, establishes the public authority to operate the health care plan.

The *Hospital Insurance Services Act*, section 3(1) and section 5, establishes the public authority to operate the hospital care plan.

Subject to the *Health Care Insurance Plan Act* (section 5), the *Hospital Insurance Services Act* (section 6) and the Regulations, it is the responsibility of the Director, Insured Health and Hearing Services to:

- › administer both plans;
- › determine eligibility for insured health services;

- › establish advisory committees and appoint individuals to advise or assist in the operation of the plans;
- › determine the amounts payable for insured health services outside the Yukon;
- › conduct surveys and research programs, and obtain statistics for such purposes;
- › appoint inspectors and auditors to examine and obtain information from medical records, reports, and accounts; and
- › perform any other functions and discharge any other duties assigned by the Minister of Health and Social Services under the Act.

Specific to the *Hospital Insurance Services Act*, the Director, Insured Health and Hearing Services has the responsibility to:

- › enter into agreements on behalf of the Government of Yukon with hospitals in or outside of Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons; and,
- › perform any other functions and discharge any other duties assigned to the administrator by the Regulations.

There were no amendments to either act in 2018–2019.

1.2 Reporting Relationship

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services make an annual report to the Minister of Health and Social Services respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and is subject to discussion at that level. The Statement of Revenue and Expenditures was tabled in the 2018 fall sitting of the Yukon legislature.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the Auditor of the Government of Yukon in accordance with section 34 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

Further, section 13(2) of the *Hospital Act* requires the Yukon Hospital Corporation to submit a report of their operations for that fiscal year to the Minister within six months after the end of each fiscal year. The report is to include the financial statements of the Corporation and the Auditor's report.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5, 6 and 9, establish authority to provide insured hospital services to insured residents. The *Yukon Hospital Insurance Services Ordinance* was first passed in 1960 and came into effect April 9, 1960.

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the legislature and the government to ensure "compliance with appropriate methods of operation and standards of facilities and care." Adopted on November 11, 1994, the annexed *Hospital Standards Regulation* sets out the conditions under which all hospitals in the territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establish and maintain a quality assurance program.

In April 1997, the Yukon Government assumed responsibility for operating health units in rural Yukon communities from the federal government. These health centres are staffed by one or more nurses and auxiliary staff. Primary Health Care Nurses in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services in 11 communities throughout Yukon along with the Whitehorse Health Centre which offers immunization clinics and prenatal and postnatal care.

In 2018–2019, insured in-patient and out-patient hospital services were delivered in 14 facilities throughout the territory. These facilities include Whitehorse General Hospital, Watson Lake Community Hospital, Dawson City Community Hospital and 11 Community Health Centres.

Pursuant to the *Hospital Insurance Services Regulations*, section 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to in-patients, namely:

- › accommodation and meals at the standard or public ward level;
- › necessary nursing service;
- › laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability;
- › drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital;
- › use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;

- › routine surgical supplies;
- › use of radiotherapy facilities where available;
- › use of physiotherapy facilities where available; and
- › services rendered by persons who receive remuneration from the hospital.

Section 2(f) of the Regulations defines “out-patient insured services” as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident (period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident):

- › necessary nursing service;
- › laboratory, radiological and other procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury;
- › drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
- › use of operating room and anaesthetic facilities, including necessary equipment and supplies;
- › routine surgical supplies;
- › use of radiotherapy facilities where available; and
- › use of physiotherapy facilities where available.

Pursuant to the *Hospital Insurance Services Regulations*, all in-patient and out-patient services provided in an approved hospital, by hospital employees, are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

2.2 Insured Physician Services

Insured physician services in Yukon are defined as medically required services rendered by a medical practitioner. Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7, 10 and 13 of the *Health Care Insurance Plan Regulations* provide for insured physician services.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. In order to participate in the Yukon Health Care Insurance Plan, physicians must:

- › register for licensure pursuant to the *Health Professions Act*; and
- › maintain licensure, pursuant to the *Health Professions Act*.

There were 80 physicians participating in the Yukon Health Care Insurance Plan in 2018–2019. These physicians were supplemented by visiting locum physicians who provide care throughout Yukon.

Section 7 of the *Yukon Health Care Insurance Plan Regulations* covers payment for medical services. Subsection 4 allows physicians to make arrangements for payment for insured services on a basis other than fee-for-service. Notice in writing of this election must be submitted to the Director, Insured Health and Hearing Services. In 2018–2019, physicians were remunerated by both fee-for-service and through alternative payment arrangements.

The process used to add a new fee to the Payment Schedule for Yukon is administered through a committee structure. This process requires physicians to submit requests in writing to the Yukon Health Care Insurance Plan, Yukon Medical Association Liaison Committee. Following review by this committee, a decision is made to include or exclude the service. The relevant fees are normally set in accordance with similar fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Public consultation is not required.

Alternatively, new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services.

The current Memorandum of Understanding (MOU) with the Yukon Medical Association maintains a focus on collaborative care and ensures greater access for patients, and targets the creation of multi-disciplinary teams that include further integration of nurse practitioners into the care system. The current five-year MOU with the Yukon Medical Association will end on March 31, 2022.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Health Care Insurance Plan of Yukon must be licensed pursuant to the *Dental Professions Act* and are given billing numbers to bill the Yukon Health Care Insurance Plan for providing insured dental services. The Plan is also billed directly for services provided outside the territory.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the *Health Care Insurance Plan Regulations*. The procedures must be performed in a hospital.

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the *Health Care Insurance Plan Regulations*. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act and Regulations* and the *Hospital Insurance Services Act and Regulations* are insured. All other services are uninsured.

Uninsured hospital services include:

- › non-resident hospital stays;
- › special or private nurses requested by the patient or family;

- › additional charges for preferred accommodation unless prescribed by a physician;
- › crutches and other such appliances;
- › nursing home charges;
- › televisions;
- › telephones; and
- › drugs and biologicals following discharge. (These services are not provided by the hospital).

Section 3 of the *Yukon Health Care Insurance Plan Regulations* contains a list of services that are prescribed as non-insured. Uninsured physician services include:

- › advice by telephone;
- › medical-legal services;
- › testimony in court;
- › preparation of records, reports, certificates and communications;
- › services or examinations required by a third party;
- › services, examinations or reports for reasons of attending university or camp;
- › examination or immunization for the purpose of travel, employment or emigration;
- › cosmetic services;
- › services not medically required;
- › giving or writing prescriptions;
- › the supply of drugs;
- › dental care except procedures listed in Schedule B; and
- › experimental procedures.

Physicians in Yukon may bill patients directly for non-insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include but are not limited to:

- › completion of employment forms;
- › medical-legal reports;
- › transferring records;
- › third-party examinations;
- › some elective services; and
- › telephone prescriptions, advice or counseling.

Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

Uninsured dental services include procedures considered restorative and procedures that are not performed in a hospital under general anaesthesia.

All Yukon residents have equal access to services. Third parties, such as private insurers or the Worker's Compensation Health and Safety Board, do not receive priority access to services through additional payment. The purchase of non-insured services, such as fiberglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

Yukon has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services to monitor usage and service concerns.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows:

Physician services—the Yukon Health Care Insurance Plan, Yukon Medical Association Fee Liaison Committee is responsible for reviewing changes to the Payment Schedule for Yukon including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing.

Hospital services—an amendment by Order-in-Council to sections 2(e) and 2(f) of the *Yukon Hospital Insurance Services Regulations* would be required. As of March 31, 2019, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured.

Surgical-dental services—an amendment by Order-in-Council to Schedule B of the *Health Care Insurance Plan Regulations* is required. A service could be de-insured if determined not medically necessary or is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services manages this process. No surgical-dental services were de-insured in 2018–2019.



3.0 UNIVERSALITY

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act and Regulations*, sections 2 and 4, and the *Hospital Insurance Services Act and Regulations*, sections 2 and 4.

Subject to the provisions of these acts and regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term “resident” is defined using the wording of the *Canada Health Act* and means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in Yukon, but does

not include a tourist, transient, foreign student or visitor. Pursuant to section 4(1) of the *Yukon Health Care Insurance Plan Regulations* and the *Yukon Hospital Insurance Services Regulations*, an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory. All persons returning to or establishing residency in Yukon are required to complete this waiting period. The only exception is for children adopted by insured persons, and for newborns.

The following persons are not eligible for coverage in Yukon:

- › persons entitled to coverage from their home province or territory (e.g., students and workers covered under temporary absence provisions);
- › visitors to Yukon;
- › refugee claimants;
- › convention refugees;
- › inmates in federal penitentiaries;
- › study permit holders, unless they are a child and they are listed as the dependent of a person who holds a one year work permit; and
- › employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

- › establish residency in Yukon;
- › become a permanent resident; or
- › for inmates at the Whitehorse Correctional Centre, the day following discharge or release if stationed in or a resident in Yukon.

As of March 31, 2019, there were 41,412 registrants in the Yukon Health Care Insurance Plan.

3.2 Other Categories of Individuals

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals, as follows:

Returning Canadians: a waiting period is applied.

Permanent Residents: a waiting period is applied.

Minister's Permit: if authorized, a waiting period is applied.

Foreign Workers: if holding an employment authorization, a waiting period is applied.

Clergy: if holding an employment authorization, a waiting period is applied.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Where applicable, the eligibility of all persons is administered in accordance with the Interprovincial Agreement on Eligibility and Portability. Under section 4(1) of both regulations, “an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory.” All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted by insured persons (see section 3.1), and newborns.

4.2 Coverage During Temporary Absences in Canada

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the *Yukon Health Care Insurance Plan Regulations* and sections 6, 7(1), 7(2) and 9 of the *Yukon Hospital Insurance Services Regulations*.

The Regulations state that, “where an insured person is absent from the Territory and intends to return, he/she is entitled to insured services during a period of 12 months of continuous absence.” Persons leaving Yukon for a period exceeding six months must contact Yukon Insured Health Services and complete a Temporary Absence form. Failure to do so may result in cancellation of coverage.

Students attending educational institutions full-time outside Yukon remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services (the Director) may approve other absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director may approve absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures.

Yukon participates fully with the Interprovincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories with the exception of Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and submit claims to the Yukon Health Care Insurance Plan for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the territory are paid at the rates established by the host province.

4.3 Coverage during Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the *Yukon Health Care Insurance Plan Regulations* and sections 6, 7(1), 7(2) and 9 of the *Yukon Hospital Insurance Services Regulations*.

Sections 5 and 6 state that, where an insured person is absent from Yukon and intends to return, the person is entitled to insured services during a period of 12 months of continuous absence.

Persons leaving Yukon for a period exceeding six months must contact Yukon Health Care Insurance Plan and complete a Temporary Absence form. Failure to do so may result in cancellation of the coverage.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada (see section 4.2 of this report).

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the *Standard Ward Rates Regulation* for the Whitehorse General Hospital. For 2018–2019 the in-patient rate was set at \$2,010 per day at Whitehorse General Hospital, \$1,788 per day at Watson Lake Community Hospital and \$1,724 per day at Dawson City Community Hospital. These rates are set annually by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Yukon or outside Canada.

When treatment is provided outside Yukon or outside Canada plan members will only be reimbursed the amounts as described in Sections 4.2 and 4.3.

Prior approval by the Director of Insured Health Services is required for full reimbursement of services sought outside of Canada.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

There are no user fees or user charges under the Yukon Health Care Insurance Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers. There is no extra-billing in Yukon for any services covered by the Plan.

If a patient has a complaint related to physician services including extra-billing or user charges they can contact the Yukon Medical Council (YMC).

Information on complaints can be found on the YMC's website:

www.yukonmedicalcouncil.ca/complaint_process.html

The YMC can be reached by phone at 867-667-3774 or by email to ymc@gov.yk.ca.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program, or the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

To improve access to insured health services, the number of both resident and visiting specialists working in Yukon continues to increase to better serve Yukoners.

Additionally, IHHS provides extended health benefits to eligible Yukon residents which include the Travel for Medical Treatment Program, the Children's Drug and Optical Program, the Chronic Disease and Disability Benefits Program, Pharmacare Program, Extended Benefits Program, and Hearing Services Program.

The Yukon Hospital Corporation operates the three hospitals in the territory: Whitehorse General Hospital, Watson Lake Community Hospital, and Dawson City Community Hospital.

5.2 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon before entering into negotiations with the Yukon Medical Association (YMA). The YMA and the government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the *Health Care Insurance Plan Regulations*.

The fee-for-service system is used to reimburse the majority of physicians providing insured services to residents. Other systems of reimbursement include alternative payment arrangements which are primarily used for specialist services in Whitehorse as well as physician services in rural communities.

5.3 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital, Watson Lake Community Hospital, and Dawson City Community Hospital) through contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated and adjusted based on operational requirements. In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act and Regulations*. The legislation and regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in its 2018–2019 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1) (d) and (e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act* acknowledge the contribution of the Government of Canada.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	37,970	38,736	39,960	40,726	41,412

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number ¹	14	14	14	14	14
3. Payments for insured health services (\$) ²	76,130,488	96,850,809	98,671,448	95,464,882	79,548,179

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY²

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	1,179	1,235	1,218	1,220	1,236
7. Total payments, in-patient (\$)	16,712,463	17,865,677	18,981,947	18,611,146	18,687,516
8. Total number of claims, out-patient	15,474	14,513	14,785	15,554	15,856
9. Total payments, out-patient (\$)	5,012,218	4,851,075	5,429,919	5,615,333	5,786,856

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA³

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not available	not available	not available	not available	not available
11. Total payments in-patient (\$)	not available	not available	not available	not available	not available
12. Total number of claims out-patient	not available	not available	not available	not available	not available
13. Total payments out-patient (\$)	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	14	23	18	10	19
15. Total payments in-patient (\$)	61,150	62,040	164,673	82,088	136,430
16. Total number of claims out-patient	70	48	42	58	56
17. Total payments out-patient (\$)	17,579	12,646	13,482	16,590	18,166

¹ Public facilities are the 11 health centres (Beaver Creek, Carcross, Carmacks, Destruction Bay, Faro, Haines Junction, Mayo, Old Crow, Pelly Crossing, Ross River, and Teslin) and 3 hospitals (Whitehorse, Dawson City and Watson Lake).

As Whitehorse, Dawson City and Watson Lake all have hospitals, the health centres in these communities are classified as a Public Health Offices.

² Hospitals have up to a year from date of service to bill jurisdictions (information is based upon date of service; therefore, 2018–2019 billing period is open until March 31, 2020).

³ Yukon does not have an electronic method of capturing pre-approved claims versus non pre-approved claims. Totals are reported as non pre-approved claims.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	72	72	78	77	80
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$)	26,400,493	27,753,925	29,654,509	30,764,362	32,836,649
22. Total payments for services provided by physicians paid through fee-for-service (\$)	19,358,977	19,851,219	20,625,637	21,013,041	22,675,907

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	61,731	62,027	52,766	55,902	56,302
24. Total payments (\$)	3,772,478	3,954,752	4,018,173	4,422,905	4,333,394

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not available	not available	not available	not available	not available
26. Total payments (\$)	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not available	not available	not available	not available	not available
28. Total payments (\$)	not available	not available	not available	not available	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY⁴

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	0	0	0	0	0
30. Number of opted-out dentists	0	0	0	0	0
31. Number of non-participating dentists	0	0	0	0	0
32. Number of services provided	0	0	0	0	0
33. Total payments (\$)	0	0	0	0	0

⁴ No insured surgical-dental services performed in Yukon.

NORTHWEST TERRITORIES



During the reporting period, the Department of Health and Social Services (DHSS) worked with the Health and Social Services Authorities to administer, manage, and deliver insured services in the Northwest Territories.

During the 2018–2019 fiscal year, the DHSS carried out the following legislative activities related to health care services:

- › Drafting regulations under the *Health and Social Services Professions Act* continued. The Act will allow for the regulation of several health and social services professions under one legislative model. This will modernize existing legislation, resulting in greater efficiency and consistency.
- › The new *Mental Health Act* came into force on September 1, 2018. The Act provides a more modern legislative framework that is similar to legislation across Canada.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Northwest Territories (NWT) Health Care Plan consists of the NWT Medical Care Plan and the Hospital Insurance Plan.

The public authority responsible for the administration of the NWT Medical Care Plan is the Director of Medical Insurance, appointed by the Minister of Health and Social Services (the Minister), under the *Medical Care Act*. The Minister establishes the Northwest Territories Health and Social Services Authority and Health and Social Service Authorities' Boards of Management as pursuant to the *Hospital Insurance and Health and Social Services Administration Act* to, among other things, administer the Hospital Insurance Plan.

1.2 Reporting Relationship

During the reporting period there were three Health and Social Service Authorities (HSSA): Northwest Territories Health and Social Services Authority (Territorial Authority), Hay River Health and Social Services Authority, and Tłıchq Community Services Agency (TCSA).

Territorial Authority affairs are directed by a Territorial Board of Management.

Six Regional Wellness Councils provide advice to the Territorial Board of Management, which is composed of the Regional Wellness Council chairpersons and the chairpersons of the TCSA and Hay River Health and Social Services Authority. The Territorial Board of Management and the remaining Boards of Management are accountable to the Minister.

The Territorial Board of Management and the remaining Boards of Management are responsible for the delivery of health and social services and for the management, control, and operation of facilities and services throughout the Northwest Territories. The Territorial Board of Management and the Boards of Management are required under legislation to comply with the territorial plan, which is set by the Minister.

The Minister appoints the Director of Medical Insurance who is responsible for administering the *Medical Care Act* and its Regulations. The Director prepares an annual report for the Minister on the operation of the NWT Medical Care Plan. This report can be found within the Department of Health and Social Services Annual Report.

The Minister appoints the Chair of the Territorial Board of Management as well as the chairperson and members of each Regional Wellness Council. The Minister also appoints the Chair and members of the Hay River Health and Social Services Authority. The chairpersons and members of the Regional Wellness Councils may serve for three years and may be re-appointed to serve another term.

The Minister may appoint a Public Administrator to assume the role of a Board of Management in certain circumstances if the Minister feels it is necessary. At reporting time, a Public Administrator is in place for the Hay River Health and Social Services Authority and acts in the place of the Board of Management.

The TCSA was established under the *Tlicho Community Services Agency Act* as part of the Tlicho Land Claims and Self Government Agreement. The Act provides for a different process of the appointment of board members and sets the term for members to a maximum of four years with the Chairperson's term being fixed by the Minister of Executive and Indigenous Affairs (EIA) who is the Minister responsible for administering the Act. Each Tlicho community government is responsible for appointing one board member and the Minister of EIA is responsible for appointing the Chairperson following a consultation with the board members. The Act stipulates that the TCSA has all the powers, duties and functions of a Board of Management under the *Hospital Insurance and Health and Social Services Administration Act*.

The Director of Medical Insurance and the Boards of Management are responsible to the Minister, as per section 8(1)(b) of the *Canada Health Act*.

1.3 Audit of Accounts

As part of the Government of the Northwest Territories annual audit, the Office of the Auditor General of Canada audits payments under the Hospital Insurance Plan and the NWT Medical Care Plan.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services in the Northwest Territories (NWT) are provided under the *Hospital Insurance and Health and Social Services Administration Act*.

During the reporting period, insured hospital services were provided to in-patients and out-patients by 23 facilities throughout the NWT. Consistent with Section 9 of the *Canada Health Act*, the NWT offers a comprehensive range of insured services to its residents.

Insured in-patient hospital services include:

- › meals and accommodation at the standard or public ward level;
- › required nursing services;
- › laboratory, diagnostic, and imaging services (along with necessary interpretations);
- › drugs, biologicals, and other preparations administered in the hospital;
- › routine surgical supplies and use of operating room;
- › case room and anesthesiology services;
- › radiology and rehab therapy (physio, audio, occupational, and speech);
- › psychiatric and psychological services within an approved program; and
- › detoxification at approved centers.

Insured out-patient hospital services include:

- › laboratory tests;
- › diagnostic imaging (including interpretations when needed);
- › physiotherapy, speech and language pathology therapy, occupational therapy, and audiology;
- › minor medical and surgical procedures and related supplies; and
- › psychiatric and psychological services under an approved hospital program.

The Minister of Health and Social Services (the Minister) may approve additions or deletions to insured services provided in the NWT.

As outlined in the Government of the NWT Medical Travel Policy, travel assistance is provided to residents with a valid NWT Health Care Card who require medically necessary insured services that are not available in their home community or elsewhere in the NWT. This ensures that residents of the NWT have reasonable access to insured hospital and physician services.

2.2 Insured Physician Services

The *Medical Care Act* and the *Medical Care Regulations* provide for insured physician services. Medically necessary services provided in approved facilities by physicians, nurses, nurse

practitioners, and midwives are considered insured services under the NWT Health Care Plan. These professionals are required by legislation to be licensed to practice in the NWT under the *Medical Profession Act* (physicians), *Nursing Profession Act* (nurses and nurse practitioners) and the *Midwifery Profession Act* (registered midwives).

For the period 2018–2019, there were 370 licensed physicians (resident, locum and visiting) active in the NWT.

Physicians may opt out and collect fees other than under the NWT Medical Care Plan by providing written notice to the Director of Medical Insurance. There were no opted-out physicians in the NWT during the reporting period.

The NWT Medical Care Plan insures all medically necessary physician services such as:

- › diagnosis and treatment of illness and injury;
- › surgery, including anaesthetic services;
- › obstetrical care, including prenatal and postnatal care; and
- › eye examinations, treatment and operations provided by an ophthalmologist.

The Director of Medical Insurance is responsible for recommending an insured services tariff for services payable by the NWT Medical Care Plan for the Minister's approval. The Minister ultimately determines if services will be added, altered, or removed from the tariff by:

- › establishing a medical care plan that provides insured services to insured persons by medical practitioners that will qualify and enable the NWT to receive transfer payments from the Government of Canada under the *Canada Health Act*; and
- › approving the fees and charges itemized in the tariff that may be paid in respect to insured services rendered by medical practitioners in the NWT and the conditions under which fees and charges are payable.

2.3 Insured Surgical-Dental Services

Licensed oral surgeons may submit claims for insured surgical-dental work in the NWT. The Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits is used as a guide.

Dentists are unable to participate in the NWT Medical Care Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Not all services provided by hospitals, medical practitioners and dentists are covered under the NWT Health Care Plan. Some uninsured services include:

- › in-vitro fertilization;
- › third party examinations;
- › dental services that are not surgical in nature;
- › medical-legal services;

- › advice or prescriptions done over the phone;
- › services rendered to the physician's family; and,
- › services carried out by people who usually are not medical practitioners such as osteopaths, naturopaths and chiropractors. Physiotherapy, psychiatry and psychological therapies are not covered if delivered in a non-approved location.

Prior approval is required for NWT residents to receive items, services, or both, that are generally considered uninsured under the NWT Health Care Plan. A Medical Advisor makes recommendations to the Director of Medical Insurance regarding the appropriateness of the request.

The Workers' Safety and Compensation Committee has several policies that are applied when interpreting workers' compensation acts. These policies are available on the [Workers' Safety and Compensation Commission site](#).

Changes to the list of uninsured hospital, physician, and surgical-dental services may be made by the Minister.



3.0 UNIVERSALITY

3.1 Eligibility

The *Medical Care Act* and the *Hospital Insurance and Health and Social Services Administration Act* define eligibility for the Northwest Territories (NWT) Health Care Plan. The NWT uses guidelines that are consistent with the legislation and Interprovincial Agreement on Eligibility and Portability to determine eligibility in order to fulfill obligations of section 10 in the *Canada Health Act*.

Every resident is, on the first day of the third month after becoming a resident, eligible for and entitled to payment of benefits in respect of insured services rendered to the resident in accordance with the *Medical Care Act* and Regulations.

According to the *Medical Care Act*, a resident is a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the NWT, but does not include a tourist, transient, or visitor to the NWT.

In order to register for the NWT Health Care Plan, residents fill out an application form and provide relevant supporting documentation (e.g., visa, immigration papers, and proof of residency). Residents may register prior to the date they become eligible. Registration is directly linked to eligibility for coverage and claims are only paid if the client has registered.

Coverage begins when a signed application has been approved.

Residents can opt out of the NWT Health Care Plan if they choose not to register. There is nothing in the *Medical Care Act* that requires a resident to register for the NWT Health Care Plan.

Individuals ineligible for NWT health care coverage are members of the Canadian Forces, federal inmates, and new residents who have not completed the minimum waiting period. For persons moving back to Canada, eligibility is restored when permanent residency is established.

If an application for an NWT Health Care Card is denied, coverage is denied for a procedure, or if a person is appealing the decision to cancel their NWT Health Care Card, individuals may appeal to the Director of Medical Insurance. Second level and final appeals may be directed to the Deputy Minister of Health and Social Services.

As of March 31, 2019, there were 43,324 individuals registered with the NWT Health Care Plan.

3.2 Other Categories of Individuals

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and guidelines for NWT Health Care Plan coverage.

Babies born to NWT residents outside of Canada are automatically covered effective on the date of birth, if:

- › At least one parent is a Canadian citizen; and
- › The parent(s) has:
 - › approved temporary absence coverage under NWT Health Care Plan; and
 - › an intended date of return to the NWT.

Foreign students and workers are eligible for coverage if they hold study or work permits valid for a period of 12 months or longer. Those holding permits of less than 12 months are not eligible for coverage.

Permanent residents (landed immigrants) and returning permanent residents are covered on the first day of arrival in the NWT provided the NWT is their first place of residence in Canada, and they intend to reside in the NWT.

Convention refugees are covered, provided they provide appropriate documentation.

The following are not eligible for an NWT Health Care Card as they are not considered residents:

- › tourists;
- › visitors;
- › transients;
- › remand clients from other jurisdictions;
- › Canadian students, who are not NWT residents, attending an educational institution in the NWT (unless the student intends to establish a permanent residence in the NWT). Permanent residence does not include student housing or living on campus;
- › A person who works in the NWT but does not intend to maintain a permanent residence (over 12 months) in the NWT (s.7, Interprovincial Agreement on Eligibility and Portability of Hospital and Medical Care Insurance);

- › Temporary Resident Permit (TRP) holders (TRPs are issued by the federal Immigration Minister and are issued to individuals who, for some reason, do not meet the immigration requirements but are admitted to Canada for compassionate or humanitarian reasons. The duration of the TRP varies but they can be issued for up to three years); and
- › individuals without valid documentation from Immigration, Refugees, and Citizenship Canada.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Waiting periods for persons moving to the Northwest Territories (NWT) are consistent with the Interprovincial Agreement on Eligibility and Portability. The waiting period ends the first day of the third month of residency for those moving permanently to the NWT.

4.2 Coverage during Temporary Absences in Canada

Section 4(2) of the *Medical Care Act* provides NWT residents with access to insured health coverage while temporarily out of the NWT but still in Canada, consistent with section 11(1) (b)(i) of the *Canada Health Act*. The Department of Health and Social Services (DHSS) adheres to the Interprovincial Agreement on Eligibility and Portability as described in the NWT Health Care Plan Registration Manual.

Once an individual has filled out the Temporary Absence Form and it is approved by DHSS, NWT residents are covered for up to one year of temporary absence for work, travel or holidays. Full-time students attending post-secondary school are covered as well. The full cost of insured services is paid for all services received in other Canadian jurisdictions.

When a valid NWT Health Care Card is produced, most doctor visits and hospital services are billed directly to DHSS. During the reporting period, approximately \$33.0 million were paid out for hospital inpatient and out-patient services in other provinces and territories. Reimbursement guidelines exist for patients having to pay up front for medically necessary services.

The NWT participates in both the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement with other jurisdictions (except Quebec).

4.3 Coverage during Temporary Absences Outside Canada

As per section 4(3) of the *Medical Care Act* and section 11(1)(b) (ii) of the *Canada Health Act*, the NWT provides reimbursement for NWT residents who require medically necessary services while temporarily outside Canada. Individuals are required to pay up front and seek reimbursement upon their return to the NWT. Costs for eligible services, including in-patient services, out-patient services, and haemodialysis rendered outside Canada, will be reimbursed up to the amounts payable in the NWT. Residents temporarily out of Canada may receive coverage for up to one year; however, prior approval as well as documentation proving the NWT will be the individual's permanent residence upon return is required.

4.4 Prior Approval Requirement

Prior approval is required for elective services rendered in other provinces and outside Canada. All services from private facilities require prior approval as well.

First level appeals of decisions may be sent to the Director of Medical Insurance. Second level appeals are considered by the Deputy Minister of Health and Social Services. The decision of the Deputy Minister is final.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

The Government of the Northwest Territories (NWT) Medical Travel Policy provides NWT residents with assistance to access medically necessary insured services not available in their home community or in the NWT, consistent with section 12(1)(a) of the *Canada Health Act*.

Diagnostic Imaging/Picture Archiving Communication System (DI/PACS) is available everywhere that digital imaging services are offered. DI/PACS has moved x-rays from film to digital format. Radiologists in Yellowknife and the south can review results in as fast as 35 minutes. This ultimately provides NWT residents with access to specialists in southern Canada without having to spend extended periods of time away from home and family.

Extra-billing is not permitted in the NWT, in adherence to section 18 of the *Canada Health Act* and section 14(1) of the *Medical Care Act*. The only exception is if a medical practitioner opts out of the NWT Medical Care Plan and collects his or her own fees. This did not occur during the 2018–2019 reporting period.

User charges are also not permitted under section 14(2) of the *Medical Care Act* unless the medical practitioner has opted-out of the NWT Medical Care Plan, collects his or her own fees, and gives reasonable notice of the intention to collect fees.

The *Medical Care Act* includes a provision to allow the Minister of Health and Social Services (the Minister) to establish a Benefits Appeal Committee that could address any matter referred to it by the Minister, including complaints where a physician engaged in extra-billing and charged user fees. At present, there has been no need to establish this committee, because almost all physicians are compensated through contractual agreements with the Government of the NWT.

Complaints of extra-billing or user charges can be made to:

The Health Services Administration Office, Health and Social Services
Bag#9
Inuvik, NT X0E 0T0
by phone at: 1-800-661-0830 or 1-867-777-7400
or by Fax at: 1-867-777-3197

5.2 Physician Compensation

The Department of Health and Social Services (DHSS), in close consultation with the NWT Medical Association, sets physician compensation. Generally, family and specialist practitioners are compensated through contractual agreements with the Government of NWT, while the remaining practitioners are compensated on a fee-for-service basis. Fee-for-service rates in the NWT are itemized in the Insured Services Tariff approved by the Minister in accordance with the *Medical Care Act*.

Under the *Medical Care Act*, the Minister may appoint medical and financial inspectors who shall, under the direction of the Director, inspect, examine, and audit books, accounts, reports, and medical records maintained in hospitals, health facilities, offices of medical practitioners, and other health care facilities respecting patients who are receiving or who have received insured services. The Director may reassess an account for insured services submitted by a medical practitioner and make any appropriate adjustment in the amount paid to the medical practitioner in respect of the insured services.

Although physicians may charge for uninsured services in accordance with the Service Fee Policy, there is no ability to charge block fees.

5.3 Payments to Hospitals

Contribution agreements between DHSS and the Boards of Management dictate payments made to hospitals. Government budgets, resources, and levels of services offered determine the allocated amounts.

Payments for the provision of insured hospital services are governed under the *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act*. A comprehensive budget is used to fund hospitals in the NWT.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Federal funding from the Canada Health Transfer has been recognized and reported by the Government of the Northwest Territories (GNWT) through the follow documents:

- › GNWT, *Public Accounts 2017–2018* (published November 1, 2018);
- › the GNWT, *Annual Business Plan, 2019–2020* (published February 2019); and
- › the GNWT, *Main Estimates, 2019–2020* (published February 6, 2019).

The Public Accounts contain the consolidated financial statements of the GNWT, audited by the Auditor General of Canada, and is presented annually to the Legislative Assembly. The Main Estimates and the Business Plan are also presented annually to the Legislative Assembly.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st	43,436	43,430	42,780	43,632	43,324

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

YEAR	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	23	23	23	23	23
3. Payments for insured health services (\$)¹	70,018,260	70,285,154	70,921,707	71,862,145	74,777,564

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)	not applicable	not applicable	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	1,200	1,316	1,278	1,290	1,373
7. Total payments, in-patient (\$)	19,034,152	21,899,702	22,181,729	19,457,472	25,586,216
8. Total number of claims, out-patient	12,108	12,641	13,444	13,902	15,277
9. Total payments, out-patient (\$)	4,593,956	4,804,337	5,684,108	6,272,018	7,422,506

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not available	not available	not available	not available	0
11. Total payments in-patient (\$)	not available	not available	not available	not available	0
12. Total number of claims out-patient	not available	not available	not available	not available	1
13. Total payments out-patient (\$)	not available	not available	not available	not available	320

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	5	14	9	13	7
15. Total payments in-patient (\$)	14,800	216,539	97,456	316,373	23,085
16. Total number of claims out-patient	32	45	44	31	38
17. Total payments out-patient (\$)	37,896	39,388	52,643	19,719	16,573

All data are subject to future revisions.

¹ Payments for insured health services are estimated and include only those health services occurring within acute care facilities (i.e. hospitals that offer both in-patient and outpatient services).

² Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years. Prior to 2018–2019 all out-of-country claims are included in the non pre-approved category.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians ³	330	326	350	359	370
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$) ⁴	53,392,587	53,732,241	55,291,472	56,505,139	57,404,503
22. Total payments for services provided by physicians paid through fee-for-service (\$)	1,545,414	1,635,526	1,259,330	1,201,976	1,182,996

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	48,995	54,333	62,078	62,035	62,222
24. Total payments (\$)	5,579,633	6,434,942	6,944,788	6,943,660	7,055,181

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not available	not available	not available	not available	1
26. Total payments (\$)	not available	not available	not available	not available	2,603

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	73	195	101	119	69
28. Total payments (\$)	5,208	171,104	7,471	18,668	6,377

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	not available	not available	not available	not available	not available
30. Number of opted-out dentists ⁵	not applicable	not applicable	not applicable	not applicable	not applicable
31. Number of non-participating dentists ⁵	not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of services provided	not available	not available	not available	not available	not available
33. Total payments (\$)	not available	not available	not available	not available	not available

³ Estimate based on total active physicians for each fiscal year.

⁴ Payments are based on an estimate of expenditures for physician services on NWT residents (including physician remuneration and clinic costs).

⁵ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

NUNAVUT



The Department of Health (the Department) faces many unique challenges when providing for the health and well-being of Nunavummiut. Of a total population of 38,824¹ approximately one third of the population is under the age of 15 years (11,921 people). The territory is made up of 25 communities located across three time zones and divided into three regions: the Qikiqtani (or Baffin), the Kivalliq and the Kitikmeot.

The Government of Nunavut incorporates Inuit Societal Values into program and policy development, as well as into service design and delivery. The delivery of health services in Nunavut is based on a primary health care model. Nunavut's primary health care providers are family physicians, nurse practitioners, midwives, community health nurses, and other allied health professionals.

In 2018–2019, the territorial operations and maintenance budget for the Department was \$442,065,000 including supplementary appropriations². One third of the Department's total operational budget was spent on costs associated with medical travel and treatment provided in out-of-territory facilities. Nunavut is a vast territory with a low population density and limited health infrastructure, therefore, access to a range of hospital and specialist services often requires that residents be sent out of the territory for care.

In 2018–2019, a total of \$21,500,000 was allocated to the Department for capital projects³. The Department's 2018–2019 capital projects include: the start of construction for the new Sanikiluaq Community Health Centre and the commencement of a detailed design for the new Cape Dorset Community Health Centre.



1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Health Care Insurance Plans of Nunavut, including physician and hospital services, are administered by the Department of Health (the Department) on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act, 1999*) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act, 1999*) enables the establishment of hospital and other health services.

¹ Nunavut Bureau of Statistics, *Nunavut Population Estimates by Sex, Age Group, Region and Community 2017*. Population estimates are based on the 2011 census counts adjusted for net census under coverage. Nunavut totals include unorganized areas and outpost camps.

² Department of Health, Division of Finance Freebalance Report

³ 2018–2019 Capital Estimates, Part 1 & 2, Government of Nunavut

The Department is responsible for delivering health care services to Nunavummiut, including the operation of community health centres, regional health centres, and a hospital. There are three regional offices that manage the delivery of health services at a regional level. Iqaluit operations are administered separately. The Government of Nunavut opted for decentralization to regional offices to support front-line workers and community based delivery of a wide range of health programs and services.

1.2 Reporting Relationship

Legislation governing the administration of health services in Nunavut was carried over from the Northwest Territories (as Nunavut statutes) pursuant to the *Nunavut Act*. The *Medical Care Act* governs who is covered by the Nunavut Health Care Plan and the payment of benefits for insured medical services. Section 23(1) of the *Medical Care Act* requires the Minister responsible for the Act to appoint a Director of Medical Insurance.

The Director is responsible for the administration of the Act and Regulations. Section 24 requires the Director to submit an annual report on the operation of the Nunavut Health Care Plan to the Minister for tabling in the Legislative Assembly. The 2017-2018 Annual Report on the Operation of the Medical Care Plan from the Director of Medical Insurance was submitted and is available on the Department's website.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General is required to conduct an annual audit of the consolidated financial statements of the Government of Nunavut. The most recent audit of the Government of Nunavut's public accounts was completed on October 25, 2018, for the fiscal year 2017–2018.



2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act and Regulations*, sections 2 to 4. No amendments were made to the Act or Regulations in 2018–2019.

In 2018–2019, insured hospital services were delivered in 28 facilities across Nunavut including:

- › one general hospital (Iqaluit);
- › two regional health facilities (Rankin Inlet and Cambridge Bay);
- › 22 community health centres;
- › two public health facilities (Iqaluit and Rankin Inlet); and
- › one family practice clinic (Iqaluit). Rehabilitative treatment is available through the Timimut Ikajuksivik Centre located at Qikiqtani General Hospital (QGH) or via contracted services in other regions.

The QGH is currently the only acute care facility in Nunavut, accredited by Accreditation Canada, providing a range of in-and out-patient hospital services as defined by the *Canada Health Act*. QGH offers 24-hour emergency services, in-patient care (including obstetrics, pediatrics and palliative care), surgical services, laboratory services, diagnostic imaging, respiratory therapy, and health information management services.

Currently, Rankin Inlet is providing 24-hour care for in-patients; out-patients receive care by on-call staff. Cambridge Bay is providing daily clinic hours, and emergency care is available, on-call, 24-hours a day. There are also a limited number of birthing beds at both facilities. Other community health centres provide public health services, out-patient services and urgent treatment services.

Public health services are provided at public health clinics located in Rankin Inlet and Iqaluit. Public health programming is provided in the remaining communities through the local health centre. The Department of Health (the Department) also operates a Family Practice Clinic in Iqaluit. This clinic operates as part of the primary care program at QGH.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities in the territory.

Insured in-patient hospital services include:

- › accommodation and meals at the standard ward level;
- › necessary nursing services;
- › laboratory, radiological and other diagnostic procedures, together with the necessary interpretations;
- › drugs, biological and related preparations prescribed by a physician and administered in hospital;
- › routine surgical supplies;
- › use of operating room, case-room and anaesthetic facilities;
- › use of radiotherapy and physiotherapy services where available;
- › psychiatric services provided under an approved program; and
- › services rendered by persons who are paid by the hospital.

Out-patient services include:

- › laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital;
- › hospital services in connection with most minor medical and surgical procedures;
- › physiotherapy, occupational therapy, limited audiology and speech therapy services in an out-patient facility or in an approved hospital; and
- › psychiatric services provided under an approved hospital program.

The Department makes the determination to add insured hospital services based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Financial Management Board. No new services were added in 2018–2019 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1), and *Medical Care Regulations*, section 3, provide for insured physician services in Nunavut. No amendments were made to the Act or Regulation in 2018–2019. The *Nursing Act* allows for licensure of nurse practitioners in Nunavut; this permits nurses to deliver insured services in Nunavut.

Upon initial registration physicians must be in good standing with a College of Physicians and Surgeons from a Canadian jurisdiction, and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. Nunavut recruits and contracts its own family physicians, and accesses specialist services primarily from its main referral centres in Ottawa, Edmonton, Winnipeg, and Yellowknife. Recruitment of full-time family physicians has improved significantly and there are 26 family physician positions, covered by a combination of locums and full-time physicians, funded through the Department, providing over 7,559 days of service annually across the territory.

Of the 26 full-time family physician positions in Nunavut, 16 are in the Qikiqtaaluk region; 7.5 in the Kivalliq region; and 2.5 in the Kitikmeot region. There are also 1.5 general surgeon positions, one anaesthetist position, and 4 pediatrician positions at the QGH. Visiting specialists, general practitioners, and locums also provide insured physician services; these arrangements are made by each of the Department's three regions.

Physicians can elect to collect fees other than those under the Medical Care Plan in accordance with section 12(2) (a) or (b) of the *Medical Care Act* by notifying the Director of Medical Insurance (the Director) in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2018–2019, no physicians provided written notice of this election. All physicians practicing in Nunavut are under contract with the Department. In 2018–2019, 139 physicians provided service in Nunavut.

Insured physician services refer to all services rendered by medical practitioners that are medically required. Where insured services are unavailable in some places in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has health service agreements with medical and treatment centres in Ottawa, Winnipeg, Churchill, Yellowknife and Edmonton. These are the out-of-territory sites to which Nunavut mainly refers its patients to access medical services not available within the territory.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service. Then the decision of the group would be presented to Cabinet for approval. No insured physician services were added or removed in 2018–2019.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Nunavut Health Care Plan must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999). Billing numbers are provided for billing the Plan regarding the provision of insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance; for example, orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis, but on rare occasions, for medically complicated situations, patients are flown out of the territory.

The addition of new surgical-dental services to the list of insured services requires government approval. No new services were added to the list in 2018–2019.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include:

- › yearly physicals;
- › cosmetic surgery;
- › services that are considered experimental;
- › prescription drugs;
- › physical examinations done at the request of a third party;
- › optometric services;
- › dental services other than specific procedures related to jaw injury or disease;
- › the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and
- › physiotherapy, speech therapy and psychology services received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include:

- › hospital charges above the standard ward rate for private or semi-private accommodation;
- › services that are not medically required, such as cosmetic surgery;
- › services that are considered experimental;
- › ambulance charges (except inter-hospital transfers);
- › dental services, other than specific procedures related to jaw injury or disease; and
- › alcohol and drug rehabilitation, without prior approval.

In 2018–2019, the Qikiqtani General Hospital charged a \$2,638 per diem rate for services provided for non-Canadian resident stays. The in-patient rate charged in Rankin Inlet and Cambridge Bay was \$1,482 per day.

When residents are sent out of the territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see section 4.2 below). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program, on behalf of Indigenous Services Canada, for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton, Yellowknife and Iqaluit), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.



3.0 UNIVERSALITY

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under sections 3(1), (2), and (3) of the *Medical Care Act*. The Department of Health (the Department) also adheres to the Interprovincial Agreement on Eligibility and Portability, as well as internal guidelines. No amendments were made to the Act or Regulations in 2018–2019.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be in or to remain in Canada, who makes his or her home and is ordinarily present in Nunavut, but does not include a tourist, transient or visitor to Nunavut. Eligible residents receive a health card with a unique health care number.

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. To streamline document processing, a staggered renewal process is used. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province or territory is required.

Coverage generally begins the first day of the third month after arrival in Nunavut, but first-day coverage is provided under a number of circumstances, for example, newborns whose mothers or fathers are eligible for coverage. Permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents, and non-Canadians who have been issued an employment visa for a period of 12 months or more, are also granted first-day coverage.

Members of the Canadian Armed Forces and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Interprovincial Agreement on Eligibility and Portability, individuals in Nunavut who are temporarily absent from their home province or territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

On March 31, 2019, 38,824 individuals were registered with the Nunavut Health Care Plan, down by 469 from the previous year. There are no formal provisions for Nunavut residents to opt out of the Nunavut Health Care Plan, and no legislated appeals process or policy related to appeals of residency or coverage decisions.

3.2 Other Categories of Individuals

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers, and individuals holding a Minister's Permit (with the possible exception of those holding a temporary resident permit who may be reviewed on a case by case basis) are not eligible for coverage. When unique circumstances occur, assessments are done on an individual basis. This is consistent with section 15 of the Northwest Territories' Guidelines for Health Care Plan Registration, which was adopted by Nunavut in 1999.



4.0 PORTABILITY

4.1 Minimum Waiting Period

Consistent with section 3 of the Interprovincial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months, or the first day of the third month following the establishment of residency in a new province or territory, or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 Coverage during Temporary Absences in Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut, but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister of Health to enter into agreements with other jurisdictions to provide health services to Nunavut residents, and the terms and conditions of payment. No legislative or regulatory changes were made in 2018–2019 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department of Health (the Department) and provide proof of enrollment to ensure continuing coverage. Requests for extensions must be renewed yearly and are subject to approval by the Director of Medical Insurance (the Director). Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months upon receiving a written request from the insured individual.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability. Nunavut participates in physician and hospital reciprocal billing. As well, special bilateral agreements are in place with Ontario, Manitoba, Alberta, and the Northwest Territories. The Hospital Reciprocal Billing Agreements provide payment of in-patient and out-patient hospital services to eligible Nunavut residents receiving insured services outside the territory. High-cost procedure rates, newborn rates, and out-patient rates are based on those established by the Interprovincial Health Insurance Agreements Coordinating Committee. The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage during Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or emergency services, the payment for hospital services is \$2,638 per day and for out-patient care it is \$359 per day.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the territory. Reimbursement is made to the insured individual or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required to receive reimbursement for elective services provided in private facilities in Canada or in any facility outside the country. There are no processes related to pre-approval appeals for out-of-jurisdiction coverage.



5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services in Inuktitut are also provided to patients. The Department of Health (the Department) does not have a specific complaints office solely for extra-billing. However, the Department has other mechanisms for Nunavummiut to register concerns regarding their health care service and can be reached at:

NHIP@gov.nu.ca

Nunavut Health Insurance Programs Office
 Department of Health
 Box 889
 Rankin Inlet, NU X0C 0G0
 Toll Free: (800) 661-0833

The Qikiqtani General Hospital, a site of Iqaluit Health Services is currently the only acute care hospital facility in Nunavut. The hospital has a total of 20 beds available for acute, medical, surgical, pediatric, rehabilitative, palliative and chronic care services. There are also four birthing rooms and four day surgery beds. The facility provides in-patient, out-patient and 24-hour emergency services. On-site physicians provide emergency services on rotation. Medical services provided include: an ambulatory care/out-patient clinic emergency stabilization services, pediatric services, and general medical, maternity and palliative care. Surgical services provided include ophthalmology, urology, orthopedics, gynaecology, pediatrics, general surgery, emergency trauma, otolaryngology and dental surgery under general anaesthesia and conscious sedation. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include: radiology, laboratory, electrocardiogram and CT scans.

Outside of Iqaluit, out-patient and 24-hour emergency nursing services are provided by local health centres in Nunavut's 24 other communities.

Nunavut has three continuing care centres located in Gjoa Haven, Igloolik and Cambridge Bay. These facilities provide full time nursing and personal care to adults. The Gjoa Haven and Igloolik facilities have 10 beds each, and the Cambridge Bay facility has 8 beds.

Nunavut has agreements in place with a number of out-of-territory regional health authorities and specific facilities to provide medical specialists and other visiting health practitioner services. The following specialist services were provided in Nunavut during 2018–2019 under the visiting specialists program: ophthalmology, orthopedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, pediatrics, obstetrics/gynecology, urology, respirology, cardiology, total joint assessment clinic (TJAC), sleep study, oral surgery, and allergist. Visiting specialist clinics are scheduled in advance, and are offered on specific weeks throughout the year.

Nunavut's Telehealth network, linking all 25 communities, allows for the delivery of a broad range of services over distances including specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counseling sessions; family visitation; and continuing medical education. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options, and allowing service providers and communities to use existing resources more effectively.

For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions.

5.2 Physician Compensation

All full-time physicians in Nunavut work under contract with the Department. The terms of the contracts are set by the Department. Visiting consultants are paid a daily contract rate for their professional services. Rates vary based on services rendered. The Department complies with the *Financial Administration Act* and Financial Administration Manual in monitoring or auditing remuneration.

5.3 Payments to Hospitals

Funding for the Qikiqtani General Hospital, regional health facilities and community health centres is provided through the Government of Nunavut's budget process.



6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Nunavummiut are aware of ongoing federal contributions through press releases and media coverage. The Government of Nunavut has also recognized the federal contribution provided through the Canada Health Transfer in various published documents. For fiscal year 2018–2019, they included the 2018–2019 Fiscal and Economic Indicators and the 2018–2021 Government of Nunavut & Territorial Corporations Business Plan.

REGISTERED PERSONS

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
1. Number as of March 31st ¹	36,667	37,764	38,662	39,293	38,824

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

YEAR	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
2. Number	28	28	28	28	28
3. Payments for insured health services (\$) ¹	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
4. Number of private for-profit facilities providing insured health services	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services (\$)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
6. Total number of claims, in-patient	3,440	3,324	3,616	3,791	3,976
7. Total payments, in-patient (\$)	36,005,461	38,830,531	40,804,893	44,156,008	44,160,583
8. Total number of claims, out-patient	27,137	24,853	26,790	27,480	26,493
9. Total payments, out-patient (\$)	9,971,833	9,638,408	11,369,138	12,178,482	12,337,509

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA²

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
10. Total number of claims in-patient	not available	not available	not available	not available	not available
11. Total payments in-patient (\$)	not available	not available	not available	not available	not available
12. Total number of claims out-patient	not available	not available	not available	not available	not available
13. Total payments out-patient (\$)	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
14. Total number of claims in-patient	not available	not available	not available	not available	not available
15. Total payments in-patient (\$)	not available	not available	not available	not available	not available
16. Total number of claims out-patient	not available	not available	not available	not available	not available
17. Total payments out-patient (\$)	not available	not available	not available	not available	not available

¹ The difference in the number of registered Nunavut residents and those covered under the Nunavut Health Care Plan is due to delays in the reconciliation of data on residents who have left the territory.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
18. Number of participating physicians	289	278	155	139	137
19. Number of opted-out physicians	0	0	0	0	0
20. Number of non-participating physicians	0	0	0	0	0
21. Total payments for services provided by physicians paid through all payment methods (\$)	not available	not available	not available	not available	not available
22. Total payments for services provided by physicians paid through fee-for-service (\$)²	54,501	152,815	502,572	565,111	574,179³

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
23. Number of services	96,070	93,365	99,539	107,416	121,456
24. Total payments (\$)	7,607,809	8,088,273	8,694,011	9,162,104	9,899,822⁴

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA⁵

PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
25. Number of services	not available	not available	not available	not available	not available
26. Total payments (\$)	not available	not available	not available	not available	not available

NON PRE-APPROVED

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
27. Number of services	not available	not available	not available	not available	7
28. Total payments (\$)	not available	not available	not available	not available	530

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019
29. Number of participating dentists	not available	not available	not available	not available	not available
30. Number of opted-out dentists⁶	not available	not available	not available	not available	not available
31. Number of non-participating dentists⁶	not available	not available	not available	not available	not available
32. Number of services provided	not available	not available	not available	not available	not available
33. Total payments (\$)	not available	not available	not available	not available	not available

² Typically, Nunavut does not pay its physicians through fee-for-service. Instead, the majority of physicians are compensated through contracted salaries.

³ For 2018–2019 this is the amount for the period April 1, 2018 to March 31, 2019.

⁴ For 2018–2019 this is the amount as of August 2019. Bills are accepted until March 2020.

⁵ Health Canada requested this information be disaggregated into pre-approved and non pre-approved data as of the 2018–2019 report, but did not require provinces or territories to report on previous years.

⁶ Health Canada requested this data as of the 2016–2017 report, but did not require provinces or territories to report on previous years.

ANNEX A

CANADA HEALTH ACT AND EXTRA-BILLING AND USER CHARGES INFORMATION REGULATIONS

This annex provides the reader with an office consolidation of the *Canada Health Act* and the *Extra-billing and User Charges Information Regulations*. An office consolidation is a rendering of the original Act, which includes any amendments that have been made since the Act's passage. The only regulations in force under the Act are the *Extra-billing and User Charges Information Regulations*. These Regulations require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with any estimated charges can be made. These Regulations are also presented in an office consolidation format. This unofficial consolidation is not necessarily current and is provided for the convenience of the reader only. For the official text of the *Canada Health Act*, please contact Justice Canada.



CANADA

CONSOLIDATION

CODIFICATION

Canada Health Act

Loi canadienne sur la santé

R.S.C., 1985, c. C-6

L.R.C. (1985), ch. C-6

Current to December 22, 2019

À jour au 22 décembre 2019

Last amended on December 12, 2017

Dernière modification le 12 décembre 2017

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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (2) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence

31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

Inconsistencies in Acts

(2) In the event of an inconsistency between a consolidated statute published by the Minister under this Act and the original statute or a subsequent amendment as certified by the Clerk of the Parliaments under the *Publication of Statutes Act*, the original statute or amendment prevails to the extent of the inconsistency.

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (2) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1^{er} juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve

31 (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

Incompatibilité — lois

(2) Les dispositions de la loi d'origine avec ses modifications subséquentes par le greffier des Parlements en vertu de la *Loi sur la publication des lois* l'emportent sur les dispositions incompatibles de la loi codifiée publiée par le ministre en vertu de la présente loi.

LAYOUT

The notes that appeared in the left or right margins are now in boldface text directly above the provisions to which they relate. They form no part of the enactment, but are inserted for convenience of reference only.

MISE EN PAGE

Les notes apparaissant auparavant dans les marges de droite ou de gauche se retrouvent maintenant en caractères gras juste au-dessus de la disposition à laquelle elles se rattachent. Elles ne font pas partie du texte, n'y figurant qu'à titre de repère ou d'information.

NOTE

This consolidation is current to December 22, 2019. The last amendments came into force on December 12, 2017. Any amendments that were not in force as of December 22, 2019 are set out at the end of this document under the heading "Amendments Not in Force".

NOTE

Cette codification est à jour au 22 décembre 2019. Les dernières modifications sont entrées en vigueur le 12 décembre 2017. Toutes modifications qui n'étaient pas en vigueur au 22 décembre 2019 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

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R.S.C., 1985, c. C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

WHEREAS the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services

L.R.C., 1985, ch. C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

Short Title

Short title

1 This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

Interpretation

Definitions

2 In this Act,

Act of 1977 [Repealed, 1995, c. 17, s. 34]

cash contribution means the cash contribution in respect of the Canada Health Transfer that may be provided to a province under sections 24.2 and 24.21 of the *Federal-Provincial Fiscal Arrangements Act*; (*contribution pécuniaire*)

contribution [Repealed, 1995, c. 17, s. 34]

dentist means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person; (*dentiste*)

extended health care services means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

- (a) nursing home intermediate care service,
- (b) adult residential care service,
- (c) home care service, and
- (d) ambulatory health care service; (*services complémentaires de santé*)

extra-billing means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province; (*surfacturation*)

health care insurance plan means, in relation to a province, a plan or plans established by the law of the

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

Titre abrégé

Titre abrégé

1 *Loi canadienne sur la santé*.

1984, ch. 6, art. 1.

Définitions

Définitions

2 Les définitions qui suivent s'appliquent à la présente loi.

assuré Habitant d'une province, à l'exception :

- a) des membres des Forces canadiennes;
- b) [Abrogé, 2012, ch. 19, art. 377]
- c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*;
- d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés. (*insured person*)

contribution [Abrogée, 1995, ch. 17, art. 34]

contribution pécuniaire La contribution au titre du Transfert canadien en matière de santé qui peut être versée à une province au titre des articles 24.2 et 24.21 de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*. (*cash contribution*)

dentiste Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice. (*dentist*)

frais modérateurs Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement

province to provide for insured health services; (*régime d'assurance-santé*)

health care practitioner means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person; (*professionnel de la santé*)

hospital includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

- (a) a hospital or institution primarily for the mentally disordered, or
- (b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children; (*hôpital*)

hospital services means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

- (a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,
- (b) nursing service,
- (c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,
- (d) drugs, biologicals and related preparations when administered in the hospital,
- (e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
- (f) medical and surgical equipment and supplies,
- (g) use of radiotherapy facilities,
- (h) use of physiotherapy facilities, and
- (i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations; (*services hospitaliers*)

insured health services means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any

soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation. (*user charge*)

habitant Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province. (*resident*)

hôpital Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

- a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;
- b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants. (*hospital*)

loi de 1977 [Abrogée, 1995, ch. 17, art. 34]

médecin Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice. (*medical practitioner*)

ministre Le ministre de la Santé. (*Minister*)

professionnel de la santé Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit. (*health care practitioner*)

régime d'assurance-santé Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés. (*health care insurance plan*)

services complémentaires de santé Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

- a) les soins intermédiaires en maison de repos;
- b) les soins en établissement pour adultes;
- c) les soins à domicile;
- d) les soins ambulatoires. (*extended health care services*)

Canada Health
Interpretation
Section 2

Santé
Définitions
Article 2

other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation; (*services de santé assurés*)

insured person means, in relation to a province, a resident of the province other than

- (a) a member of the Canadian Forces,
- (b) [Repealed, 2012, c. 19, s. 377]
- (c) a person serving a term of imprisonment in a penitentiary as defined in Part I of the *Corrections and Conditional Release Act*, or
- (d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services; (*assuré*)

medical practitioner means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person; (*médecin*)

Minister means the Minister of Health; (*ministre*)

physician services means any medically required services rendered by medical practitioners; (*services médicaux*)

resident means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province; (*habitant*)

surgical-dental services means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures; (*services de chirurgie dentaire*)

user charge means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing. (*frais modérateurs*)

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11; 2012, c. 19, ss. 377, 407; 2017, c. 26, s. 11(E).

services de chirurgie dentaire Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement. (*surgical-dental services*)

services de santé assurés Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail. (*insured health services*)

services hospitaliers Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

- a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;
- b) les services infirmiers;
- c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;
- d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;
- e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;
- f) le matériel et les fournitures médicaux et chirurgicaux;
- g) l'usage des installations de radiothérapie;
- h) l'usage des installations de physiothérapie;
- i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements. (*hospital services*)

services médicaux Services médicalement nécessaires fournis par un médecin. (*physician services*)

surfacturation Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à

Canadian Health Care Policy

Primary objective of Canadian health care policy

3 It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

Purpose

Purpose of this Act

4 The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

Cash Contribution

Cash contribution

5 Subject to this Act, as part of the Canada Health Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36; 2012, c. 19, s. 408.

6 [Repealed, 1995, c. 17, s. 36]

Program Criteria

Program criteria

7 In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

- (a) public administration;
- (b) comprehensiveness;
- (c) universality;
- (d) portability; and

payer pour la prestation de ce service au titre du régime provincial d'assurance-santé. (*extra-billing*)

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11; 2012, ch. 19, art. 377 et 407; 2017, ch. 26, art. 11(A).

Politique canadienne de la santé

Objectif premier

3 La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

Raison d'être

Raison d'être de la présente loi

4 La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

Contribution pécuniaire

Contribution pécuniaire

5 Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé (ci-après, « Transfert »).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36; 2012, ch. 19, art. 408.

6 [Abrogé, 1995, ch. 17, art. 36]

Conditions d'octroi

Règle générale

7 Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujéti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

- a) la gestion publique;
- b) l'intégralité;
- c) l'universalité;
- d) la transférabilité;

(e) accessibility.

1984, c. 6, s. 7.

Public administration**8 (1)** In order to satisfy the criterion respecting public administration,**(a)** the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;**(b)** the public authority must be responsible to the provincial government for that administration and operation; and**(c)** the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.**Designation of agency permitted****(2)** The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency**(a)** to receive on its behalf any amounts payable under the provincial health care insurance plan; or**(b)** to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness**9** In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality**10** In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the**e) l'accessibilité.**

1984, ch. 6, art. 7.

Gestion publique**8 (1)** La condition de gestion publique suppose que :**a)** le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;**b)** l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;**c)** l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.**Désignation d'un mandataire****(2)** La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :**a)** soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;**b)** soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité**9** La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité**10** La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé

province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11 (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Transférabilité

11 (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoit et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoit et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of *elective insured health services*

(3) For the purpose of subsection (2), ***elective insured health services*** means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12 (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

Définition de *services de santé assurés facultatifs*

(3) Pour l'application du paragraphe (2), ***services de santé assurés facultatifs*** s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibilité

12 (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoit la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoit une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoit le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)c) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa a), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa b), sauf par une loi de la province.

1984, ch. 6, art. 12.

Conditions for Cash Contribution

Conditions

13 In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(b) shall give recognition to the Canada Health Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37; 2012, c. 19, s. 409(E).

Defaults

Referral to Governor in Council

14 (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

Contribution pécuniaire assujettie à des conditions

Obligations de la province

13 Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37; 2012, ch. 19, art. 409(A).

Manquements

Renvoi au gouverneur en conseil

14 (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15 (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

(c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Décret de réduction ou de retenue

15 (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Reimposition of reductions or withholdings

16 In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17 Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

Extra-billing and User Charges

Extra-billing

18 In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19 (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an inpatient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20 (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information

Nouvelle application des réductions ou retenues

16 En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17 Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

Surfacturation et frais modérateurs

Surfacturation

18 Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19 (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20 (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les

provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21 Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1^{er} avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21 Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

Regulations

Regulations

22 (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs (a) to (d) of the definition *extended health care services* in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to the Canada Health Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40; 2012, c. 19, s. 410(E).

Report to Parliament

Annual report by Minister

23 The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance

Règlements

Règlements

22 (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas a) à d) de la définition de *services complémentaires de santé* à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13a) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13b).

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)a) ou b) qu'avec l'accord de chaque province.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)a) s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1^{er} avril 1984.

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)c) ou d) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40; 2012, ch. 19, art. 410(A).

Rapport au Parlement

Rapport annuel du ministre

23 Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les

Canada Health
Report to Parliament
Section 23

plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

Santé
Rapport au Parlement
Article 23

provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.



CANADA

CONSOLIDATION

CODIFICATION

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

Current to December 22, 2019

À jour au 22 décembre 2019

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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (3) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence

31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

...

Inconsistencies in regulations

(3) In the event of an inconsistency between a consolidated regulation published by the Minister under this Act and the original regulation or a subsequent amendment as registered by the Clerk of the Privy Council under the *Statutory Instruments Act*, the original regulation or amendment prevails to the extent of the inconsistency.

LAYOUT

The notes that appeared in the left or right margins are now in boldface text directly above the provisions to which they relate. They form no part of the enactment, but are inserted for convenience of reference only.

NOTE

This consolidation is current to December 22, 2019. Any amendments that were not in force as of December 22, 2019 are set out at the end of this document under the heading “Amendments Not in Force”.

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (3) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1^{er} juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve

31 (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

[...]

Incompatibilité – règlements

(3) Les dispositions du règlement d'origine avec ses modifications subséquentes enregistrées par le greffier du Conseil privé en vertu de la *Loi sur les textes réglementaires* l'emportent sur les dispositions incompatibles du règlement codifié publié par le ministre en vertu de la présente loi.

MISE EN PAGE

Les notes apparaissant auparavant dans les marges de droite ou de gauche se retrouvent maintenant en caractères gras juste au-dessus de la disposition à laquelle elles se rattachent. Elles ne font pas partie du texte, n'y figurant qu'à titre de repère ou d'information.

NOTE

Cette codification est à jour au 22 décembre 2019. Toutes modifications qui n'étaient pas en vigueur au 22 décembre 2019 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

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Regulations Prescribing the Types of Information that the Minister of National Health and Welfare may Require under Paragraph 13(a) of the Canada Health Act in Respect of Extra-Billing and User Charges and the Times at which and the Manner in which such Information shall be Provided by the Government of each Province

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Règlement déterminant les genres de renseignements dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province

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Registration
SOR/86-259 February 27, 1986

CANADA HEALTH ACT

Extra-billing and User Charges Information Regulations

P.C. 1986-499 February 27, 1986

Whereas the Minister of National Health and Welfare has consulted with the Ministers responsible for health care in the provinces respecting proposed *Regulations prescribing the types of information that the Minister may require under paragraph 13(a) of the Canada Health Act in respect of extra-billing and user charges and the times at which and the manner in which such information shall be provided by the government of each province.*

Therefore, Her Excellency the Governor General in Council, on the recommendation of the Minister of National Health and Welfare, pursuant to paragraph 22(1)(c) of the *Canada Health Act*^{*}, is pleased hereby to make the annexed *Regulations prescribing the types of information that the Minister of National Health and Welfare may require under paragraph 13(a) of the Canada Health Act in respect of extra-billing and user charges and the times at which and the manner in which such information shall be provided by the government of each province*, effective April 1, 1986.

Enregistrement
DORS/86-259 Le 27 février 1986

LOI CANADIENNE SUR LA SANTÉ

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

C.P. 1986-499 Le 27 février 1986

Vu que le ministre de la Santé nationale et du Bien-être social a consulté ses homologues chargés de la santé dans les provinces quant au projet de *Règlement déterminant les genres de renseignements sur la surfacturation et les frais modérateurs dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province;*

À ces causes, sur avis conforme du ministre de la Santé nationale et du Bien-être social et en vertu de l'alinéa 22(1)c) de la *Loi canadienne sur la santé*^{*}, il plaît à Son Excellence le Gouverneur général en conseil de prendre, à compter du 1^{er} avril 1986, le *Règlement déterminant les genres de renseignements dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province*, ci-après.

^{*} S.C. 1984, c. 6

^{*} S.C. 1984, ch. 6

Regulations Prescribing the Types of Information that the Minister of National Health and Welfare may Require under Paragraph 13(a) of the Canada Health Act in Respect of Extra-Billing and User Charges and the Times at which and the Manner in which such Information shall be Provided by the Government of each Province

Règlement déterminant les genres de renseignements dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province

Short Title

1 These Regulations may be cited as the *Extra-billing and User Charges Information Regulations*.

Titre abrégé

1 *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.*

Interpretation

2 In these Regulations,

Act means the *Canada Health Act*; (*Loi*)

Minister means the Minister of National Health and Welfare; (*ministre*)

fiscal year means the period beginning on April 1 in one year and ending on March 31 in the following year. (*exercice*)

Définitions

2 Les définitions qui suivent s'appliquent au présent règlement.

exercice La période commençant le 1^{er} avril d'une année et se terminant le 31 mars de l'année suivante. (*fiscal year*)

Loi La *Loi canadienne sur la santé*. (*Act*)

ministre Le ministre de la Santé nationale et du Bien-être social. (*Minister*)

Types of Information

3 For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4 For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to

Genre de renseignements

3 Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4 Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui

*Extra-billing and User Charges Information Regulations*Types of Information
Sections 4-5*Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*
Genre de renseignements
Articles 4-5

provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

- (a)** an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and
- (b)** a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

Times and Manner of Filing Information

5 (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

- (a)** in respect of the estimates referred to in paragraphs 3(a) and 4(a), before April 1 of the fiscal year to which they relate; and
- (b)** in respect of the financial statements referred to in paragraphs 3(b) and 4(b), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(a) and 4(a) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

- a)** une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;
- b)** un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

Communication de renseignements

5 (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

- a)** pour les estimations visées aux alinéas 3a) et 4a), avant le 1^{er} avril de l'exercice visé par ces estimations;
- b)** pour les états financiers visés aux alinéas 3b) et 4b), avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3a) et 4a), avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

ANNEX B

POLICY INTERPRETATION LETTERS

There are three key policy statements that clarify the federal position on the *Canada Health Act*. These statements were made in the form of ministerial letters from former federal Health Ministers to their provincial and territorial counterparts.

[Following is the text of the letter sent on June 18, 1985, to all provincial and territorial Ministers of Health by the Honourable Jake Epp, federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985
OTTAWA, K1A 0K9

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act*. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role—both financial and otherwise—to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

PUBLIC ADMINISTRATION

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

COMPREHENSIVENESS

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

UNIVERSALITY

The intent of the *Canada Health Act* is to ensure that all bonafide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act*.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bonafide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

PORTABILITY

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bonafide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting interprovincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a coordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

REASONABLE ACCESSIBILITY

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

CONDITIONS

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

- (1) to make as few regulations as possible and only if absolutely necessary;
- (2) to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
- (3) to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
- (4) to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

- (1) estimates and statements on extra-billing and user charges;
- (2) an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985–86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on “amounts charged” or “amounts collected”. The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

REGULATIONS

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp
Attachments

[Following is the text of the letter sent on January 6, 1995, to all provincial and territorial Ministers of Health by the federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the

user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of “hospital” set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as “clinics”. As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- › weakened public support for the tax funded and publicly administered system;
- › the diminished ability of governments to control costs once they have shifted from the public to the private sector;

- › the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- › the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system—resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

“we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability.”

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

[Following is the text of the letter sent on August 8, 2018, to all provincial and territorial Ministers of Health by the federal Minister of Health, the Honourable Ginette Petitpas Taylor.]

Dear Minister,

It was a pleasure to see you recently at our Federal/Provincial/Territorial Health Ministers' Meeting in Winnipeg. As I have explained, when I was appointed as federal Health Minister, the Prime Minister tasked me with promoting and defending the *Canada Health Act* and quite specifically with eliminating patient charges for services that should be publicly insured. As you are aware, I have taken this responsibility seriously.

Following our conversations earlier this year, I was pleased to hear that all provinces and territories participated in officials' level discussions convened by Health Canada this Spring. We fine-tuned our approach based on the feedback provided in a series of multi- and bilateral meetings.

The purpose of this letter is to formally advise that I am proceeding with the three *Canada Health Act* initiatives I discussed with you. Taken together, the Diagnostic Services Policy, the Reimbursement Policy, and strengthened reporting, will provide me with tools to effectively administer the Act in the interest of all Canadians.

DIAGNOSTIC SERVICES POLICY

One of the overarching objectives of the *Canada Health Act* is to ensure that Canadians have access to medically necessary care based on their health needs and not their ability or willingness to pay. However, in many jurisdictions patients are charged for medically necessary diagnostic services provided at private clinics. Since the inception of the *Canada Health Act*, the federal position has always been that all medically necessary physician and hospital services—including diagnostic services—must be covered by provincial and territorial health insurance plans.

If an authorized provider has referred a patient for a medically necessary diagnostic test, the status of the procedure as a publicly insured service should not change simply because the service is delivered in a private clinic rather than in a hospital. I do not accept the premise that since some patients are willing to pay for expedited access to medically necessary services, they should be provided with a venue to do so. This practice results in patients jumping the queue twice – first, for the diagnostic service itself and then for any follow-up care that may be required. Simply put, this is not fair and goes against the fundamental principle of Canadian health care—that is, that access should be based on health need, not on the ability or willingness, to pay.

The *Canada Health Act* does not preclude the private delivery of insured services. Many insured health services are provided to Canadians in private clinics and are paid for by the provincial or territorial health insurance plan. As long as there are no patient charges, provinces and territories can provide insured services as they best see fit. However, my clarification of the status of medically necessary diagnostic services through this letter means, in effect, that any charges to patients for these services will be considered to be in contravention of the *Canada Health Act*.

I fully appreciate that it may take time in some jurisdictions to align provincial and territorial systems with the Diagnostic Services Policy. As I indicated in Winnipeg, the policy will not take effect until April 1, 2020 and reporting on any patient charges for diagnostic services will begin in December 2022 (for the fiscal year 2020–21). That would mean, in accordance with the *Canada Health Act*, that any Canada Health Transfer deductions would only be made in March 2023. If, in the interim, a jurisdiction has eliminated patient charges for diagnostic services, that jurisdiction would be eligible for reimbursement of deducted funds through the new Reimbursement Policy.

REIMBURSEMENT POLICY

The *Canada Health Act* was enacted to eliminate the unfair practice of patient charges. The Act is clear—when a province allows patient charges, mandatory deductions to federal transfer payments must be made. During the first three years of the *Canada Health Act*, a provision in the Act allowed deductions to be refunded if the jurisdiction took the necessary steps to eliminate patient charges for services which should be publicly insured. This proved effective, and by 1987, patient charges were eliminated for most hospital and physician services across Canada. However, when this refund provision expired, the incentive structure under the Act went from a positive one, to a purely negative one. I believe this needs to change.

With the aim of emulating the success of the original refund provision, I am introducing a new Reimbursement Policy. Going forward, provinces and territories would be eligible to be reimbursed for deductions taken in respect of patient charges, should they demonstrate they have taken action to remove these barriers to access. The attached document provides details on the scope and application of the Policy. Any deductions made starting from March 2018 will be eligible for reimbursement under this Policy.

STRENGTHENED REPORTING

Finally, in order to ensure that I have the information needed to administer the Act in an even-handed manner and in order to report to Canadians on the state of their publicly funded health care insurance system, reporting from provinces and territories to Health Canada and from Health Canada to Canadians will be strengthened and standardized. Details, which were discussed with your officials this past Spring, will be communicated by my Deputy in the coming weeks. Again, respecting that a new approach cannot be instituted overnight, we will phase in the new reporting measures.

Canadians are rightfully proud of their health care system and have high expectations that their governments will work together to protect their access to it. I am confident these initiatives will help us meet that challenge and will safeguard our universal health care system for future generations.

I have appreciated our discussions to date and look forward to ongoing collaboration.

Yours sincerely,
The Honourable Ginette Petitpas Taylor, P.C., M.P.

REIMBURSEMENT POLICY FOR PROVINCES AND TERRITORIES— SUBJECT TO DEDUCTIONS UNDER THE CANADA HEALTH ACT (the Reimbursement Policy)

Background

A fundamental premise of the Canadian health care system is that Canadians should have access to medically necessary physician and hospital services unimpeded by financial or other barriers. The Canada Health Act (CHA) was enacted in response to a growing concern that access to publicly insured health care services was increasingly undermined by point of service charges to patients.

The CHA established the conditions and criteria provinces must meet in order to qualify for their full cash contribution under the Canada Health Transfer (CHT). The Act also established discretionary and mandatory deductions for violations of the CHA principles and the extra-billing and user chargesFootnote 5 (EBUC) provisions of the Act, respectively. The Minister is required to make dollar-for-dollar deductions to a province's or territory's (PT's) CHT payments when EBUC are permitted. The intent of the CHA with respect to deductions is to encourage compliance with the Act and its objective of ensuring Canadians' access to health care services on uniform terms and conditions and without financial barriers.

At the time the CHA came into force, many jurisdictions had legal frameworks for public health insurance which either explicitly allowed EBUC to be levied on patients, or, by convention, had permitted such fees to become entrenched in their health care systems. In view of these factors, it was acknowledged that it would take time for PTs to align their systems with the values and requirements of the CHA. The Act, therefore, included a provision for the first three years (1984-1987) which, in effect, provided refunds of amounts deducted from federal transfers for EBUC violations once the PT succeeded in eliminating EBUC.

PTs adopted legislation governing their public health insurance systems which mirrored, and in most cases went well beyond, the requirements of the CHA. As a result, over \$244 million was refunded to seven PTs in respect of patient charges levied in the 1984-1987 period. The advent of the CHA, including the refund provision, helped eliminate EBUC for a considerable period of time in most parts of the country and in most care settings.

Time for a New Reimbursement Policy

Despite provisions discouraging or prohibiting EBUC in both federal and PT legislation, there are still instances of patients paying for access to insured health care services in some jurisdictions. As was the case in 1984, these charges put at risk the fundamental value of universal access to health care.

Some jurisdictions have been active in investigating allegations of patient charges, adopting legislative and regulatory measures to deter EBUC, ensuring that patients are reimbursed and that providers or institutions who contravene PT law (and the CHA) are disciplined. These governments are to be commended for their vigilance on behalf of patients.

Given the success of the original refund provision of the CHA in eliminating EBUC, the federal government is implementing a new Reimbursement Policy for Provinces and Territories Subject to Deductions under the Canada Health Act (the Reimbursement Policy). Under this new policy, if a province or territory is subject to a deduction, the federal Minister of Health has the discretion to provide a reimbursement if the PT comes into compliance with the Act by the end of the calendar year.

Current Process

Under the CHA's Extra-billing and User Charges Information Regulations (the Regulations), PTs are obligated to report to Health Canada on EBUC occurring within their jurisdiction. This takes the form of a financial statement submitted each year, by December 16, which describes any EBUC activity occurring in the fiscal year two years previous. If the Minister does not receive a statement, or believes the information was not provided in accordance with the Regulations, the Act obligates the Minister to estimate an amount after consultation with the PT. The CHT payments to the jurisdiction are then reduced by a corresponding amount in March of the following year.

Working Together to Eliminate Patient Charges

The objective of the Reimbursement Policy is to work collaboratively with PTs subject to a CHT deduction to ultimately eliminate these patient charges. When a PT is informed it will be subject to a CHT deduction for EBUC (typically in January/February), the conditions for reimbursement will also be outlined. In instances where the PT has already eliminated patient charges and a sufficient period of time has elapsed to assure Health Canada that the circumstances that led to these charges have been addressed, reimbursement may be made immediately. Where such charges are ongoing, Health Canada will work with PT officials on the elements of an action plan to meet the conditions for reimbursement. Action plans, and PT progress on meeting them, will be published in the Canada Health Act Annual Report.

To be considered for reimbursement, the jurisdiction would need to demonstrate it has followed through on the agreed upon action plan within the specified time period – typically 12 months but no more than two years following the initial deduction. Because the circumstances leading to deductions will vary from province to province, so will the action plans. Nonetheless, it is expected that all action plans will require the PT to submit the following documents to Health Canada in the January following the deduction:

- › A financial statement of any EBUC levied in the jurisdiction since the deduction
- › A report on the steps the jurisdiction has taken to eliminate EBUC, and how these charges have been addressed
- › An attestation as to the completeness and accuracy of the information submitted

Upon review of the jurisdiction's report, if the Minister is satisfied that the elements of the action plan have been fulfilled, the PT would receive a reimbursement. However, if the Minister is not satisfied that the conditions were fulfilled, no reimbursement would occur and the deduction amount would be forfeited. Following an initial deduction and reimbursement cycle, if the Minister remains satisfied that appropriate action has been taken, the Reimbursement Policy would allow for the immediate reimbursement of subsequent CHT deductions.

In order to qualify for continued consideration under the Reimbursement Policy, a PT must also comply with the regular reporting requirements set out in the Regulations and submit an accurate EBUC financial statement to Health Canada in the December following the CHT deduction and commit to doing so on an annual basis going forward.



ANNEX C

DISPUTE AVOIDANCE AND RESOLUTION PROCESS UNDER THE CANADA HEALTH ACT

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government- to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the *Canada Health Act* Dispute Avoidance and Resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's Letter to the Honourable Gary Mar, as well as a fact sheet on the *Canada Health Act* Dispute Avoidance and Resolution Process.

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act*.

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- › collect and share all relevant facts;
- › prepare a fact-finding report;
- › negotiate to resolve the issue in dispute; and
- › prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of \$21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and Health Ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

FACT SHEET: CANADA HEALTH ACT DISPUTE AVOIDANCE AND RESOLUTION PROCESS

SCOPE

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

DISPUTE AVOIDANCE

To avoid and prevent disputes, governments will continue to:

- › participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- › undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

DISPUTE RESOLUTION

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- › collect and share all relevant facts;
- › prepare a fact-finding report;
- › negotiate to resolve the issue in dispute; and
- › prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- › Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who together will select a chairperson.
- › The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- › The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

PUBLIC REPORTING

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

REVIEW

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

ANNEX D

FINANCIAL STATEMENTS OF ACTUAL AMOUNTS OF EXTRA-BILLING AND USER CHARGES FOR THE PERIOD APRIL 1, 2016 TO MARCH 31, 2017

The *Canada Health Act* and the *Extra-billing and User Charges Information Regulations* require provinces/territories to report annually to the federal Minister of Health. This report takes the form of a financial statement of actual amounts of extra-billing and user charges levied in the province/territory for the fiscal year in question, along with an explanation regarding the method used to determine the reported amount as indicated in below.

The information reported in the financial statements may be used to determine amounts deducted from the Canada Health Transfer payments of a province/territory where extra-billing and user charges are occurring. However, pursuant to Section 20 of the Act, the federal Minister of Health may estimate amounts of extra-billing and user charges levied, if there is evidence that the information reported in the financial statement does not accurately reflect amounts actually charged to patients in the province or territory.

Under the Act, **extra-billing** is defined as a charge by a physician or dentist to an insured person for an insured health service in addition to the amount normally paid by the provincial/territorial health insurance plan.

Under the Act, a **user charge** is defined as any charge for an insured health service, other than extra-billing. A facility fee is a patient charge levied for non-physician related services provided in conjunction with an insured physician service at a non-hospital facility (e.g., clinic).

While Quebec did not submit a financial statement in the standard form provided, amounts of extra-billing and user charges levied in the province during 2017–2018 were confirmed in the form of two letters, which are reproduced in this annex.

- › N.B. Charges may be levied for accommodation and meal costs related to a patient who, in the opinion of the attending physician, is a permanent resident in a hospital or other chronic care institution as per the limitation of Section 19 (2). Charges related to this limitation should not be included in the financial statement.

NEWFOUNDLAND AND LABRADOR

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

EBUC was discovered through patient complaints regarding cataract surgery to the provincial. Department of Health and Community Services (DHCS). Following these complaints, the DHCS issued a Public Service Announcement in an effort to identify beneficiaries in the province that felt they had been billed inappropriately for insured cataract surgery.

The DHCS regularly audits providers. No such instances of EBUC have been identified in this manner for the year specified.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 1,348.94

Explanation of method used to determine amounts of user charges reported (including nil amounts):

In Newfoundland and Labrador, the Department of Health and Community Services ("HCS") administers the Medical Care Insurance Plan. Subsection 7(1) of the *Medical Care and Hospital Insurance Act*, SNL 2016 c, M-5.01 prohibits extra billing. Administration of the Medical Care Insurance Plan, including deterrence of extra-billing, is in accordance with the Act and the associated regulations. Of particular note are the *Medical Care Insurance Insured Services Regulations*, NLR 21/96 (the "**Regulations**").

HCS conducts regular audits of provider billings. No instances of extra billing or user charges were identified during the relevant period through the regular auditing process. HCS received six complaints from beneficiaries of direct billing for cataract surgery. HCS issued a Public Service Announcement on February 7, 2018 inviting individuals to contact HCS with respect to suspected instances of extra billing and user charges related to cataract surgery. The phone line received over 600 calls. Of the callers, 73 provided documentation that cataract surgery was performed at a cost to the beneficiary. Two such cases fall within the applicable period.

One beneficiary paid \$674.47 out of pocket for cataract surgery and associated fees that would have otherwise been covered by the Medical Care Plan. The cost breakdown for that patient is as follows (see next page):

INVOICED ITEM	COST CHARGED TO PATIENT	IS THIS AN INSURED SERVICE?
Fees paid by beneficiary that are considered an upgrade and are not covered by the Medical Care Plan		
Femto laser		
Optical coherence biometry and autoreffaction	\$195.00	No
Corneal vector \$400.00 analysis and astigmatism planning	\$400.00	No
OCT of anterior segment	\$150.00	MCP does not cover this test when performed for cataract surgery or when performed outside the hospital. OCT may be considered an insured service under specific clinical indications and only when performed in a hospital. OCT is not an insured service for this patient, who paid out of pocket for OCT associated with cataract surgery.
Corneal topography	\$150.00	No
Total upgrade amount charges to patient	\$1895.00	
User fees paid by beneficiary that should have been covered by the Province		
Physician fees for cataract surgery	\$574.47	Yes.
Basic sold foldable lens	\$100.00	No. At the time this lens was considered an upgrade. As of January 1st, 2019, the soft or foldable lens will be accepted as standard of care and patients will no longer pay out of pocket for this lens.
Total user charges for patient 1	\$674.47	

Patient 2 incurred the same user charges as patient 1. The total amount of extra-billing then is \$1348.94 for two patients in the applicable fiscal year.

At this time, there have been no reimbursements to patients for cataract surgeries paid out of pocket. As the matter is currently before the Supreme Court of Newfoundland and Labrador, HCS will further consider next steps once there is a judicial determination.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 1,348.94
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PRINCE EDWARD ISLAND

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ NIL
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

Extra billing is not permitted, as per the Province of Prince Edward Island's *Health Services Payment Act*.

Health PEI administers a robust system of internal controls when reviewing physician billings, and investigates irregularities in billing. Physicians are subject to internal audit of billing practices to ensure all amounts billed are appropriate.

The Province of Prince Edward Island offers several avenues for patients and the general public to provide feedback and complaints, including a "Compliments and Complaints" link on the Health PEI website. The Minister of Health and Wellness, the CEO of Health PEI and staff can also be contacted by anyone who may have been subject to any extra billing. Health PEI follows up on any complaints, including those around billing practices.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ NIL
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ NIL

Explanation of method used to determine amounts of user charges reported (including nil amounts):

Annual financial results for Health PEI are reviewed to identify irregularities and significant variances. This includes a review of revenues to identify any new revenue items. These revenues are also subject to review by the Auditor General.

The Province of Prince Edward Island offers several avenues for patients and the general public to provide feedback and complaints, including a "Compliments and Complaints" link on the Health PEI website. The Minister of Health and Wellness, the CEO of Health PEI and staff can also be contacted by anyone who may have been subject to any user charges. Health PEI follows up on any complaints, including those around billing practices.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ NIL
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NOVA SCOTIA

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 0
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NEW BRUNSWICK

AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

New Brunswick uses a robust “comment based” approach to identifying individual citizens’ concerns on a wide range of health issues. In a typical month in the 2016–17 fiscal, the Department of Health received, logged, and responded to 100–150 concerns from individual New Brunswickers on issues including access to primary or specialized care, pharmaceutical approvals, access to services in a citizen’s language of choice, wait times for specific services, the structure of specific programs, etc. The Department’s web page provides several mechanisms to make such comments, including mailing addresses, e-mail addresses, telephone numbers, and a web-based message service. No concerns respecting EBUC were received in the 2016–17 fiscal year.

AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of “hospital” and “hospital services” in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

New Brunswick uses a robust “comment based” approach to identifying individual citizens’ concerns on a wide range of health issues. In a typical month in the 2016–17 fiscal, the Department of Health received, logged, and responded to 100–150 concerns from individual New Brunswickers on issues including access to primary or specialized care, pharmaceutical approvals, access to services in a citizen’s language of choice, wait times for specific services, the structure of specific programs, etc. The Department’s web page provides several mechanisms to make such comments, including mailing addresses, e-mail addresses, telephone numbers, and a web-based message service. No concerns respecting EBUC were received in the 2016–17 fiscal year.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 0
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QUEBEC

BY EMAIL

Quebec, December 14, 2018

Gigi Mandy
Executive Director
Canada Health Act Division
Strategic Policy Branch
Health Canada
Brooke-Claxton Building, 8th floor
70 Columbine Driveway, Tunney's Pasture
Postal Locator 0908C
Ottawa, Ontario K1A 0K9

Dear Ms. Mandy,

This is further to the letter to the Deputy Minister of Health and Social Services, Michel Fontaine, on November 5, requesting the total amount of extra-billing and user fees for 2016–2017.

In Quebec, the health insurance plan is based on the *Health Insurance Act* (the Act). The Act does not allow user fees to be imposed. It also prohibits any person from demanding or receiving any payment from a person for incidental fees related to an insured service, except in cases prescribed by regulation or provided for in an agreement and the conditions mentioned therein.

In order to provide further clarification about this prohibition, the Government of Quebec has approved a draft regulation expressly prohibiting any fees related to services insured by Quebec's health insurance plan as well as all accessory fees provided for in compensation agreements with physicians. This regulation has been in effect since January 2017. Of course, in the event of actions, whatever they may be, that are contrary to Quebec's statutes and regulations, the Régie de l'assurance maladie du Québec will take the appropriate measures to rectify the situation.

As you are no doubt aware, health and social services are within the exclusive jurisdiction of the provinces. As such, Quebec intends to remain responsible for the management, organization and planning of care and services on its territory.

Moreover, the Government of Quebec is accountable to the National Assembly and the people of Quebec with respect to how the Quebec healthcare system is run. Thus, Quebec will continue to fulfill this responsibility to Quebec's citizens, who are the ultimate arbiters as to the quality and accessibility of the services provided to them by our healthcare system.

For your information, you may consult the 2016–2017 annual management report of the Ministère de la Santé et des Services sociaux (MSSS), tabled in the National Assembly on October 4, 2017, which provides an accounting of how Quebec manages its health care system and which you can find on the MSSS website in the Publications du MSSS section.

Sincerely,

Valerie Fontaine, Director

Direction des affaires intergouvernementales et de la coopération internationale
(Intergovernmental Affairs and International Cooperation Directorate)

Ref. No.: 18-MS-03361-07

BY EMAIL

Quebec City, February 22, 2019

Simon Kennedy
Deputy Minister
Health Canada
70 Colombine Driveway, Tunney's Pasture
Ottawa, Ontario K1A 0K9

Dear Deputy Minister,

We read your letter of February 20 concerning the fees charged by Quebec physicians to patients in 2016–2017 and the Reimbursement Policy under the *Canada Health Act*.

As requested, we are confirming that we agree with the content of your executive summary of the plans that Quebec has put in place to eliminate the fees charged by Quebec physicians to patients. Furthermore, we confirm that the \$8,256,024 in fees charged by Quebec physicians is indeed the amount reported over 10 months in the findings of the Quebec Auditor General.

Sincerely,

Deputy Minister,
Yvan Gendron

Our ref: 19-MS-01783

ONTARIO

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ NIL
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

The *Commitment to the Future of Medicare Act* (CFMA) is a piece of Ontario legislation that prohibits any person or entity from charging for all or part of an insured service (such as physician and dental surgical services) under the Ontario Health Insurance Plan (OHIP) rendered to an insured person. This is known as extra-billing.

The Ontario Ministry of Health and Long-Term Care (the ministry) investigates all possible violations of the CFMA that come to its attention. Patient complaints regarding possible CFMA violations and questions from the public are received via a dedicated toll free number and email address. In addition to patient complaints, possible violations also come to the ministry's attention from other sources such as the media, advertisements, MPPs, Health Canada, etc.

Investigations regarding extra-billing follow a process outlined in legislation (the CFMA) and as part of that process often require examination of specific patient records to determine whether a specific service provided to a patient was insured. The ministry may request these and other relevant records and/or information from providers under authority of the CFMA. If the ministry finds through a CFMA investigation that a patient has paid an illegal extra-billing fee to a physician or dentist, the ministry ensures that the full amount is reimbursed to the patient.

The ministry also takes steps to prevent patient extra-billing from occurring by launching proactive CFMA investigations that are not tied to a specific patient complaint, but are instead initiated by the ministry to target providers in high-risk areas of practice known to have frequent instances of extra-billing. In many cases, these investigations are done for the purposes of provider education, in order for the ministry to communicate the provider's obligations under the CHA and CFMA and to ensure that their billing practices are amended as appropriate to comply with Ontario legislation. The ministry has also in the past undertaken patient education initiatives to increase awareness among members of the general public about the protections under the CFMA and to encourage filing complaints to the CFMA program so that investigations can be opened. For example, the ministry maintains a webpage which provides public information regarding the CFMA, including what is prohibited under the Act (i.e., extra-billing, queue jumping, illegal block fees), how to determine if they have been charged for an insured service or for access to an insured service, and how to contact the ministry in order to open an investigation.

The CFMA contains provincial offence provisions, where individuals and corporations in violation of the CFMA are subject to fines if convicted of an offence under the Provincial Offences Act (POA). Additionally, when a CFMA investigation identifies possible inappropriate OFIIP billing or fraud, the matter is referred to either the ministry's Payment Accountability Unit or to the Ontario Provincial Police health fraud investigation unit for more serious cases.

The total extra-billing amount reported above represents the net amount of unauthorized payments for insured physician and dental surgery services levied in Ontario, as identified through 52 CFMA investigations that were closed during the period April 1, 2016 to March 31, 2017. Unauthorized payments for insured physician and dental services identified during this time period account for a total of \$13,125.00. However, for each investigation in which the ministry determined that an unauthorized payment was received, the patient was reimbursed the full amount by either the person or entity that received the payment or by the ministry, which then recovered the amount from the provider plus an administrative charge of \$150.00 for each unauthorized payment received. This resulted in a net amount of \$0.00 in extra-billing for fiscal year 2016/17.

Of the 52 investigations involving potential unauthorized payments for physician or dental services, 48 were for physician services and 4 were for dental services.

Of the 48 CFMA investigations involving charges for physician services, 16 were found to constitute illegal extra-billing for insured physician services. These illegal charges account for a total of \$9,228.00, and include the following types services:

# OF CASES	SERVICE DESCRIPTION	CHARGE PER SERVICE	# OF PATIENTS REPAID	TOTAL AMOUNT CHARGED	TOTAL AMOUNT REIMBURSED TO PATIENT(S)
1	Septorhinoplasty (i.e., with prior ministry approval)	\$3,390.00	1	\$3,390.00	\$3,390.00
3	Lesion excision (i.e., chalazion, lipoma, etc.)	\$300.00–\$1,293.00	3	\$1,988.00	\$1,988.00
3	Services associated with OHIP-insured cataract surgery (i.e., intra-ocular lens, testing, etc.)	\$125.00–\$1,100.00	3	\$1,990.00	\$1,990.00
1	Sleep endoscopy	\$1,150.00	1	\$1,150.00	\$1,150.00
3	Other ophthalmological services (e.g., testing retinal photography, injections for macular degeneration, etc.)	\$50.00–\$375.00	3	\$475.00	\$475.00
2	Prescriptions (i.e., orthotics, physiotherapy, massage therapy)	\$40.00	2	\$80.00	\$80.00
1	Injections	\$75.00	1	\$75.00	\$75.00
1	Physician assessment when patient presented without a valid health card, but was eligible for OHIP coverage on the date of service	\$60.00	1	\$60.00	\$60.00
1	Cryotherapy of skin lesions (i.e., actinic keratosis)	\$20.00	1	\$20.00	\$20.00
16	Total Physician Extra-Billing Cases	Total Physician Extra-Billing Amount		\$9,228.00	\$9,228.00

All of the 4 CFMA investigations involving charges for dentist services were found to constitute illegal extra-billing for insured dentist services. These illegal charges account for a total of \$3,897.00 and include the following services:

# OF CASES	SERVICE DESCRIPTION	CHARGE PER SERVICE	# OF PATIENTS REPAYED	TOTAL AMOUNT CHARGED	TOTAL AMOUNT REIMBURSED TO PATIENT(S)
1	Dental assessment	\$150.00	1	\$150.00	\$150.00
3	Dental surgery (i.e., extractions, alveolar ridge reconstructions, etc.) performed in-hospital	\$500.00–\$2,249.00	3	\$3,747.00	\$3,747.00
4	Total Dentist Extra-Billing Cases	Total Dentist Extra-Billing Amount		\$3,897.00	\$3,897.00

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of “hospital” and “hospital services” in the Act:	\$ NIL
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ NIL

Explanation of method used to determine amounts of user charges reported (including nil amounts):

In Ontario, the CFMA prohibits any person or entity from charging for all or part of an OHIP-insured hospital service rendered to an insured person, which is known as a user charge. For services rendered outside of a hospital, the *Independent Health Facilities Act* (IHFA) prohibits any person from charging for the cost of any premises, equipment, supplies and personnel that support, assist and/or provide a necessary adjunct to certain OHIP-insured services (facility fees).

The ministry’s CFMA program also investigates illegal user charges and facility fees in hospitals and other health facilities. If the ministry finds through a CFMA investigation that a patient has paid an illegal user charge or facility fee to a hospital or facility, the ministry ensures that the full amount is reimbursed to the patient.

The ministry also takes steps to prevent illegal user charges and facility fees from occurring by launching proactive CFMA investigations and provider and patient education initiatives.

The total amounts reported above represent the net amount of illegal hospital user charges or facility fees in Ontario levied in Ontario, as identified through 22 CFMA investigations that were closed during the period April 1, 2016 to March 31, 2017. Illegal hospital user charges and facility fees identified during this time period account for a total of \$143,030.41. However, for each investigation in which the ministry determined that an illegal hospital user charges or facility fee was received, the patient was reimbursed the full amount by either the person or entity that received the payment or by the ministry which then recovered the amount from the provider or entity plus an administrative charge for each unauthorized payment received. This resulted in a net amount of \$0.00 in illegal hospital user charges or facility fees for fiscal year 2016/17.

Of the investigations involving potential illegal hospital user charges or facility fees, 8 were for hospitals and 14 were for non-hospital health facilities.

Of the 8 total CFMA investigations involving charges for hospital services, 2 were found to constitute illegal user charges for insured hospital services. These illegal charges account for a total of \$1,356.66, and include the following services:

# OF CASES	SERVICE DESCRIPTION	CHARGE PER SERVICE	# OF PATIENTS REPAID	TOTAL AMOUNT CHARGED	TOTAL AMOUNT REIMBURSED TO PATIENT(S)
1	Botox with electromyography (EMG) guidance (i.e., to treat cervical dysphonia)	\$1,257.32	1	\$1,257.32	\$1,257.32
1	Bone mineral density testing	\$99.34	1	\$99.34	\$99.34
2	Total Hospital User Charge Cases	Total Hospital User Charge Amount		\$1,356.66	\$1,356.66

Of the 14 total CFMA investigations involving charges by non-hospital facilities, 5 were found to constitute illegal facility fees. These illegal charges account for a total of \$141,673.75, and include the following services:

# OF CASES	SERVICE DESCRIPTION	CHARGE PER SERVICE	# OF PATIENTS REPAID	TOTAL AMOUNT CHARGED	TOTAL AMOUNT REIMBURSED TO PATIENT(S)
1	Block fee, including insured services provided in association with OHIP-insured colonoscopy procedures (e.g., telephone advice, completion of documents, transfer of records, prescriptions, etc.)	\$40.00	3,501	\$140,040.00	\$140,040.00
1	Services associated with OHIP insured cataract surgery	\$1,200.00	1	\$1,200.00	\$1,200.00
1	Abortion procedure	\$250.00	1	\$250.00	\$250.00
1	Services associated with in-vitro fertilization (IVF) (i.e., cycle monitoring, blood tests, semen analysis, etc.)	\$1,150.00	1	\$1,150.00	\$1,150.00
1	Physician assessment when patient presented without a valid health card, but was eligible for OHIP coverage on the date of service	\$40.00	1	\$40.00	\$40.00
5	Total Illegal Facility Fee Cases	Total Illegal Facility Fee Amount		\$141,673.75	\$141,673.75

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ NIL
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MANITOBA

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

The Department of Health, Seniors and Active Living has limited ability to monitor charges billed by physicians and/or dentists that are not employees of the Regional Health Authorities.

Methods used to determine that there has not been extra-billing occurring include:

- › no complaints from residents regarding extra-billing for insured health services;
- › routine audits of physician billings have not revealed extra-billings.
- › *Health Services Insurance Act* prohibits extra-billing for insured services and outlines penalties
- › to deter regional health authorities, hospitals, medical practitioner etc.
- › Section 66—Unauthorized charging an offense

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of “hospital” and “hospital services” in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

Methods used to determine that there has not been extra-billing occurring include:

- › no complaints from residents regarding extra-billing for insured health services;
- › confirmation from regional health authority Chief Financial Officers;
- › *Health Services Insurance Act* prohibits extra-billing for insured services and outlines penalties to deter regional health authorities, hospitals, medical practitioner etc.
- › Section 66—Unauthorized charging an offense

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 0
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SASKATCHEWAN

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

For the 2016–17 fiscal year Saskatchewan is reporting \$0 in extra-billing.

Saskatchewan has no information extra-billing charges have been levied during the reporting period. The *Saskatchewan Medical Care Insurance Act* precludes physicians/dentists who provide insured services from charging patients more than the amount paid for that service under the Act, unless the physician/dentist has opted out entirely from receiving payments under the Act.

Notice must also be given to the province where a physician/dentist opts out. No notices have been received for the reporting period.

With regards to extra-billing compliance is monitored through consultations with the provincial health authority, physicians and dentists, as well as complaints from members of the public.

When requests are made by a beneficiary to reimburse monies paid directly to a physician for insured physician services that are extra-billing charges, correspondence is sent to the beneficiary (copying the physician) advising them of Section 18 (1.1) of the *Saskatchewan Medical Care Insurance Payment Act* that a physician must accept the negotiated rate as payment in full for insured services provided to a beneficiary. Once they have received payment from Medical Services for the eligible service(s), reimbursement for any difference in the amount charged by the practitioner and the amount paid by Medical Services should be collected directly from the practitioner. If a further complaint is made, the beneficiary is directed to address complaints to the Saskatchewan College of Physicians and Surgeons.

Persons who have a complaint of an extra-billing charge may raise the concern with the College of Physicians and Surgeons of Saskatchewan. Section 7.1(Code of Ethics) in the College's bylaws notes the following:

- › Treat all patients with respect; do not exploit them for personal advantage. Contravention of, or failure to comply with, the code of ethics is unbecoming, improper, unprofessional or discreditable conduct for the purposes of the *Medical Care Insurance Act*.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

Saskatchewan has no information user charges have been levied during the reporting period. Saskatchewan is not aware of charges being levied for insured services provided in a hospital which are not permitted under the *Canada Health Act*. Nor is Saskatchewan aware of any additional charges for insured services being levied in a physician clinic as defined in the federal private clinics policy.

We would note that The Saskatchewan Medical Care Insurance Act includes provisions which indicate that any amount that a physician who provides insured services requires a beneficiary to pay or to have paid as a condition of receiving an insured service which exceeds the amount to be paid for that service under the Act, is considered to be a charge.

With regards to user charges compliance is monitored through consultations with the provincial health authority, physicians and dentists, as well as complaints from members of the public.

Persons who have a complaint of user charges may raise the concern with the College of Physicians and Surgeons of Saskatchewan. Section 7.1 (Code of Ethics) in the College's bylaws notes the following:

- › Treat all patients with respect; do not exploit them for personal advantage. Contravention of, or failure to comply with, the code of ethics is unbecoming, improper, unprofessional or discreditable conduct for the purposes of the *Medical Care Insurance Act*.

General Commentary on 2-for-1MRI/CT policy

We note that before Saskatchewan implemented its 2-for-1MRI policy, the option of privately paying for community-based MRI services existed in some provinces for a couple of decades. However, these jurisdictions have not experienced a reduction in their health transfer.

Saskatchewan would also note that our 2-for-1MRI and CT policy is about expanding options for patients. In the past, some patients chose to pay for a MRI in another province. By implementing this option, Saskatchewan residents stay closer to home and save on travel expenses. The unique-to-Saskatchewan requirement ensures there is also a benefit to the public system, by requiring private providers to provide a second scan, free of charge, to an individual who is waiting on the public list.

The *Patient Choice Medical imaging Act* (PCMIA) ensures quality oversight of the images produced in private facilities, and ensures that these facilities cannot negatively impact the operations of the public system by not allowing private facilities to take staff or physicians from the public system.

The addition of private-pay scans to complement publicly funded services provides an opportunity to expand in-hospital capacity and reduce overall public wait times. It also helps to ensure greater capacity in the health system, at no additional cost to the taxpayer, and assists in reducing overall wait times.

Saskatchewan is working with an external firm on an evaluation of our unique private pay MRI policy and we look forward to its completion in 2019.

General Commentary on Administering of intravenous drugs in community settings

In 1994, Saskatchewan adopted a policy to cover prescription drugs for chronic conditions administered in hospital settings to patients in their homes. Refer to our letter to former Acting Director General of Intergovernmental Affairs, Frank Fedyk, dated August 2, 2001.

Under the terms of the previous provincial Drug Plan, intravenous drugs for chronic conditions would be subject to co-payment and deductibles. We understand costs would be absorbed by the health districts for which they are not fully funded for by the Government of Saskatchewan.

In adopting this policy, Saskatchewan recognizes it may violate the comprehensiveness criteria of the Canada Health Act, yet finds this practice enables early discharge from hospital or prevents admission in the first place.

TOTAL FOR EXTRA-BILLING AND USER CHARGES

\$ 0

ALBERTA

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

Alberta Health has reviewed the Canada Health Act form Financial Statement of Actual Amounts of ExtraBilling and User Charges for the Period April 1, 2016 to March 31, 2017 and reporting guidelines.

AMOUNTS OF EXTRA BILLING \$ Nil

The explanation of the method used to determine the amounts of EBUC reported are outlined below:

1. Alberta Health has conducted audits and compliance reviews in accordance with the authority and the provisions of the Alberta Health Care Insurance Act (AHCIA) that mirrors the fundamental principles of the *Canada Health Act*.
2. AHCIA prohibits EBUC in the following sections:
 - › Section 9(1) of the AHCIA, Extra billing, prescribes that “No physician or dentist who is opted into the [Alberta Health Care Insurance Plan (the Plan)] who provides insured services to a person shall charge or collect from any person an amount in addition to the benefits payable by the Minister for those insured services.”
 - › Section 11(1) of the AHCIA, Other prohibited fees, prescribes that “No person shall charge or collect from any person (a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan, or (b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is opted into the Plan where the amount is in addition to the benefits payable by the Minister for the insured service.”
 - › Section 26(1)(2)(3) prescribes that an insurer (carrier, employer, corporation or unincorporated group that administers a self-insurance plan) shall not enter into, issue, maintain in force or renew a contract or initiate or renew a self-insurance plan under which any resident or group of residents is provided with any prepaid basic health services or extended health services or indemnification for all or part of the cost of any basic health services or extended health services.
 - › Sections 18 and 39 authorize Alberta Health to reassess claims and conduct audits and compliance reviews after the Minister has paid the claim. Such audits and reviews allow Alberta Health personnel to enter the premises and examine practitioner records to gather evidence, which Alberta Health can use to determine EBUC that falls within the premise of the AHCIA.
3. Alberta Health uses the following mechanisms to deter EBUC:
 - › Sections 9(2), 11(3)(4), 12(1), 13(3) and 14(a)(b) of the AHCIA prescribes that the Minister may send warnings to practitioners, refer contraventions to the practitioners’ professional regulators, opt practitioners out the Plan, recover the benefits paid, recover and reimburse the amount charged or collected as other prohibited fees, and apply fines.
 - › Alberta Health uses a risk based planning process to identify potential areas of inappropriate billing under the AHCIA, which includes non-compliance with extra-billing provisions.

- › Alberta Health issued Bulletin Med 184 on May 25, 2016 to provide information to physicians and billing staff about prohibited billing activities under sections 9 and 11 of the AHCIA. This bulletin is available on the Alberta Health website (<https://open.alberta.ca/publications>) and is attached for your reference.
4. If patients in Alberta have questions or concerns regarding extra-billing or user charges they can direct their inquiries to Alberta Health. The primary mechanisms of inquiry or complaint are:
 - › Contacting the Alberta Health Care Insurance Plan (AHCIP) by phone, fax, mail, or email.
 - › The Alberta Health TIPS line. Patients can call to express concerns and those that are physician or claims related will be directed to Claims Specialist Unit.
 - › The Statement of Benefits Paid (SOBP) phone line. The SOBP is a list of practitioner services a patient receives during a specified period that have been paid for by the AHCIP. The statement lists dates, general types of service, physician names, and the amount paid to physicians. Albertans who find health services on their SOBP that they do not recognize can outline the discrepancies and return the SOBP to Alberta Health for investigation.
 - › Additionally, Alberta Health staff may investigate claims if billing irregularities are noticed as they are being processed.
 5. Once an inquiry or complaint is received Alberta Health personnel will enter the information on a tracking sheet, conduct a preliminary review, and consult further with the complainant, and the practitioner if needed, to gather additional information regarding the billing scenario and from there typically one of three things occur:
 - 1) The billing inquiry may be resolved with the patient and/or the health practitioner by clarifying coverage under the Alberta Health Care Insurance Plan.
 - 2) If a billing error has been identified the health practitioner will be notified and the claim will be reversed and, if needed, the patient reimbursed.
 - 3) If the matter cannot be resolved with the health practitioner through communication or education it may proceed to a compliance review.
 6. In 2016/2017 one patient made an extra-billing inquiry to Alberta Health regarding a \$118.00 charge for a visit to a psychiatrist. Several attempts were made to contact the patient and clinic but calls were not returned.
 7. Alberta Health uses a risk based planning process to identify potential areas of inappropriate billing under the AHCIA, which includes provisions to address non-compliance with regards to extra-billing and prohibited fees by any person. Based on this process, high risk subjects for audit and/or compliance review are selected. The scope of work includes all physicians and other practitioners receiving compensation through the Plan on a fee-for-service basis or through Clinical Alternative Relationship Plans. Payments to hospitals, which Alberta Health Services operates and funds, are not in scope.
 8. Alberta Health does not report on audit and/or compliance reviews that are not yet concluded.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of “hospital” and “hospital services” in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

As above.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 0
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BRITISH COLUMBIA

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:

› Charges Based on Unresolved Patient Complaints	\$ 7,533
› Based on Health Canada Methodology per Attachment	\$ 16,169,726

Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

The Province has implemented an ongoing extra billing audit program and intends to audit clinics on a cyclical basis; and has proclaimed, and will shortly enact, legislative amendments to enforce the *Canada Health Act*.

2016–2017 Methodology for Extrapolating BC Audit Data

The following table presents our methodology that attempts to capture the amount of extra billing that was occurring at private surgery centres in the Province of British Columbia during fiscal year 2016–2017. The methodology used to calculate the amount of extra billing is as follows;

All private surgical centres have been divided into small, medium, and large facilities based on the number of physicians practicing at each clinic. They were then further subdivided into audited and unaudited facilities.

Audited Facilities

The Ministry of Health's Billing Integrity Program has conducted six audits of Private Surgery Centers in B.C for the 2016–2017 period. These clinics are; The False Creek Surgical Centre, Seafeld Surgical Centre, Okanagan Surgical Centre, New Westminster Surgery Centre, Prince George Surgical Centre, and the Kamloops Surgical Centre. For each of the Surgical Centres listed (except Kamloops whose records are still being reviewed) extra billing amounts were calculated and are listed in the table below. With regards to the Cambie Surgical Centre the amount used was derived using evidence provided in *Cambie Surgeries Corporation (Cambie) et al. v. Medical Services Commission et al.*

Unaudited Facilities

For each of the audited facilities we calculated an average cost per physician from our audited small, medium, and large facilities. Using the average cost per physician we multiplied this amount by the number of physicians at each unaudited clinic to come up with a province wide amount of extra billing.

Conclusion

Applying this methodology results in \$16.2 being extra billed from Private Surgical Centres in BC to be reported to Health Canada

TABLE 1: ESTIMATE OF PATIENT CHARGES IN PRIVATE SURGICAL FACILITIES (2016/2017)

SURGICAL FACILITY	FACILITY SIZE ¹	# OF PHYSICIANS AT FACILITY	ESTIMATED AVERAGE BILLING AMOUNT PER PHYSICIAN (\$) ⁸	ESTIMATED AMOUNT OF PATIENT CHARGES (\$) ⁷	NON EXTRAPOLATED ERRORS FOUND
Unaudited Facilities:					
White Rock Orthopaedic Surgery Centre ¹	Small	8	3,555	28,440	N/A
Valley Surgery Centre ¹	Medium	25	14,023	350,575	N/A
ASC Vancouver Surgical Centre ¹	Medium	29	14,023	406,667	N/A
Victoria Surgical Centre ¹	Medium	56	14,023	785,288	N/A
Kamloops Surgical Centre ^{1,4}	Medium	32	14,023	448,736	N/A
Audited Facilities:					
False Creek Health Care Centre ²	Large	103		6,095,172	532,551
Seafeld Surgical Centre ²	Small	22		2,979	2,979
Okanagan Surgical Centre ²	Medium	43		430,983	170,040
New Westminster Surgical Centre ²	Medium	54		973,199	594,793
Prince George Surgical Centre ^{2,3}	Small	21		146,476	146,476
Cambie Surgical Centre ^{2,5}	Large	126		4,703,885	N/A
Total:				14,372,400	1,446,839

TABLE 2: ESTIMATE OF PATIENT CHARGES FROM ALL SOURCES

SOURCE OF PATIENT CHARGES	ESTIMATED AMOUNT OF PATIENT CHARGES (\$)	EXTRA-BILLING NON-EXTRAPOLATED ERRORS FOUND
Surgical Facilities (above)	14,372,400	1,446,839
False Creek Family Practice (BC “clinic-level” extrapolation) ⁶	444,424	25,211
False Creek extra billing errors associated with MRI's ⁹	1,352,902	21,525
Total:	\$16,169,726	1,493,575

¹ Clinics were categorized based upon the number of surgical physicians into the following size categories—small (<25); medium (>25<100) and large >100 physicians.

² These Clinics have been audited by the BC Ministry of Health and extra billing amounts have been calculated.

³ Prince George Surgery Centre was 100% tested. As such, the error is a known error, not an extrapolated error. Furthermore, the Prince George Error rate is based on the initial review by the Medical Inspector. The amount in error may be subject to change based on new audit findings.

⁴ The onsite portion for the Audit of the Kamloops Surgery Center has been completed. However, the medical records are still being reviewed and we do not have a calculation for the amount of extra billing. As such, the extra billing amount was estimated using the same methodology as other unaudited facilities.

⁵ Clinics that were categorized as a large size were False Creek and Cambie Surgery Centre. Instead of using the average rate for large clinics to estimate the amount of private charges in Cambie Surgery Centre, the private charge amounts were calculated using information derived by Health Canada that from evidence provided in *Cambie Surgeries Corporation (Cambie) et al. v. Medical Services Commission et al.*

⁶ Family Practice extra billing was not included in the report to the MSC due to Scope Limitations. The number was calculated as \$444,424.

⁷ The Extra Billing amounts for our audited facilities come from the audit report. Extra billing for our unaudited facilities was calculated based on the formula in note.

⁸ Estimated average billing amount per physician (\$).

⁹ Seafeld sample found to be in error was from a population that was 100% tested.

SMALL CLINICS

AUDITED FACILITY	EXTRA BILLING PER PHYSICIAN (EXTRA BILLING CALCULATED AMOUNT/ # OF PHYSICIANS)
Seafeld Surgical Centre	135.41
Prince George Surgical Centre	6,975.05
Average Extra Billing per Physician Small (Rounded)	3,550.00

MEDIUM CLINICS

AUDITED FACILITY	EXTRA BILLING PER PHYSICIAN (EXTRA BILLING CALCULATED AMOUNT/ # OF PHYSICIANS)
Okanagan Surgical Centre	10,022.86
New Westminster Surgical Centre	18,022.20
Average Extra Billing per Physician Medium (Rounded)	14,023.00

LARGE CLINICS

AUDITED FACILITY	EXTRA BILLING PER PHYSICIAN (EXTRA BILLING CALCULATED AMOUNT/ # OF PHYSICIANS)
False Creek Surgical Centre	59,176.43
Cambie Surgical Centre	37,332.42
Average Extra Billing per Physician Large (Rounded)	48,255.00

Under the current legislation which was updated in April 2019, the billing for MRIs privately is not considered extra billing.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of “hospital” and “hospital services” in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 16,177,259
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YUKON

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ 0
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

In Yukon we have no Extra Billing charges for insured services. Both physician and hospital visits are 100% covered and we currently don't have any private physician clinics, hospitals or private surgery clinics.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ 0
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ 0

Explanation of method used to determine amounts of user charges reported (including nil amounts):

In Yukon we have no user charges or facility fees for insured services. Both physician and hospital visits are 100% covered and we currently don't have any private physician clinics, hospitals or private surgery clinics.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ 0
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NORTHWEST TERRITORIES

1. AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ NIL
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

There are two pieces of legislation in the Northwest Territories which prohibit extra billing and user charges. Section 14(1) of the *Northwest Territories Medical Care Act* states that: "No medical practitioner shall charge to or collect from an insured person a fee in excess of the benefit in respect of the insured service, unless the medical practitioner has made an election that is still in effect." In addition, section 8(2) of the *Hospital Insurance Regulations* under the *Hospital Insurance and Health and Social Services Administration Act* also states that: "The rate payable to a hospital or federal hospital that is situated in a province or territory participating under the federal Act (i.e. *Canada Health Act*) shall not exceed the rate established for the hospital by that province or territory, less the authorized charge." Therefore, residents of the NWT are protected from extra billing and charges when receiving insured services both within the territory, and when receiving insured services outside the territory under a reciprocal billing agreement.

2. AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ NIL
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ NIL

Explanation of method used to determine amounts of user charges reported (including nil amounts):

The NWT has a "complaint-based" system in place, and takes steps to respond to concerns and improve care and services for NWT residents. When a resident has a concern or issue with the care they have received they are first encouraged to speak with their local health provider. If the issue is not resolved they are encouraged to contact their designated Patient Representative to help address the issue and file a formal complaint. During the reporting period of 2016–2017 there were no complaints received regarding extra billing or user charges in the NWT.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ NIL
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NUNAVUT

AMOUNTS OF EXTRA-BILLING

Aggregate amount of extra-billing levied by physicians and dentists for insured health services:	\$ NIL
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Explanation of method used to determine amounts of extra-billing reported (including nil amounts):

All Nunavut practicing physicians are contractual employees of the Government of Nunavut and do not bill fee for service. As such, there is no extra-billing to report.

AMOUNTS OF USER CHARGES (INCLUDING FACILITY FEES)

a) Aggregate amount of user charges levied in the province for insured hospital services, as per the definition of "hospital" and "hospital services" in the Act:	\$ NIL
b) Aggregate amount of user charges levied for insured services provided by a physician in a clinic, as defined by the federal private clinics policy:	\$ NIL

Explanation of method used to determine amounts of user charges reported (including nil amounts):

All health care facilities within Nunavut are owned and operated by the Government of Nunavut or contractors to the Government of Nunavut. The Department of Health does not impose any additional fees upon clients for the use of health care facilities within Nunavut. The response to the inquiry is NIL as a result.

TOTAL FOR EXTRA-BILLING AND USER CHARGES	\$ NIL
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ANNEX E

REIMBURSEMENT ACTION PLANS & PROGRESS REPORTS

Under the Reimbursement Policy, provinces and territories (PT) subject to a Canada Health Transfer (CHT) deduction as a result of patient charges are eligible for reimbursement should they demonstrate action has been taken to come into compliance with the *Canada Health Act* and the patient charges have been eliminated.

Following a CHT deduction as a result of patient charges, Health Canada officials work collaboratively with PT officials to reach a mutually agreed upon Action Plan. Given the circumstances leading to deductions will vary by jurisdiction, so too will the conditions for reimbursement, and the resulting Action Plans. However, the overarching objective of the Reimbursement Policy is the effective elimination of patient charges.

In addition to the Reimbursement Action Plan, PTs must submit annual progress reports to Health Canada that outline the degree to which the plan has been implemented. Upon review of the jurisdiction's report, if Health Canada is satisfied that key elements of the Action Plan have been fulfilled, the PT could receive a partial or full reimbursement. Following an initial deduction and reimbursement cycle, if Health Canada remains satisfied that patient charges have been eliminated, the Reimbursement Policy allows for the immediate reimbursement of subsequent CHT deductions.

Action plans, and PT progress reports on meeting their plans, are published on the following pages.

For further details on the Reimbursement Policy please refer to Annex B which includes the full text.

[Following is the text of the British Columbia Extra-Billing Elimination Action Plan and the Newfoundland and Labrador Reimbursement Action Plan]

BRITISH COLUMBIA'S EXTRA BILLING ELIMINATION ACTION PLAN

This report outlines British Columbia's (BC) Action Plan to address extra-billing. Central to the plan is the implementation of Bill 92, the amendment to the BC *Medicare Protection Act* (Appendix A), which strengthens the province's legislative provisions against extra billing.

Background

The *Canada Health Act* requires the Federal Government to impose financial penalties on provinces where extra billing has occurred. As a result, BC has been subject to reductions in the amount it receives under the Canada Health Transfer. Previous federal deductions reported by BC to Health Canada have been approximately \$200,000 per year. In 2017/18, the Ministry of Health (MoH) audited three private clinics. Based on the audits, Health Canada estimated that extra billing in BC for the 2015/16 fiscal year was \$15.9 million and as a result, BC's federal health funding was reduced by that amount.

In the spring of 2018, BC's Minister of Health announced, in part to bring BC in compliance with the *Canada Health Act*, that the Government would bring into force the remaining provisions of the 2003 Bill 92 to address the province's ability to respond to and address extra billing. Most of these provisions came into force on October 1, 2018. The key changes include:

- › New offence provisions for practitioners and/or clinics related to contravention of the extra billing provisions in the *Medicare Protection Act* (Act), including fines of up to \$10,000 for a first offence and up to \$20,000 for a second or subsequent offence; (s. 46(5.1) and (5.2))
- › The ability for the Medical Services Commission to cancel the enrollment of a practitioner for "cause", if the practitioner: (a) contravenes; (b) attempts to contravene; or (c) authorizes, assists or allows someone else to contravene, the extra billing provisions in the Act; (s. 15)
- › A beneficiary (or the person who pays for the service) is entitled to a refund for an amount that is paid contrary to the extra billing provisions contained in the Act; (s. 20)
- › The Medical Services Commission may pay a beneficiary (or the person who paid for an insured service) in exchange for assigning the claim arising due to extra billing, and pursue the debt against the person who improperly charged for the service; (s. 21)
- › The general limits on extra billing by enrolled practitioners have been clarified; (s. 17) and
- › There is an increase in the scope of the limits on extra billing by non-enrolled medical practitioners. (s. 18)

In addition to the above changes, Bill 92 includes a prohibition for charging in relation to diagnostic services (s. 18.1). This provision is scheduled to take effect on April 1, 2019.

Bringing into force these provisions serves to strengthen enforcement against extra billing and reinforces the province's commitment to universal public health care.

The enforceability of the Bill 92 provisions has been challenged in Court in *Cambie Surgeries Corporate v. British Columbia (Attorney General)*. On November 23, 2018, the BC Supreme Court issued an injunction enjoining the enforcement of the extra billing provisions in the Act until June 1, 2019 or further order of the Court (the Court Order). BC is appealing this decision.

Since BC's announcement to bring into force Bill 92, a number of steps have been taken. The following provides a summary of the province's approach to implementation.

Physician/Clinic Notification

A letter serving notice of the changes was issued to all registered medical practitioners, accredited diagnostic facilities and private surgical clinics on September 10, 2018 (Appendix B). These letters were sent via registered mail to ensure there is a record of them being delivered.

Sections of the BC government website aimed at medical practitioners—<https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp>—have been updated to articulate the changes that have been made. This includes an FAQ document for practitioners, as well as contact information for further questions (Appendix C).

Partners/Stakeholders

Briefings were conducted prior to October 1, 2018, with various associations including: Doctors of BC, the BC College of Physicians and Surgeons, the Canadian Medical Protective Association and the Vice Presidents of Medicine for the Health Authorities, to ensure awareness around the legislative changes and new expectations.

Public Awareness

On April 4, 2018, the MoH issued a press release announcing the province would be bringing into force the remaining provisions of Bill 92, effective October 1, 2018. An additional press release was issued on September 7, 2018, providing an overall update on Bill 92 and reporting a six-month extension to April 1, 2019 of the *Medicare Protection Act* measures applicable to diagnostic services.

A number of relevant sections of the BC government website aimed at the public have been updated to prominently feature alerts that will link patients directly, through multiple paths, to information concerning extra billing. These include:

- › On the BC government's Health homepage, <https://www2.gov.bc.ca/gov/content/health>, the language under *Popular Topics* has been amended to indicate that extra billing information is available under the *MSP for BC Residents* webpage. This page has an alert button that takes patients directly to information about extra billing: <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents>.
- › Additional links to extra billing information can be accessed from the homepage, under *Health Care Complaints*, <https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/health-care-complaints>, and under *Medical Services Plan*, <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp>.

Applicable patient information on the changes to the *Medicare Protection Act* and the ability to seek reimbursement from the Medical Services Commission is profiled at <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/benefits/additional-fees-and-charges>. Updates also include an FAQ document for patients, as well as contact information for further questions (Appendix D).

The MoH will monitor ongoing patient inquiries and consider additional formats to make information available to the public, as required.

Health Authority Contracts

Currently, there are ten contracts between Health Authorities and private clinics for surgical services. The MoH issued a letter on September 13, 2018 notifying all Health Authorities of expectations about contracting between Health Authorities and private clinics for the provision of medical services (Appendix E). This included a requirement for all Health Authorities to amend their current surgical services contracts with private clinics to include termination provisions in the event of extra billing. As a requirement of the amended contracts, medical practitioners and clinics have been required to sign compliance statements (Appendix F). This letter of expectations was revised following the Court Order (Appendix G), as was the compliance statement—which is now referred to as a “notice to physician” (Appendix H).

Medical Services Commission—Compliance and Monitoring

The MoH has developed a series of operational processes to protect patients from extra billing. However, due to the recent Court Order, the Ministry is not able to implement these processes at this time. These processes include: processing complaints, investigating allegations and making a determination as to whether extra billing has taken place. Once the Ministry is able to move forward, these processes will enable the Medical Services Commission to reimburse beneficiaries directly, assume debt on behalf of a beneficiary and recover the charge from the practitioner and/or clinic. In addition, once enforcement is not prohibited by the Court Order, extra billing offences may be referred to the MoH’s Audit and Investigations Branch and the Special Investigations Unit for the purpose of recommending charges and penalties, where appropriate. As noted above, the Ministry is appealing the recent Court Order and will be seeking for the injunction to be overturned.

Diagnostic Imaging and Laboratory Services

On August 8, 2018, the Honourable Ginette Petitpas Taylor, Minister of Health Canada, wrote to BC Minister of Health, Adrian Dix, regarding the Federal Government’s Diagnostic Services Policy. In the letter, Minister Petitpas Taylor stated:

“I fully appreciate that it may take time in some jurisdictions to align provincial and territorial systems with the Diagnostic Services Policy. As I indicated in Winnipeg, the policy will not take effect until April 1, 2020, and reporting on any patient charges for diagnostic services will begin in December 2022 (for the fiscal year 2020–2021.) That would mean, in accordance with the Canada Health Act, that any Canada Health transfer deductions would only be made in March 2023. If in the interim, a jurisdiction has eliminated patient charges for diagnostic services, that jurisdiction would be eligible for reimbursement of deducted funds through the new Reimbursement Policy.”

Further, on September 20, 2018, Deputy Minister of Health Canada, Simon Kennedy emailed all of the provinces and territories on the issue of the diagnostic services. In his email, it stated:

“You will note the Minister has indicated that the Diagnostic Services Policy will take full effect from April 1, 2020. This policy is a clarification of the application of the CHA to diagnostic services. It confirms the federal position that medically necessary diagnostic services are insured services, regardless of the venue where the services are delivered. This means that provinces and territories not currently reporting to Health Canada on patient charges in respect of medically necessary diagnostic services will be required to do so as of December 2022 (for the fiscal year 2020–21). This extended phase-in period is to allow any jurisdiction where patient charges for diagnostic services are permitted to make the changes necessary to align with the Policy. Naturally, moving earlier than 2020–21 to eliminate such charges is strongly encouraged.”

BC is committed to addressing patient charges for diagnostic services. To that end, in March 2018, the BC Surgical and Diagnostic Imaging Strategy was announced which seeks to provide faster access and to reduce wait times for all medical imaging modalities within the province. The priority focus for 2018/19 was providing faster access to magnetic resonance imaging (MRI), which included by performing 37,000 more MRI exams by the end of March 2019, establishing a centralized intake and pooled referrals approach (where appropriate) and to reduce wait times for high priority patients. To support these initiatives, \$11 million in additional funding was made available to the Health Authorities.

1. MRI Volumes

- › In 2018/19, the target number of publicly-funded MRI exams performed is 225,000.
- › This is approximately 35,000 more MRI exams performed than in 2017/18.
- › Year-to-Date (Period 6, up to September 20, 2018), BC has performed 103,683 MRI publicly-funded MRI exams, which is:
 - › 971 above the 2018/19 YTD Period 6 target; and
 - › 25,607 more MRI exams performed compared to 2017/18 YTD Period 6.

2. MRI Inventory

- › There are 31 MRI units in the province operating over 800 hours per week.
- › There is an expected deployment of 9 net new MRI units over the next two years. There may be more net new MRI units as further business cases are approved by the Ministry.
- › The 9 net new MRI units include 2 private MRI clinics that were recently purchased by Fraser Health Authority and the new clinics will start seeing patients in early 2019.
- › There are no active contracts between Health Authorities and private clinics to perform MRI exams, but there are 7 contracts that are ready for demand if needed.

3. HHR Recruitment and Retention

- › All Health Authorities, except Northern Health Authority, were able to recruit more MRI technologists to meet their needs. This includes the addition of 17 MRI technologists in the Lower Mainland.
- › The Northern Health Authority has had issues with recruiting and retaining MRI technologists. To secure MRI technologists coverage, they are contracting with an out-of-province agency for locums, aggressively recruiting for full-time FTEs (three positions currently posted), and investigating other options to overcome the shortage, such as working with other Health Authorities to share resources.

BC believes the above steps will address the demand for medically necessary MRIs in the province. In addition, as of April 1, 2019, BC will bring into effect Section 18.1 of the *Medicare Protection Act*, which will make it illegal for a medical practitioner to charge for diagnostic imaging. This will deter the private delivery of the service and provide greater protection to patients being charged for medically necessary diagnostic services.

With regard to the *Laboratory Services Act*, the Ministry plans to bring forward in the fall/winter of 2019/20 a proposed series of consequential amendments for Cabinet to consider. These changes are not anticipated to be material in nature; rather, they are to ensure elements in the *Laboratory Services Act* are consistent with the updated *Medicare Protection Act*.

Audits of Private Clinics

The MoH has completed three audits of private clinics – False Creek Healthcare Centre, Seafeld Surgical Centre, and Okanagan Health Surgical Centre. The results of these audits were shared with Health Canada in accordance with the agreement signed by our respective ministers in 2017.

The MoH has established an audit unit that is responsible for the ongoing audit of existing private surgical centers, and in the 2018/19 fiscal year is aiming to complete a further three audits, subject to impediments due to the Court Order, bringing the total completed and underway to ten, including Cambie. The clinics are selected on a risk-based approach, taking into account factors such as complaints made by patients, types of services offered, number of physicians providing services and evidence from clinics' websites that they extra bill.

The purpose of the audits is two-fold:

- (1) To monitor and assess compliance with the *Medicare Protection Act*, and
- (2) To help determine an accurate estimate of the extent of extra billing in the province.

Subject to clarification from the Court, the MoH is committed to full transparency and will continue to work with Health Canada in reviewing audit findings as the work is completed. Going forward, it is suggested that the monthly conference calls to discuss audit findings are re-established.

Reporting Requirements

BC commits to submitting a complete and accurate 2016/2017 extra billing and user charges financial statement to Health Canada in December 2018, per the reporting requirements set out in the *Canada Health Act* and Regulations.

As per the Reimbursement Policy, BC also commits to submitting a January 2019 report to Health Canada, assessing the degree to which the elements of the Action Plan have been completed.

This report will include:

- › A financial statement of any EBUC levied in BC since the March 2018 deduction;
- › A report on the steps BC has taken to eliminate EBUC, and how these charges have been addressed; and,
- › An attestation as to the completeness and accuracy of the information submitted.

Conclusion:

In summary, BC's MoH is appealing the Court Order to be able to use the Bill 92 provisions, and, if successful, will monitor and assess the impact of the implementation of Bill 92. BC's MoH will also determine whether further changes to policy and/or legislation are warranted to address extra billing. By moving forward with the above noted actions, BC believes it has taken the necessary steps to address extra billing within the province and is seeking reimbursement from Health Canada for the 2018/19 \$15.9 million penalty.

At the time of this report's publication, British Columbia's status update on its Reimbursement Action Plan was not available. Once available it will be published at www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2018-2019/british-columbia-status-update-reimbursement-action-plan.html

[Following is the text of the Newfoundland and Labrador Reimbursement Action Plan Outline]

NEWFOUNDLAND AND LABRADOR REIMBURSEMENT ACTION PLAN

BACKGROUND

In the winter of 2017–2018, the Department of Health and Community Services (HCS) received phone calls from Medical Care Plan (MCP) beneficiaries complaining that they had paid out of pocket for cataract surgery.

INVESTIGATION

In February 2018, HCS issued a Public Service Announcement (PSA) in an effort to identify beneficiaries in the province who felt that they had been billed inappropriately for insured cataract surgery and created a hotline for reporting of such instances.

- › The hotline received over 600 calls after the PSA was launched.
- › Documentation was provided by 73 callers confirming that cataract surgery was performed and paid for out of pocket.
 - › It was determined that the callers who produced documentation paid varying totals from approximately \$1,000 to \$4,000 total per eye.
 - › Two of these 73 cases fell within the 2016–2017 fiscal year, which resulted in a \$1,349 deduction to NL's Canada Health Transfer in March 2019, as per the *Canada Health Act*.
- › HCS continues to receive calls and documents regarding cataract surgery paid out of pocket by MCP beneficiaries.

Corrective action through patient reimbursement and further investigation

HCS plans to reimburse patients for the excision of the cataract and intraocular lens replacement at a rate of \$574.47 per eye when patients can produce documents verifying that they have paid for cataract surgery in a private clinic until June 15, 2018. The amount of \$574.47 represents the professional fees billable for the excision of the cataract (\$473.09) and insertion of the intraocular lens (\$101.38). HCS is not reimbursing the costs of non-insured services associated with providing cataract surgery in a private clinic.

- › The callers without documentation will not be included in the totals for extra-billing and user charges reporting under the *Canada Health Act* as there is insufficient evidence to demonstrate that the patients paid out of pocket for cataract surgery.
- › To date, HCS has not further contacted callers who have not provided documentation. However, HCS will review the cataract phone line results, directly reaching out to any patients who may meet criteria for reimbursement but did not submit the relevant documents.
 - › To ensure that reimbursement is available to eligible patients who have not yet been identified, HCS plans to issue a news release regarding reimbursement for insured professional fees in a further attempt to identify patients who may have paid charges associated with cataract surgery in the private clinic setting.

LEGAL DECLARATION

On March 28, 2018, in *Jackman v. Newfoundland and Labrador*, the Applicants filed an application for declaratory relief with the Supreme Court of Newfoundland and Labrador, General Division, on three matters:

- (1) That there is no legislative prohibition to removing a cataractous lens in a private office.
- (2) That the removal of a cataractous lens by an ophthalmologist in a private office is a non-insured service.
- (3) That a supplementary list of services, when provided by an ophthalmologist in a private clinic, are non-insured services.

On March 6, 2019, Justice Goodridge declared that:

- (1) Prior to June 15, 2018, there was no legislative prohibition to removing a cataractous lens in a private office.
- (2) Prior to June 15, 2018, the removal of a cataractous lens by an ophthalmologist in a private clinic was an insured service.
- (3) The supplementary list of services provided are non-insured services when provided in a private clinic.

Corrective action through legislative and policy amendments

- › On June 15, 2018, legislative amendments were filed in order to clarify the type of cataract surgery that is insured under MCP and where those surgeries could occur. Section 4(1)(x.1) of the *Medical Care Insurance Insured Services Regulations* which stated that non-insured services included those not otherwise authorized or grandfathered into private clinics as of a certain date, was subject to different interpretations in *Jackman v. Newfoundland and Labrador*.
 - › Recognizing the difficulties in interpretation of this particular clause, the section was later repealed and replaced on June 15, 2018, with: 3. (2) For greater certainty, the medically necessary removal and replacement of a cataractous lens by any procedure is an insured service and shall be performed in a hospital or a facility designated by the Lieutenant-Governor in Council (Reg. 47/18).
- › On January 30, 2019, HCS announced that cataract surgery would be available in private offices throughout the province in the near future.
 - › HCS worked with the Newfoundland and Labrador Medical Association (NLMA) to establish, on April 17, 2019, Schedule O: Cataract Surgery Service Fees in Non-Hospital Designated Facilities. This schedule is an amendment to the 2013–2017 Memorandum of Agreement between the Government of Newfoundland and Labrador and the NLMA.
 - › As part of the transition to include cataract surgery in private offices, HCS will be working with the Regional Health Authorities to establish a central intake process with the objective of improving wait times for cataract surgery across the province.

- › HCS is continuing to undertake the necessary steps towards establishing a policy to designate non-hospital facilities that will include, but is not limited to, issues concerning patient safety and facility accreditation.
- › HCS is also considering introducing broader legislation for the transitioning of other hospital-based procedures.
- › HCS is investigating models to prevent extra-billing and user charges related to cataract surgery.
 - › Providers operating out of designated facilities will be required to inform patients that they are not required to purchase any additional optional add-on services which are uninsured.
 - › HCS plans to publish guidelines for physicians and patients outlining insured costs associated with cataract surgery in a plain language format.
- › As of January 1, 2019, HCS has adopted the aspheric lens as the new standard, ensuring that patients will no longer be billed for the basic lens associated with cataract surgery.

CONCLUSION

This action plan was created as part of the Reimbursement Policy under the *Canada Health Act* and with the intention of eliminating patient charges for medically necessary cataract surgery. These efforts have been made in hopes of obtaining a reimbursement for Canada Health Transfer deductions in the amount of \$1,349 taken in March 2019 for fiscal year 2016–2017, and in hopes of obtaining an immediate reimbursement for deductions resulting from the remaining patient charges that occurred in subsequent fiscal years.

JANUARY 2020 STATUS REPORT, IMPLEMENTATION OF NEWFOUNDLAND AND LABRADOR'S REIMBURSEMENT ACTION PLAN

INVESTIGATION

Corrective Action through Patient Reimbursement and Further Investigation

In February 2018, HCS issued a PSA in an effort to identify beneficiaries in Newfoundland and Labrador who were billed directly for insured cataract surgery. Approximately seventy-three callers to HCS submitted documents that indicated that they had paid for insured cataract surgery for one or both eyes. Further detailed examination of documents submitted has identified one hundred and eight instances (i.e. eyes) in sixty-three beneficiaries that are eligible for reimbursement of the professional fees associated with cataract surgery. HCS is preparing written correspondence to these individuals with instructions on how to obtain the reimbursement for the insured professional fees that would have been paid by the Medical Care Plan (MCP).

HCS has further identified another forty beneficiaries that may be eligible for reimbursement but documents to support eligibility were inconclusive or unavailable. HCS is preparing written correspondence inviting these individuals to submit documents for review to determine eligibility.

HCS has not yet issued any public communication regarding patient reimbursement of out-of-pocket charges associated with cataract surgery. However, HCS has made plans to set up a phone line similar to the Cataract Surgery Information Line used in February 2018 for patients who may be eligible for reimbursement but did not report charges for cataract surgery in 2018.

LEGAL DECLARATION

Corrective Action through Legislative and Policy Amendments

HCS has developed a draft Policy Framework for the Provision of Cataract Surgery in Non-Hospital Designated Facilities that is currently under review by stakeholders. This policy framework addresses issues concerning patient safety, facility accreditation, as well as preventing user charges and extra-billing.

CONTACT INFORMATION IS PROVIDED BELOW FOR RESIDENTS WHO BELIEVE THEY MAY HAVE BEEN SUBJECT TO INAPPROPRIATE PATIENT CHARGES FOR INSURED HEALTH SERVICES

Refer to Chapter 1 for key definitions under the *Canada Health Act*. For detailed information on what health services are insured under provincial or territorial health insurance plans, refer to section 2.0—Comprehensiveness, under each provincial and territorial section.

NEWFOUNDLAND AND LABRADOR

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1-800-387-6665 (toll-free in Nova Scotia)
1-800-670-8888 (TTY/TDD)
www.novascotia.ca/dhw/about/contact

NEW BRUNSWICK

<https://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan.html>

QUEBEC

www.ramq.gouv.qc.ca/en/citizens/health-insurance/covered-services/Pages/covered-services-accessory-costs.aspx

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1-310-0000 then 780-427-1432 (toll-free in Alberta)
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BRITISH COLUMBIA

<https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/msp/bc-residents/benefits/additional-fees-and-charges>

YUKON

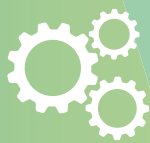
1-867-667-3774
ymc@gov.yk.ca
www.yukonmedicalcouncil.ca/complaint_process.html

NORTHWEST TERRITORIES

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Public
Administration



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Universality



Portability



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