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Minister of Health



Ministre de la Santé

The Honourable/L'honorable Tony Clement

Ottawa, Canada K1A 0K9

*Her Excellency, the Right Honourable Michaëlle Jean,
Governor General and Commander-in-Chief of Canada*

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year that ended March 31, 2005.

Tony Clement

Canada



Acknowledgements

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

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

Quebec Department of Health and Social Services

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

British Columbia Ministry of Health

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

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Introduction

Canada's national health insurance program is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services on a prepaid basis. Instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the *Canada Health Act*, the principles governing our health care system are symbols of the underlying Canadian values of equity and solidarity.

Roles and responsibilities for Canada's health care system are shared between the federal and provincial and territorial governments. Under the *Canada Health Act* (CHA), our federal health insurance legislation, criteria and conditions are specified that must be satisfied by the provincial and territorial health care insurance plans in order for them to qualify for their full share of the federal cash contribution, available under the Canada Health Transfer (CHT).

On an annual basis, the federal Minister of Health is required to report to Parliament on the administration and operations of the CHA, as set out in section 23 of the Act. The vehicle for doing so is the *Canada Health Act Annual Report* (CHAAR).

The approach taken for gathering information on provincial and territorial health care plans for the annual report continues to follow that set out in the letter sent in June 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, federal Minister of Health and Welfare, confirming the government's position with

respect to the interpretation and implementation of the CHA. The approach outlined by Minister Epp established the foundation on which the CHA has been subsequently interpreted and applied. It is based on collaboration and interaction where the provinces, territories and the federal government work together to supply the information needed by the Minister for the CHAAR.

While the principal and intended audience for the report is parliamentarians, it is a readily accessible public document that offers a comprehensive report on insured services in each of the provinces and territories across Canada. The annual report is framed to address the mandated reporting requirements of the CHA. Its scope does not extend to commenting on the status of the Canadian health care system as a whole.

Section 22 of the Act prescribes the type of information that the Minister may reasonably require from a province or territory to assess compliance with the five criteria in order to qualify for a full federal transfer under the CHT.

The report itself is divided into three chapters, which include material specific to the reporting year, as well as several annexes comprised of relevant supporting documents:

- Chapter 1 of the report provides an overview of the CHA, its regulations and federal policies that are used in the administration of the Act.
- Chapter 2 reviews the administration of the CHA during the fiscal year, from April 1, 2004 through March 31, 2005, including a summary of compliance issues addressed and details on deductions to the federal CHT cash contributions. The chapter concludes with an overview of current federal "health" funding initiatives and the evolution of health programs and financing.
- Chapter 3 describes the provincial and territorial health insurance plans, including statistical data on insured hospital, physician and surgical-dental health care services.

The annexes to this report provide additional information relevant to the administration of the Act and its place in the Canadian health care system. Annex A is an office consolidation of the CHA and its regulations (dated June 2001). Annex B presents the text of two key policy statements that clarify the federal interpretation of the criteria and conditions of the Act. Annex C provides a description of the Canada Health Act Dispute Avoidance and Resolution process, which came into effect in 2002. Annex D provides references to documents that support information found in provincial and territorial narratives. Annex E is a glossary of terminology used in the report. Also included, inside the back cover of the report, is contact information for all provincial and territorial departments of health.

Chapter 1 – Canada Health Act Overview

This section describes the *Canada Health Act* (CHA), its requirements and key definitions under the Act. Also described are the regulations and regulatory provisions of the CHA and the interpretation letters by former federal Ministers of Health Jake Epp and Diane Marleau to their provincial and territorial counterparts that are used in the interpretation and application of the Act.

What is the Canada Health Act?

The CHA is Canada's federal legislation for publicly funded health care insurance. The 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 the full federal cash contribution under the Canada Health Transfer (CHT).

The aim of the CHA is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service for such services.

Key Definitions under the Canada Health Act

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the CHA 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."

Persons excluded under the CHA include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Insured health services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the CHA and 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 therefore from the hospital, but does not include services that are excluded by the regulations.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the CHA 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.

Requirements of the Canada Health Act

The CHA 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 services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charge provisions that apply only to insured health services.

The Criteria

1. Public Administration (section 8)

The public administration criterion, set out in section 8 of the CHA, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans 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.

2. Comprehensiveness (section 9)

The comprehensiveness criterion of the CHA requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e. surgical-dental services that require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health 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 plans to establish entitlement.

Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health services.

4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

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 necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

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.

Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from his/her 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 on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g. discrimination on the basis of age, health status or financial circumstances).

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

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

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the CHA using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

1. **Information (section 13(a))** — the provincial and territorial governments shall provide information to the Minister of Health as may be reasonably required, in relation to insured health services and extended health care services, for the purposes of the CHA.

2. **Recognition (section 13(b))** — the provincial and territorial governments shall recognize the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the CHA, which discourage extra-billing and user charges for insured health services in a province or territory, are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory in accordance with the *Extra-billing and User Charges Information Regulations* (described below).

Extra-billing (section 18)

Under the CHA, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e. a surgical-dentist providing insured health services in a hospital setting) 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 or territory. For example, if a physician were to charge patients any amount for an office visit that is insured by the provincial or territorial health 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 contrary to the accessibility criterion.

User Charges (section 19)

The CHA defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, that fee would be considered a user charge. User charges are not permitted

under the Act because, as is extra-billing, they constitute a barrier or impediment to access.

Other Elements of the Act

Regulations (section 22)

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

- ☐ defining the services included in the CHA definition of "extended health care services";
- ☐ prescribing which services to exclude from hospital services;
- ☐ prescribing the types of information that the federal Minister of Health may reasonably require, and the times at which and the manner in which that information may be provided; 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 provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied. They must also provide financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex A.)

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the CHA, 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. In plain terms, when it has been determined that a province has allowed \$500,000 in extra-billing by physicians,

the federal cash contribution to that province or territory will be reduced by that same amount.

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the CHA is subject to a discretionary penalty. The amount of any deduction from federal transfer payments under the CHT is based on the gravity of the default.

The CHA 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 applied.

Excluded Services and Persons

Although the CHA requires that insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- ☐ services that fall outside the definition of insured health services; and
- ☐ certain services and groups of persons are excluded from the definitions of insured services and insured persons.

These exclusions are discussed below.

Non-insured Health Services

In addition to the medically necessary insured hospital and physician services covered by the CHA, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services and optometric services.

The additional services provided by provinces and territories are often targeted to specific population groups (e.g. children, seniors or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, 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, testimony in court and cosmetic services.

Excluded Persons

The CHA definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programs.

As well, other categories of residents such as landed immigrants and Canadians returning to live from other countries may be subject to a waiting period by a province or territory. The CHA stipulates that the waiting period cannot exceed three months.

In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g. foreign refugees) or under the workers' compensation legislation of a province or territory.

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

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the CHA. These statements have been made in the form of ministerial letters from former federal Ministers of Health to their provincial and territorial counterparts. Both letters are reproduced in Annex B of this report.

Epp Letter

In June 1985, approximately one year following the passage of the CHA in Parliament, then-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.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent that clarify the CHA's criteria, conditions and regulatory provisions. These clarifications have been used by the federal government in assessing and interpreting compliance with the Act. The Epp letter remains an important reference for interpreting the Act.

Marleau Letter – Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal-provincial/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 its impact on Canada's universal, publicly funded health care system.

At the Federal-Provincial/Territorial Health Ministers Meeting of September 1994 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 CHA 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 CHA includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health 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.

Dispute Avoidance and Resolution Process

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 CHA, 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 CHA issues; and CHA 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 CHA. 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 included in Annex C of this report.

Chapter 2 – Administration and Compliance

Administration

In administering the *Canada Health Act* (CHA), the federal Minister of Health is assisted by Health Canada policy, communications and information officers located in Ottawa and in the six regional offices of the Department, and by lawyers with the Department of Justice.

Health Canada takes its responsibilities under the CHA seriously, working with the provinces and territories to ensure that the principles of the CHA are respected. Our preference is always to work with provinces and territories to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

The Canada Health Act Division (the Division) is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and is responsible for administering the CHA. Officers of the Division located in Ottawa and in regional Health Canada offices fulfill the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charge provisions of the CHA;

- working in partnership with provinces and territories to investigate and resolve CHA compliance issues and pursue activities that encourage compliance with the CHA;
- informing the Minister of possible non-compliance and recommending appropriate action to resolve the issue;
- developing and producing the *Canada Health Act Annual Report* on the administration and operation of the CHA;
- developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to share information;
- collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- disseminating information on the CHA and on publicly funded health care insurance programs in Canada;
- responding to information requests and correspondence relating to the CHA by preparing responses to inquiries about the CHA and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media;
- conducting issue analysis and policy research in order to provide policy advice and
- collaborating with provincial and territorial health department representatives on the recommendations to the Minister concerning the interpretation of the CHA; and Interprovincial Health Insurance Agreements Coordinating Committee (see below).

Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee and provides a secretariat for the Committee. The Committee was formed in 1991 to address issues affecting the interprovincial billing of hospital and medical

services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the CHA.

The within-Canada portability provisions of the CHA are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives 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. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and signing them is not a requirement of the CHA.

In 2004-2005, IHIACC updated its high cost procedure (e.g. organ transplants) rates to reflect current costs.

Compliance

As mentioned in Chapter 1, provinces and territories must comply with the CHA criteria and conditions in order to receive the full amount of the Canada Health Transfer (CHT) cash contribution (previous to April 1, 2004, the cash contribution was payable under the Canada Health and Social Transfer). The following section outlines how Health Canada determines provincial/territorial compliance.

Health Canada's approach to resolving possible CHA compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough

examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to administering and interpreting the CHA have been addressed and resolved without resorting to deductions.

Health Canada officials routinely liaise with provincial and territorial health ministry representatives and health insurance plan administrators to help resolve common problems experienced by Canadians related to eligibility for health insurance coverage and portability of health services within and outside Canada.

The Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Sources for this information include: provincial and territorial government officials and publications; media reports; and correspondence received from the public and other non-government organizations. Staff in the Compliance and Interpretation Unit, 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 may reveal issues that are not directly related to the CHA, while others may pertain to the CHA but are a result of misunderstanding or miscommunication, and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff, then discuss the issue and its possible resolution with provincial 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.

Compliance Issues

No new CHA compliance issues arose during 2004-2005. With respect to compliance issues noted in previous reports, other than specific developments noted below, bilateral communications on these issues are ongoing.

This information is factual as of March 31, 2005. Unless otherwise indicated, bilateral communications on these issues are ongoing. Consult previous Canada Health Act Annual Reports for further details on issues pre-dating April 2004. In addition, Health Canada continues to review, monitor and assess the impact and implications of a number of other health issues.

Patient charges for magnetic resonance imaging (MRI) and computed tomography (CT) scans

There are private clinics in British Columbia, Alberta, Quebec and Nova Scotia that provide MRI and CT services on a private basis. In these provinces, MRI and CT scans are covered under the provincial health care insurance plan only when the service is performed in an approved hospital. Under the CHA, MRI and CT services are considered to be insured health services when they are medically necessary for maintaining health, preventing disease or diagnosing or treating an injury, illness or disability and are provided in a hospital or a facility providing hospital care.

Health Canada met with provincial officials in January and February 2005 to clarify the federal position and to reiterate the commitment of the federal government to work collaboratively to address the issue.

Patient charges by specialty referral centres and for self-referrals to physician specialists

Since 2002, two specialist referral clinics in British Columbia have been offering expedited consultations with physician specialists for a fee for individuals who choose to bypass their family

physicians to seek specialized treatment. Under the CHA, charges over and above the rate paid by a provincial health insurance plan to insured persons for medically necessary hospital and physician services constitute extra-billing. In December 2004, Health Canada officials restated this position to British Columbia. Further bilateral consultations are required on this issue.

Patient charges for insured health services in private surgical clinics

Health Canada has been engaged in bilateral discussions with British Columbia on patient charges for insured health services in private surgical clinics since June 2000, and has continued to press British Columbia to improve its capacity to audit and investigate charges at these facilities so that insured persons are not charged for insured health services. A deduction of \$72,464 was made to British Columbia's March 2005 CHT payment in respect of extra-billing and user charges, as reported by the province for 2002-2003. In March 2005, Health Canada wrote to the British Columbia government to request a meeting to discuss B.C.'s methods for reporting the extent of extra-billing and user charges levied at private surgical facilities in the province.

Following media reports in March 2000, the Régie de l'assurance maladie du Québec (RAMQ) launched an investigation into claims that a Quebec private clinic was charging patients up to \$400 for the use of operating rooms to perform medical procedures for which physicians billed the RAMQ. Health Canada communicated the CHA concerns about insured persons being charged for insured health services to the Quebec Department of Health and Social Services. Health Canada and Quebec officials met to discuss this issue in February 2005, at which time Quebec reiterated that information pertaining to RAMQ investigations are confidential. They added that there had been no recent patient complaints, but were unable to confirm that the situation had been resolved.

Patient charges for medical/surgical supplies

Health Canada received correspondence from Manitoba Health in February 2005 about the ongoing patient charges for medical/surgical supplies and the issue of “tray fees”. The issue continues to be the subject of ongoing discussion between Health Canada and Manitoba Health.

Canada Health Transfer Deductions in 2004-2005

Deductions were taken from the March 2005 Canada Health Transfer (CHT) payments to three provinces as a result of charges to patients that occurred during 2002-2003. A deduction of \$72,464 was made to British Columbia on the basis of charges reported by the province for extra-billing and patient charges at surgical clinics. A deduction of \$1,100 was made to Newfoundland and Labrador as a result of patient charges for an MRI in a hospital, and a deduction of \$5,463 was made to Nova Scotia as a reconciliation for deductions that had already been made to Nova Scotia for patient charges at a private clinic.

History of Deductions and Refunds under the *Canada Health Act*

The *Canada Health Act*, which came into force April 1, 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.

During the period 1984 to 1987, subsection 20(5) of the CHA 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, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of \$244.732 million in deductions were refunded to New Brunswick (\$6.886 million), Quebec (\$14.032 million), Ontario (\$106.656 million), Manitoba (\$1.270 million), Saskatchewan (\$2.107 million), Alberta (\$29.032 million) and British Columbia (\$84.749 million).

Following the CHA's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the CHA did not reoccur until fiscal year 1994-1995. 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 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 insurance plan. This higher amount constituted extra-billing under the CHA. Including deduction adjustments for prior years, dating back to fiscal year 1992-1993, deductions began in May 1994 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 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992-1993 and 1995-1996. These deductions and all subsequent deductions are non-refundable.

In January 1995, the 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 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 CHA. 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.

From November 1995 to June 1996, total deductions of \$3.585 million were made 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 insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of \$284,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998.

From November 1995 to December 1998, deductions from Manitoba's CHST cash contribution amounted to \$2,055,000, ending 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 \$50,033 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 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.

With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal

Policy on Private Clinics. Before it closed, a total deduction of \$372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.

In January 2003, British Columbia provided a financial statement in accordance with the CHA Extra-Billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000-2001, totalling \$4,610. Accordingly, a deduction of \$4,610 was made to the March 2003 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, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a \$126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001-2002.

Deductions were taken from the March 2005 CHT payments to three provinces as a result of charges to patients which occurred during 2002-2003. A deduction of \$72,464 was made to British Columbia on the basis of charges reported by the province for extra-billing and patient charges at surgical clinics. A deduction of \$1,100 was made to Newfoundland and Labrador as a result of patient charges for an MRI in a hospital, and a deduction of \$5,463 was made to Nova Scotia as a reconciliation for deductions that had already been made to Nova Scotia for patient charges at a private clinic.

Since the enactment of the CHA, from April 1984 to March 2005, deductions totalling \$8,832,178 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the CHA. This amount excludes deductions totalling \$244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces as per subsection 20(5) of the CHA.

Deductions to Cash Contributions under the CHA: 1994-1995 through 2004-2005

(in dollars \$)

Provinces/ Territories	1994- 1995	1995- 1996	1996- 1997	1997- 1998	1998 -1999	1999 -2000	2000 -2001	2001 -2002	2002 -2003	2003 -2004	2004 -2005	TOTAL
NL	0	-46,000	-96,000	-132,000	-53,000	42,570	0	0	0	0	-1,100	-285,530
PE	0	0	0	0	0	0	0	0	0	0	0	0
NS	0	-32,000	-72,000	-57,000	-38,950	-61,110	-57,804	-35,100	-11,052	-7,119	-5,463	-377,598
NB	0	0	0	0	0	0	0	0	0	0	0	0
QC	0	0	0	0	0	0	0	0	0	0	0	0
ON	0	0	0	0	0	0	0	0	0	0	0	0
MB	0	-269,000	-588,000	-586,000	-612,000	0	0	-300,201	0	0	0	-2,355,201
SK	0	0	0	0	0	0	0	0	0	0	0	0
AB	0	-2,319,000	-1,266,000	0	0	0	0	0	0	0	0	-3,585,000
BC	-1,982,000	-43,000	0	0	0	0	0	0	-4,610	-126,775	-72,464	-2,228,849
NT	0	0	0	0	0	0	0	0	0	0	0	0
NU	0	0	0	0	0	0	0	0	0	0	0	0
YT	0	0	0	0	0	0	0	0	0	0	0	0
Total	-1,982,000	-2,709,000	-2,022,000	-775,000	-703,950	-18,540	-57,804	-335,301	-15,662	-133,894	-79,027	-8,832,178

Note: Deductions are shown in the year they were applied to the cash contribution.
Deductions made in one fiscal year may include adjustments to previous fiscal year periods.

Evolution of Federal Health Care Transfers

Grants to help establish programs

Federal support for provincial health care goes back to the late 1940s when the National Health Grants were created. These grants were considered to be essential building blocks of a national health care system. While the grants were mainly used to build up the Canadian hospital infrastructure, they also supported initiatives in areas such as professional training, public health research, tuberculosis control and cancer treatment. By the mid-1960s, the grants available to the provinces totalled more than \$60 million annually.

In the mid-1950s in response to public pressures, the federal government agreed to provide financial assistance to provinces to help them establish health insurance programs. In January 1956, the federal government placed concrete proposals before the provinces to inaugurate a phased health insurance program, with priority given to hospital insurance and diagnostic services. Discussions on these proposals led to adopting the *Hospital Insurance and Diagnostic Services Act* in 1957. The implementation of the Hospital Insurance and Diagnostic Services (HIDS) program started in July 1958, by which time Newfoundland, Saskatchewan, Alberta, British Columbia and Manitoba were operating hospital insurance plans. By 1961, all provinces and territories were participating in the program.

The second phase of the federal intervention supporting provincial and territorial health insurance programs resulted from the recommendations of the Royal Commission on Health Services (Hall Commission). In its final report, tabled in 1964, the Hall Commission recommended establishing a new program that would ensure that all Canadians have access to necessary medical care (physician services, outside a hospital setting).

The *Medical Care Act* was introduced in Parliament in early December 1966, and received Royal Assent on December 21, 1966. The implementation of the Medical Care program started on July 1, 1968. By 1972, all provinces and territories were participating in the program.

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (1966), the federal contribution was set at 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory. Funding protocols based on conditional grants continued until the move to block funding was made in fiscal year 1977-1978.

Established Programs Financing (EPF)

On April 1, 1977, federal funding supporting insured health care services was replaced by a block fund transfer with only general requirements related to maintaining a minimum standard of health services through the passage of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, 1977. Known also as the EPF Act, the new legislation provided federal contributions to the provinces and territories for insured hospital and medical care services (as well as for post-secondary education) that were no longer tied to provincial expenditures. Rather, federal contributions made in fiscal year 1975-1976 under the existing cost-sharing programs were designated as the base year for contributions, to be escalated by the rate of growth of nominal Gross National Product (GNP) and increases to the population.

Under the EPF Act, and subsequent funding arrangements, the total amount of the provincial and territorial health entitlement was now made up of relatively equal cash and tax transfers. The

federal tax transfer involves the federal government ceding some of its “tax room” to the provincial and territorial governments, reducing its tax rate to allow provinces to raise their tax rates by an equivalent amount. With the EPF “health” tax transfer, the changes in federal and provincial tax rates offset one another, meaning there was no net impact on taxpayers. The total amount of the health care entitlement did not change.

The EPF Act also included a new transfer for the Extended Health Care Services Program. This group of health care services, defined as nursing home intermediate care, adult residential care, ambulatory health care and the health aspects of home care, were block funded on the basis of \$20 per capita for fiscal year 1977-1978, and subject to the same escalator as insured health services. This portion of the EPF transfer was made on a virtually unconditional basis and, unlike the insured services transfer, was not subject to specified program delivery criteria.

The health care portion of the EPF cash transfer was made on a semi-monthly basis to each province and territory by Health Canada. While this federal-provincial-territorial health care insurance funding arrangement did include certain program delivery criteria, Health Canada did not have a viable mechanism to compel the provinces and territories to fully comply with the conditions set out in the existing hospital and medical care legislation. Under the prevailing legislative framework, the Government of Canada was required to withhold all of the monthly health care transfer to a province or territory for each month the conditions were not met.

It was not until the enactment of the *Canada Health Act* in 1984 that special deduction provisions came into force allowing for dollar-for-dollar deductions for extra-billing and user charges, and discretionary deductions when provincial and territorial plans failed to fully comply with other provisions set out in the Act. These criteria and conditions remain in force to the present day.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced a restructuring of the EPF Act, then to be called the *Federal-Provincial Fiscal Arrangements Act*, with special provisions for a Canada Health and Social Transfer (CHST). The new omnibus or block transfer, beginning in fiscal year 1996-1997, merged the health and post-secondary education funding of the EPF Act with Canada Assistance Plan funding (the federal-provincial cost-sharing arrangement for social services). When the CHST came into effect on April 1, 1996, provinces and territories received CHST cash and tax transfer in lieu of entitlements under the Canada Assistance Plan (CAP) and Established Programs Financing. The combined value of EPF and CAP cash was greater than the CHST cash amount provided to provinces and territories, reflecting the need for fiscal restraint at the time the CHST was introduced.

The new block fund was provided to fulfill the national criteria in the CHA (public administration, comprehensiveness, universality, portability and accessibility) and the provisions relating to extra-billing and user charges, as well as maintaining the CAP-related national standard that no period of minimum residency be required or allowed with respect to social assistance. Extended health care services continued as part of the CHA, subject only to providing information and recognizing the federal transfer, as set out in section 13 of the CHA. These requirements have remained unchanged since 1984.

The new legislation also transferred the cash payment authority from Health Canada to the Department of Finance. However, the Minister of Health continued to be responsible for determining the amounts of any deductions or withholdings pursuant to the CHA, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance before the payment dates.

2002-2003 Health Accords: Increasing and restructuring federal support for health

In 2000 and 2003, First Ministers met to discuss health care, focusing on reform, reporting and funding requirements. In 2000, the federal government announced \$23.4 billion in new spending over five years on health care renewal and early childhood development. Between 2001-2002 and 2005-2006, the government announced an additional \$21.1 billion dollars for increases to the CHST cash contributions, as well as an additional \$1.8 billion for targeted programs (medical equipment and primary health care reform), and \$500 million for Canada Health Infoway. In 2003, the government committed \$36.8 billion over five years to support priority areas of reform (primary care, home care and catastrophic drugs) through increased CHST transfers (\$14 billion) and new, targeted transfers (\$16 billion for the Health Reform Transfer; \$1.5 billion for medical equipment), as well as support for federal direct spending on health (\$5.3 billion for health information technologies, Aboriginal health initiatives, patient safety and other health-related federal initiatives). CHST increases included \$3.9 billion in unrealized increases committed under the original time frame of the 2000 Accord (up to and including 2005-2006).

The federal government also agreed to restructure the CHST to enhance the transparency and accountability of federal support for health.

The Canada Health Transfer

The CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), effective April 1, 2004. The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the CHA. The CST, a block fund that supports post-secondary education and social assistance and social services, continues to give provinces and territories the flexibility to allocate funds among these social programs according to their respective priorities.

The existing CHST-legislated amounts were apportioned between the new transfers, with the percentage of cash and tax points allocated to each transfer reflecting provincial and territorial spending patterns among the areas supported by the transfers: 62 percent for the CHT and 38 percent for the CST.

2004 10-year Plan to Strengthen Health Care

Federal transfers to the provinces and territories were further increased as a result of the 10-Year Plan to Strengthen Health Care. Signed by all first Ministers on September 16, 2004, this initiative committed the Government of Canada to an additional \$41.3 billion over 10 years in funding to provinces and territories for health, including \$35.3 billion in increases to the CHT, \$5.5 billion in Wait Times Reduction funding, and \$500 million in support of diagnostic and medical equipment.

The 10-Year Plan to Strengthen Health Care set out a long-term predictable, sustainable and growing funding framework for CHT, providing legislated cash levels through to 2013-2014, while the tax transfer component continues to grow in line with the economy.

In fiscal year 2004-2005, the cash contribution for the CHT increased to \$12.650 billion, which included a \$1 billion increase to the CHT base. In fiscal year 2005-2006, the CHT base will increase to \$19 billion, which will include another \$2 billion increase of the CHT, plus \$500 million for home care and catastrophic drug coverage. It also reflects the commitment to roll the former Health Reform Transfer in the CHT.

Additional information on federal-provincial-territorial funding arrangements is available upon request from the Department of Finance, or by visiting its website at:

<http://www.fin.gc.ca/fedprov/ftppte.html>

History of Federal Transfers Related to Health Care

- 1957 *The Hospital Insurance and Diagnostic Services Act* is passed unanimously in both the House of Commons and the Senate, establishing a cost-shared program providing universal insurance coverage and access to hospital services to all residents of participating provinces. By 1961, all provinces and territories have joined this program.
- 1966 The Canada Assistance Plan (CAP) is introduced, establishing a cost-shared program with provinces and territories for the provision of adequate assistance and institutional care programs for persons in need, including certain health care service (for example drugs and dental care services not covered under provincial programs or under existing transfer programs).
- 1968 The *Medical Care Act* is enacted, establishing a cost-sharing program that empowers the federal Minister of Health to make financial contributions to those provinces and territories that operate medical care insurance plans and meet minimum delivery criteria. By 1972, all provinces and territories are participating in this program.
- 1977 The *Federal-Provincial-Territorial Fiscal Arrangements and Established Programs Financing Act* (EPF Act) is passed. The Extended Health Care Services Program is established providing virtually unconditional per capita funding for certain types of long-term residential care services, home care and adult day care services.
- 1984 The *Canada Health Act* is passed, amalgamating the provisions of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. The Act also includes the extended health care services provisions, which had previously been included under the EPF. The CHA now provides for dollar-for-dollar deductions regarding extra-billing and user charges, and discretionary deductions relating to other elements of the criteria and conditions set out in the Act.

The EPF Act is re-named *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, 1977.
- 1995 It is announced in the federal budget that in “established programs” funding under the EPF Act and CAP, cost-sharing will be replaced by Canada Health and Social Transfer (CHST) block fund beginning April 1, 1996. CHST entitlements are set at \$26.9 billion for 1996-1997. CHST entitlements for 1996-1997 are to be allocated in the same proportion as combined EPF and CAP entitlements for 1995-1996.

Section 6 of the CHA (amount payable for extended health care services) was deleted in 1995 to reflect the new fiscal arrangements adopted by the government (i.e. Canada Health and Social Transfer) that required one payment to provinces and territories rather than multiple payments. This change did not reduce the scope of insured health services under the Act. Extended health care services are not and never were insured health services under the CHA.
- 1996 A five-year CHST funding arrangement (1998-1999 to 2002-2003) is announced in the federal government budget. It provides a cash floor transfer to provinces and territories originally set at \$11 billion per year.
- 1998 The *Federal-Provincial-Territorial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* is amended to put in place a \$12.5 billion CHST cash floor, beginning in 1997-1998 and extending to 2002-2003.
- 1999 Increases in provincial and territorial CHST cash entitlements of \$11.5 billion over five years are announced in the federal government budget. The \$11.5 billion is

provided to address fiscal pressures in the health care sector.

- 2000 Increased CHST funding of \$2.5 billion to help provinces and territories fund health care and post-secondary education is announced in the February Budget. This brings CHST cash to \$15.5 billion for each of the years from 2000-2001 to 2003-2004.

Following the First Ministers Meeting of September 11, 2000, the Prime Minister announces an increase in the CHST of more than \$21 billion dollars in cash entitlements over five years. The agreement provided provinces and territories with additional funds earmarked for health renewal and early childhood development.

A \$1 billion Medical Equipment Fund is established to enable provinces and territories to immediately purchase and install medical equipment for diagnostic services and treatment. The Fund is allocated on an equal per capita basis in fiscal years 2000-2001 and 2001-2002.

- 2003 Federal transfers supporting provincial and territorial health care are restructured following the February 2003 Health Care Renewal Accord and the subsequent 2003 Budget. The CHST is complemented by the five-year \$16 billion Health Reform Fund beginning in 2003-2004. Two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), are to be established by April 1, 2004, from a split in the CHST.

As part of the 2003 Accord, the federal government agrees to provide provinces and territories with a three-year, \$1.5 billion Diagnostic/Medical Equipment Fund for the acquisition of diagnostic and medical equipment and related to support specialized staff training to improve access to publicly funded diagnostic services.

- 2004 In September, the First Ministers sign the 10 Year Plan to Strengthen Health Care. In support of the Plan, the Government of Canada commits \$41.3 billion in additional

funding to provinces and territories for health, including \$35.3 billion in increases to the CHT, \$5.5 billion in Wait Times Reduction funding, and \$500 million in support of medical equipment. The CHT base cash contribution amount will be increased to \$19 billion starting in 2005-2006 and an escalator of six per cent annually will be applied to the CHT effective 2006-2007 to provide continued predictable growth in federal support for health.

Additional information on the 10-Year Plan is available online at:

<http://www.pm.gc.ca/eng/news.asp?id=260>

Chapter 3 - Provincial and Territorial Health Care Insurance Plans in 2004-2005

The following chapter presents the 13 provincial and territorial health 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* (CHA) program criteria and conditions in 2004-2005.

Officials in the provincial, territorial and federal governments have collaborated to produce the detailed plan overviews contained in Chapter 3. While all provinces and territories have submitted detailed descriptive information on their health insurance plans, New Brunswick and Quebec have chosen not to submit supplemental statistical information which is contained in the tables in this year's report. The information that Health Canada requested from the 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 five criteria and the first condition (that of providing the Minister of Health with information in relation to insured health services and extended health care services) of the CHA, which can be found following this chapter; and
- statistics identifying trends in the provincial and territorial health care systems.

The first component is used to help with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the CHA, while statistics identify current and future trends in the Canadian health care system.

To help prepare their submissions to the report, Health Canada provided provinces and territories with the document *Canada Health Act Annual Report 2004-2005: A Guide for Updating Submissions*. This guide was developed through discussion with provincial and territorial officials and is designed to help provinces and territories meet the reporting requirements of Health Canada. It was developed through discussion with provincial and territorial officials. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for the 2004-2005 CHAAR was launched late spring 2004 when letters were sent to all provinces and territories confirming the timetable for this year's annual report, identifying issues that needed to be addressed in individual submissions. An updated User's Guide is also sent to the provinces and territories at that time.

Additionally, bilateral meetings were held this year with provincial and territorial officials from the Yukon, Northwest Territories, Saskatchewan, Nunavut, Newfoundland and Prince Edward Island to review the process and reporting requirements.

Insurance Plan Descriptions

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health insurance plan according to the program criteria areas of the CHA in order to illustrate how the plans satisfy these criteria. This narrative description also includes information on how each jurisdiction met the CHA requirement for recognition of federal contributions that support insured and extended

health care services and a section outlining the range of extended health care services in their jurisdiction; where extended health care includes nursing home intermediate care services, adult residential care services, home care services and ambulatory health care services.

Improvements to Accessing Health Care Services

During 2004-2005, provinces and territories continued to implement initiatives to ensure and enhance access by residents to insured health services. The following offer some examples:

- On June 6, 2004 the Minister of Health and Wellness in New Brunswick tabled a four-year plan, *Healthy Futures: Securing New Brunswick's Health Care System*. This document sets out a plan for improving the health and well-being of New Brunswickers and providing health services in a sustainable and affordable manner.
- The Government of Newfoundland and Labrador invested \$4.5 million for medical and diagnostic equipment, including x-ray and ultrasound units, nuclear medicine equipment and an additional MRI machine.
- Quebec has increased the number of family medicine groups from 21 to 103. These groups provide access to health services 24 hours a day, seven days a week.
- The Surgical Patient Registry in Saskatchewan tracks patients needing surgery in the province. This information will allow the surgical care system to improve the management of surgical access, resource requirements and reduce wait time for patients.
- In PEI, the Registered Nurse Recruitment and Retention Strategy was renewed in 2004 to enhance recruitment and retain registered nurses in the health system. This initiative supports sponsorship, relocation assistance, student nurse summer employment and an ongoing commitment to recruitment resources.
- Nova Scotia's Telehealth Network (NSTHN) allows patients in rural areas to consult with specialists in large health centres. It also provides health professionals remote access to educational opportunities. In 2004-2005, 2,700 sessions were provided over the network.
- In Alberta a \$700 million investment was announced to expand capacity and improve access to health care services. This was one of the largest ever single investments in Alberta's health system with \$350 million provided to Alberta Health and Wellness.
- In 2004-2005 the British Columbia Ministry of Health took steps to enhance a number of strategies across the span of health services, including population health and safety, primary care, chronic disease management, Fair PharmaCare, hospital and surgical services, home care, residential care and end-of-life care. The redesign of the province's health system has enhanced patient access to quality health services.
- Health care initiatives in the Yukon Territory target areas such as access and availability of services, recruitment and retention of health care professionals, primary health care, systems development and alternative payment and service delivery systems.
- The Northwest Territories introduced a family health and support line (Tele-Care NWT) for all residents. The free and confidential telephone service is staffed by bilingual (French and English) registered nurses in the NWT and operates 24 hours, seven days a week. It also offers a three-way interpretation service in all NWT Aboriginal languages.
- Nunavut's Telehealth network provides communities with a broad range of health-related services, including specialist consultation services, health education; continuing medical education; family visitation; and administrative functions. Nunavut expanded Telehealth in 2004-2005 to include all communities.

Provincial and Territorial Health Care Insurance Plan Statistics

In 2003-2004, the section of the annual report containing the statistical information submitted from the provinces and territories was simplified and streamlined following feedback received from provincial and territorial officials, and based on a review of data quality and availability. The format remains the same for the 2004-2005 report. The supplemental statistical information can be found at the end of each provincial or territorial narrative, except for New Brunswick and Quebec.

The purpose of the statistical tables is to place the administration and operation of the CHA 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 federal Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental by province and territory for five consecutive years ending on March 31. 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 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.

Public Facilities: Statistics on facilities providing insured hospital services, excluding psychiatric

hospitals and nursing homes (which are not covered under the CHA), are provided in fields two and three

Private-for-Profit Facilities: Measures four through six capture statistics on private-for-profit health care facilities that provide insured hospital services. These measures have been broken down into two sub-categories based on the services provided under the definition of insured hospital services in the CHA.

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

Insured Services Provided Outside Canada – Hospitals: Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory.

Insured Services Provided Outside Canada – Physicians: Physician services provided out-of-country represent a person's 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

Introduction

For the past decade, 14 regional boards have delivered the majority of the publicly funded health services in Newfoundland and Labrador. Of these, eight were institutional health boards, four were health and community services boards and two were integrated boards, delivering both institutional and community services. Included in the eight institutional boards were a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

In September 2004, the Government announced the re-organization of the 14 health boards to form four new regional integrated health authorities. The new structure will achieve greater collaboration of services on a regional basis. The four new regional authorities will focus on the full continuum of care including public health, community services and acute and long-term care services. By the end of fiscal year 2004-2005, new Boards of Trustees were appointed and Chief Executive Officers were recruited.

The provincial government appoints Boards of Trustees who serve as volunteers. These boards are responsible for delivering health services to their regions and, in some cases, to the province as a whole, interacting with the public to determine health needs. The boards receive their funding from the provincial government, to which they are accountable. The Department of Health and Community Services provides the boards with policy direction and monitors programs and services.

This province has the highest rate of several chronic diseases such as heart disease, obesity and diabetes in Canada. Healthy living can help prevent these chronic diseases; therefore, the Department of Health and Community Services committed to improving areas such as health promotion, health surveillance, injury prevention, smoke-free environment legislation and programs to support early childhood development. Some of the initiatives implemented in the fiscal year included:

- The Government confirmed its intention to proceed with legislation to create 100 percent smoke-free indoor environments.
- The Government implemented a "Healthy Students Healthy Schools" program.
- In November 2004, the Department established a Division of Aging and Seniors to be a focal point for information on aging and seniors' issues and ensure that policies, programs and services meet the needs of seniors. The Division will also be the secretariat for the Ministerial Council on Aging and Seniors and the Provincial Advisory Council.
- Budget 2004 allocated \$4.3 million to implement seven primary health care projects and expand some of the existing networks.
- In January 2005, a framework for mental health services was approved by the Minister to bring forward for government consideration.

The Department continues to address the challenges of delivering quality health and community services to the people of the province while recognizing the challenges of an aging population, fiscal resource constraints, diverse geography and human resource issues.

In Newfoundland and Labrador, almost 19,000 health care providers and administrators provided health services to 516,000 residents.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and are audited by the Auditor General of the Province.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act gives the Minister of Health and Community Services the authority to make Regulations for providing insured services on uniform terms and conditions to residents of the province under the conditions specified in the *Canada Health Act* and Regulations.

The *Medical Care Insurance Act* (1999) which came into force on April 1, 2000, empowers the Minister to administer a plan of medical care insurance for residents of the province. It allows for developing regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to administering the medical care insurance plan.

There were no legislative amendments to the *Medical Care Insurance Act* (1999) or the *Hospital Insurance Agreement Act* in 2004-2005.

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 MCP operates in accordance with the provisions of the *Medical Care Insurance Act* (1999) and Regulations, and in compliance with the criteria of the *Canada Health Act*.

1.2 Reporting Relationship

The Department is mandated with administering the Hospital Insurance and Medical Care Plans. The Department reports on these plans through

the regular legislative processes; e.g. Public Accounts and the Estimates Committee of the House of Assembly.

The Department will be tabling its 2004-2005 Annual Report in the House of Assembly in fall 2005. All health authorities, on behalf of predecessor boards, and some health agencies will also table their reports.

The Department's Annual Report highlights the accomplishments of 2004-2005 and overviews the initiatives and programs that will continue to be developed in 2005-2006. The report is a public document and is circulated to stakeholders. It will be posted on the Department's website.

During 2004-2005, the Department also released *Health Scope 2004*, a comparative health indicators report as part of the 2003 First Ministers (FMM) reporting commitments.

1.3 Audit of Accounts

Each year the Province's Auditor General independently examines provincial public accounts. MCP expenditures are now considered a part of the public accounts. The Auditor General has full and unrestricted access to MCP records.

Health authorities are subject to Financial Statement Audits, Reviews and Compliance Audits. Financial Statement Audits were performed by independent auditing firms that are selected by the boards under the terms of the *Public Tendering Act*. Review engagements, compliance audits and physician audits were carried out by personnel from the Department under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records and professional medical corporation records were reviewed to ensure that the records supported the services billed and that the services are insured under the MCP.

Beneficiary audits were performed by personnel from the Department under the *Medical Care Insurance Act* (1999). Individuals are randomly selected on a bi-weekly basis.

The Auditor General was also engaged in specified audit procedures in preparing *Health Scope 2004*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (1990) and the *Hospital Insurance Regulations* 742/96 (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 33 facilities (14 hospitals and 19 community health centers) and 14 nursing stations. Insured services include:

- ☐ accommodation 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 anesthetic facilities;
- ☐ rehabilitative services (e.g. physiotherapy, occupational therapy, speech language pathology and audiology);
- ☐ out-patient and emergency visits; and
- ☐ day surgery.

Coverage policy for insured hospital services is linked to the coverage policy for insured physician services, although there is no formalized process. Ministerial direction is required to add to or to de-insure a hospital service from the list of insured services. The Department of Health and Community Services manages the process.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act* (1999).

Other governing legislation under the *Medical Care Insurance Act* includes:

- ☐ the *Medical Care Insurance Insured Services Regulations*;
- ☐ the *Medical Care Insurance Beneficiaries and Inquiries Regulations*; and
- ☐ the *Medical Care Insurance Physician and Fees Regulations*.

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed by the Newfoundland Medical Board (now referred to as the College of Physician and Surgeons) to practice in the province.

An insured service is defined as one that is:

- (a) listed in section 3 of the *Medical Care Insurance Insured Services Regulations*;
- (b) medically necessary;
- (c) and/or recommended by the Department of Health and Community Services.

There are no limitations on the services covered, subject to the above qualifications.

Physicians can choose not to participate in the health care insurance plan as outlined in subsection 12(1) of the *Medical Care Insurance Act* (1999), namely:

- (1) Where a physician providing insured services is not a participating physician¹, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:
 - (a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician

1 The *Medical Care Insurance Act* (1999) defines "participating physician" as a physician who has not made an election, under subsection 7(3), to collect payments in respect of insured services rendered by him or her to residents, otherwise than from the Minister.

and that the physician may so charge the beneficiary; and

- (b) provide the beneficiary to whom the physician has provided the insured service with the information required by the minister to enable payment to be made under this Act to the beneficiary in respect of the insured service.
- (2) Where a physician who is not a participating physician provides insured services through a professional medical corporation, the professional medical corporation is not, in relation to those services, subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services and the professional medical corporation and the physician providing the insured services shall comply with subsection (1).

As of March 31, 2005, there were no physicians who had opted out of the MCP.

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;
- ☐ group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- ☐ diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and Regulations made under the Act.

Ministerial direction is required to add to or de-insure a physician service from the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial medical association. The Department manages the process and public consultation is involved. There were no services added during the fiscal year to the list of insured physician services covered by the health care insurance plan. There were no services deleted during the fiscal year to

the list of insured physician services covered by the health care insurance plan.

2.3 Insured Surgical-Dental Services

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

All dentists licensed to practice in Newfoundland and Labrador and who have hospital privileges are allowed to provide surgical-dental services. The dentist's license is issued by the Newfoundland Dental Licensing Board.

Dentists may opt out of the Plan. These dentists must advise the patient of their opted-out status, stating the fees expected, and provide the patient with a written record of services and fees charged. One dentist is currently in the opted-out category.

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

Addition of a surgical-dental service to the list of insured services must be approved by the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

- ☐ preferred accommodation at the patient's request;
- ☐ cosmetic surgery and other services deemed to be medically unnecessary;
- ☐ ambulance or other patient transportation before admission or upon discharge;
- ☐ private duty nursing arranged 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;
- ☐ fibreglass splints;
- ☐ services covered by Workers' Compensation legislation or by other federal or provincial legislation; and
- ☐ services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board.

The use of the hospital setting for any services deemed not insured by the Medicare Plan are also uninsured under the Hospital Insurance Plan.

For purposes of the *Medical Care Insurance Act* (1999), the following is a list of non-insured physician services:

- ☐ any advice given by a physician to a beneficiary by telephone;
- ☐ 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 appropriate authority;
- ☐ plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- ☐ 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 Newfoundland Medical Board;
- ☐ sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- ☐ in vitro fertilization and OSST (ovarian stimulation and sperm transfer);
- ☐ reversal of previous sterilization procedure;
- ☐ surgical, diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
- ☐ other services not within the ambit of section 3 of the Act.

All 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 the

standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

Surgical-dental and other services not covered by the Surgical-Dental Program include the dentist's fee and the oral surgeon's or general practitioner's fees for routine dental extractions in a hospital.

3.0 Universality

3.1 Eligibility

Residents of Newfoundland and Labrador are eligible for coverage under the provincial health care program.

The *Medical Care Insurance Act* (1999) defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the province, but does not include tourists, transients or visitors to the province.

The *Medical Care Insurance Beneficiaries and Inquiries Regulations* (Regulation 20/96) identify those residents eligible to receive coverage under the plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the plans include:

- ☐ students and their dependants already covered by another province or territory;
- ☐ dependants of residents if covered by another province or territory;
- ☐ certified refugees and refugee claimants and their dependants;
- ☐ foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
- ☐ foreign students and their dependants;
- ☐ tourists, transients, visitors and their dependants;

- ☐ Canadian Forces and Royal Canadian Mounted Police (RCMP) personnel;
- ☐ inmates of federal prisons; and
- ☐ armed forces personnel from other countries who are stationed in the province.

3.2 Registration Requirements.

Registration under the MCP and possession of a valid MCP card are required in order to access insured services. New residents are advised to apply for coverage as soon as possible on arriving in Newfoundland and Labrador.

It is the parent's responsibility to register a newborn or adopted child. The parents of a newborn child will be given a registration application upon discharge from hospital. Applications for newborn coverage will require, in most instances, a parent's valid MCP number. A birth or baptismal certificate will be required where the child's surname differs from either parent's surname.

Applications for coverage of an adopted child require a copy of the official adoption documents, the birth certificate of the child, or a Notice of Adoption Placement from the Department. Applications for coverage of a child adopted outside Canada require Permanent Resident documents for the child.

3.3 Other Categories of Individual

Foreign workers, clergy and dependants of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Holders of Minister's Permits are also eligible, subject to MCP approval.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons 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 Forces, the RCMP and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada who are authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

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

Sections 12 and 13 of the *Hospital Insurance Regulations* (1996) define portability of hospital coverage during temporary absences both within and outside Canada. Portability of medical coverage during temporary absences both within and outside Canada is defined in departmental policy.

Eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services, although there is no formalized process.

Coverage is provided to residents during temporary absences within Canada. The Government has entered into formal agreements (i.e. the Hospital Reciprocal 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.

Except for Quebec, medical services incurred in all provinces or territories are paid through the Medical Reciprocal 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

MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province 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:

- ❑ before leaving the province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate;
- ❑ beneficiaries leaving 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;
- ❑ students leaving the province may receive a certificate, renewable each year, provided they submit proof of full-time enrollment in a recognized school located outside the province;
- ❑ persons leaving the province for employment purposes may receive a certificate for coverage up to 12 months. Verification of employment may be required;
- ❑ persons must not establish residence in another province, territory or country while maintaining coverage under the Newfoundland 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;
- ❑ for out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the province; and
- ❑ failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills 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. Coverage is immediately discontinued when residents move permanently to other countries.

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- and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. 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 Government's hospitalization plan 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 hæmodialysis 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. Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the 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.

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.

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 provincial health insurance plan will pay the costs of services necessary for the patient's care. However, it is necessary in these circumstances for such referrals to receive prior

approval from the Department. The referring physicians must contact the Department or the MCP for prior approval.

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the MCP so that patients may be made aware of any financial implications. General practitioners and specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the province or elsewhere within Canada.

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. There are no co-insurance charges for insured hospital services and no extra-billing by physicians in the province.

5.2 Access to Insured Hospital Services

In Newfoundland and Labrador there is a health care workforce of nearly 19,000 individuals. Half of this workforce are members of regulated professional groups.

The supply of health professionals is a high-priority issue in the province, especially in rural areas.

In 2004-2005, the Department continued with its commitment to health human resource planning in the province. The Physician Resource Planning Committee was formed in March 2005 to develop a human resource plan for physicians in the province.

The Atlantic Health Education Training Planning Study was initiated to allow for informed health education planning and decision-making in Atlantic Canada. The study's deliverables include

comparative analysis of the previous provincial studies and roll-up of data, inventories of health education programmes, an environmental scan, reusable simulation modelling software and recommendations. The study is scheduled for completion in the 2005-2006 fiscal year.

The forecasts of the Health Human Resources Planning report showed potential shortages for some health occupations, mostly the younger, mobile, allied health groups where turnover is the highest. Generally the study found that while there are health human resource issues needing attention, stability in the system is expected in the next three to five years.

Forty-eight awards totaling \$1.2 million were granted to physicians and medical residents in exchange for a commitment to work in this province for a designated period. Seventeen Nurse Practitioner bursaries were awarded. Eighteen bursaries were awarded to other health professionals such as occupational therapy, physiotherapy, speech language pathology and audiology. Fifty-six nursing students used the Rural Student Nursing Incentive Program. As well, three scholarships were awarded by the Department for the Graduate Program in Health Administration.

Best practices and operational reviews were carried out at some health boards to improve service delivery and address operating deficits.

The Government invested \$4.5 million in medical and diagnostic equipment in 2004-2005. The funding was allocated to purchase equipment such as x-ray units, ultrasound units, nuclear medicine equipment and a second Magnetic Resonance Imaging (MRI) machine located in Corner Brook. This machine became operational in March 2005 and is addressing diagnostic and specialized testing for residents of the western region of the province.

Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services:

- an MRI unit is located in St. John's; and a second unit became operational in February

2005 in Corner Brook; a third unit was announced for St. John's in March 2005;

- Computed Tomography (CT) scanners are available in St. John's, Carbonear, Clarenville, Gander, Grand Falls/Windsor, Corner Brook, St. Anthony and Happy Valley/Goose Bay;
- renal dialysis is provided in St. John's, Clarenville, Gander, Grand Falls/Windsor, Corner Brook and Stephenville;
- cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and regional clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony; and
- specialized surgical services are available at six regional hospitals.

Basic surgery is also offered at these locations and in seven district hospitals. Tertiary surgery, e.g. trauma, cardiac, neonatal and neurosurgery, is offered in St. John's. Quaternary care is not available. Residents access this level of care at out-of-province facilities.

Following an extensive public consultation, the Department approved a provincial primary health care renewal framework, *Moving Forward Together: Mobilizing Primary Health Care*. The framework outlines the structure for remodelling primary health care in Newfoundland and Labrador through an incremental approach.

The framework supports four goals: (1) enhanced access to, and sustainability of, primary health care; (2) an emphasis on self-reliant and healthy citizens and communities; (3) promotion of a team-based, interdisciplinary and evidenced-based approach to services provision; and (4) enhanced accountability and satisfaction of health professionals. Provincial supports included establishing the Office of Primary Care, the Primary Health Care Advisory Council, linkages with local college and university programs and professional associations, and developing provincial working groups to support learning/problem-solving and provider capacity-building.

Seven proposals for interdisciplinary, team-based, primary health care projects across the province

were approved and are actively being implemented, since 2004, with formal evaluation. An eighth proposal has been approved for the Placentia area and will begin implementation next year.

Primary health care working groups were initiated to develop partnerships, processes and tools for scope of practice shifts, physician payment models and information management. The initial focus was on enhanced electronic sharing of information, including electronic medical information.

Agreements on two Atlantic projects were reached: *Building a Better Tomorrow Initiative* (BBTI) and Self-care/Telecare. The BBTI will support team and inter-professional development and change management in project areas. A needs assessment for 24/7 telephone advice service was also initiated through the Self-care/Telecare project. The Province will be proceeding with an advice line in partnership with New Brunswick.

A major policy framework – *Working Together for Mental Health*, which has been endorsed by the system – was approved by the Minister in January 2005. The policy is in the process of being reviewed by Government before its anticipated release in fall 2005.

The report *Investing in Health - A Report on Public Health Capacity in Newfoundland and Labrador* summarized the findings on public health capacity and made recommendations for future actions to ensure health protection, injury prevention and protection of the population from existing and emerging communicable and chronic diseases.

The integrated Public Health Information System (iPHIS) developed by Health Canada was piloted in the Eastern Region of the province (2003-2004) as a tool to optimize disease surveillance and case management. This was placed on hold while the Department explores the Health Infoway Pan-Canadian Health Surveillance Solution.

The Government's Provincial Wellness Advisory Council made recommendations for wellness priorities. These included: healthy eating; physical activity; tobacco control; injury

prevention; mental health promotion; child and youth development; environmental health; and health protection. An initial focus is on healthy students/healthy schools.

5.3 Access to Insured Physician and Surgical-Dental Services

The number of physicians practicing in the province has been relatively stable, with an upward trend since 2003. The Department is committed to working with regional health boards to develop a provincial human resource plan for physicians based on the principle of access to services.

As of March 31, 2005, there were 460 general practitioners and 494 specialists in practice, compared with 451 general practitioners and 499 specialists as of March 31, 2004. This represents a two percent increase in general practitioners and a one percent increase in specialists.

The Department initiated several measures to ensure access for insured physician services. Some of these included:

- (a) continued support and funding for the Provincial Office of Recruitment;
- (b) retention bonuses for salaried physicians, which recognize years of retention as well as geography; and
- (c) an annual bursary program valued at \$1.1 million for post-graduates willing to commit to provide medical services in areas of need within the province. During fiscal year 2004-2005, 38 bursaries and travelling fellowships were funded.

5.4 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act* (1999).

The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract and sessional block funding.

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. Arising from the most recent agreement, the Physician Services Liaison Committee was formed to provide a mechanism whereby medical issues of mutual concern are addressed cooperatively between the Government and the NLMA.

In 2003, an arbitrated award was reached with the provincial medical association which resulted in a three-year agreement being implemented in May 2003. The total value of the award was \$54 million over three years. The award was unique in that it included varying increases to different fee-for-service physician groups based upon fee rate comparisons with their Maritime peers, dedicated dollars to increase emergency department rates, a universal on-call payment policy and salary increases of 18 percent.

The dispute resolution in the agreement to determine deficits or surplus for fee-for-service funding is arbitration under the *Arbitration Act*.

The current methods of remuneration to compensate physicians for providing insured health services are fee-for-service (60% of physicians); salaried (35 percent of physicians); and alternate payment plans (five percent of physicians) such as block funding, new case payments, etc.

5.5 Payments to Hospitals

The Department is responsible for funding regional boards for ongoing operations and capital purchases. Funding for insured services is provided to the regional boards as an annual global budget and is distributed in 12 monthly advance payments. Payments are made in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act*. As part of their accountability to the Government, the boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The

global budgeting process devolves the budget allocation authority, responsibility and accountability to all appointed boards in the discharge of their mandates.

Throughout the fiscal year, the health boards forwarded additional funding requests to the Department for any changes in program areas or increased workload volume. These requests were reviewed and, when approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for additional approved positions or program changes, were funded based on the implementation date of such increases and the cash flow requirements.

Boards are continually facing challenges in addressing increased demands when costs are rising, staff workloads are increasing, patient expectations are higher and new technology introduces new demands for time, resources and funding. Boards continue to work with the Department to address these issues and provide effective, efficient and quality health services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) 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 2004-2005, these documents included:

- the 2004-2005 Public Accounts;
- the Estimates 2004-2005; and
- the Budget Speech 2004.

The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available to Newfoundland and Labrador residents and have been shared with Health Canada for information purposes.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community-based programs as alternatives to hospital services. These programs are provided by the health boards. Services include the following:

- ❑ Long-term residential accommodations are provided for residents requiring high levels of nursing care in 19 community health centres and 22 nursing homes. There are approximately 2,800 beds located in these facilities. Residents pay a maximum of \$2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department.
- ❑ Persons requiring supervised care or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,750 beds located in 94 homes across the province. These homes are operated by the private for-profit sector. Residents are subsidized a maximum of \$1,138.10 per month, based on an individual client assessment using standardized financial criteria.

Home Care Services

Home care services include professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed by six regional boards. Non-professional services include personal care, household management, respite and behavioural management. These services are delivered by home support workers through agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial

criteria. The monthly ceiling for home support services (fiscal 2004-2005) is \$2,707 for seniors and \$3,875 for persons with disabilities.

Special Assistance Program

The Special Assistance Program is a provincial program that provides basic supportive services to assist financially eligible clients in the community with activities of daily living. The benefits include access to health supplies, oxygen, orthotics and equipment.

Drug Programs

The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who receive the Guaranteed Income Supplement and who are registered for Old Age Security benefits. Eligible individuals are given coverage for the ingredient portion of benefit prescription items. Any additional cost, such as dispensing fees, is the client's responsibility. Income support recipients are eligible for the Income Support Drug Plan, which covers the full cost of benefit prescription items, including a set markup amount and dispensing fee.

Other Programs

The Department administers the Emergency Air and Road Ambulance Programs through the Emergency Health Services Division.

The Road Ambulance Program provides quality pre-hospital emergency and routine treatment, care and transportation. It also includes the transfer of patients between facilities and return of patients to their place of residence. Road ambulances are operated by 59 organizations – 30 private companies, 22 community or volunteer groups, and seven regional health boards throughout the province.

The Air Ambulance Program provides air transport for patients requiring emergency care who could not be transported by a commercial airline or by road ambulance because of urgency or time, or remoteness of location. This program uses two fixed-wing aircraft and five chartered helicopters. These helicopters are also used for

routine transportation of doctors and nurses to remote communities for clinics. A third fixed-wing aircraft is used in Labrador for regional medical services transports, including routine appointments by coastal residents in Happy Valley/Goose Bay.

Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the province, may qualify for financial assistance under the Medical Transportation Assistance Program. This program is administered by the Department. Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance, as administered by the Health Care Corporation of St. John's, when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance and Medical Care Plans.

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at six-month intervals; cleanings at 12-month intervals; fluoride applications at 12-month intervals for children aged 6 to 12; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. Services are available under the social assistance component to recipients of social assistance who are 13 to 17 years of age: examinations (every 24 months); x-rays (with some limitations); routine fillings and extractions; emergency extractions, when the patient is seen for pain, infection or trauma. Adults receiving social assistance are eligible for emergency care and extractions. Beneficiaries covered under the Dental Health Plan must pay a variable amount directly to the dentist for each service provided (e.g., fillings, extractions, etc.). In circumstances where the beneficiary is receiving income support, a \$5 co-payment is paid by the Dental Health Plan.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	616,944	565,000	560,644	599,907	569,835

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	32	32	32	33	33
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	32	32	32	33	33
3. Payments (\$):					
a. acute care	537,428,824	619,884,087	666,472,833 ¹	666,773,382 ¹	679,024,717 ¹
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	537,428,824	619,884,087	666,472,833 ¹	666,773,382 ¹	670,024,717 ¹
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	0	0	0	0	0
c. total	not available	not available	not available	not available	not available
6. Payments (\$):					
a. surgical facilities	270,750	338,200	286,425	280,250	264,575
b. diagnostic imaging facilities	0	0	0	0	0
c. total	270,750	338,200	286,425	280,250	264,575

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#): ²					
a. general practitioners	420 ³	421 ³	437 ³	451 ³	460 ³
b. specialists	473 ³	465 ³	477 ³	499 ³	494 ³
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	893 ³	886 ³	914 ³	950 ³	954 ³
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	2,340,000	2,263,000	2,147,000	2,109,987	2,145,000
b. specialists	2,318,000	2,218,000	2,206,000	1,843,902	1,874,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,657,000	4,481,000	4,353,000	3,953,889	4,019,000
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	43,251,000	42,751,000	50,961,000	62,613,000	72,225,000
b. specialists	73,239,000	75,177,000	78,157,000	90,739,000	103,685,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	116,490,000	117,928,000	129,118,000	153,352,000	175,910,000
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	18.49	18.89	23.74	23.97	33.67
b. specialists	31.60	33.90	35.43	38.79	55.33
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	25.01	26.32	29.66	31.38	43.77
13. Number of services provided through <u>all payment methods</u> (#): ⁴					
a. medical	2,878,000	2,728,000	2,607,000	3,170,000	3,195,000
b. surgical	433,000	398,000	379,000	270,000	270,000
c. diagnostic	1,346,000	1,345,000	1,367,000	480,000	502,000
d. other	not applicable	not applicable	not applicable	34,000	52,000
e. total	4,657,000	4,481,000	4,353,000	3,954,000	4,019,000
14. Total payments to physicians paid through <u>all payment methods</u> (\$): ⁴					
a. medical	71,987	not available	not available	96,261,000	105,090,000
b. surgical	10,834	not available	not available	26,456,000	27,946,000
c. diagnostic	33,670	not available	not available	12,430,000	14,611,000
d. other	not applicable	not applicable	not available	18,205,000	28,263,000
e. total	116,490,000	117,928,000	129,118,000	153,352,000	175,910,000
15. Average payment per service, <u>all payment methods</u> (\$): ⁴					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not applicable	not available	not available	not available	not available
e. all services	25.01	26.30	29.66	31.38	43.77

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	1,699	1,681	1,588	1,640	1,699
17. Total number of claims, out-patient (#).	24,929	26,155	26,464	25,762	26,467
18. Total payments, in-patient (\$).	10,608,368	10,312,515	10,817,595	12,397,072	12,248,758
19. Total payments, out-patient (\$).	3,047,375	3,213,978	3,488,186	3,232,235	4,321,173
20. Average payment, in-patient (\$).	6,244.00	6,135.00	6,812.00	7,559.00	7,209.00
21. Average payment, out-patient (\$).	122.00	123.00	132.00	125.00	163.00
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	173,000	143,000	143,000	121,072	140,000
23. Total payments (\$).	4,562,000	4,082,000	4,231,000	4,222,118	4,459,000
24. Average payment per service (\$).	26.35	28.56	29.57	34.87	31.85

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	111	62	61	62	50
26. Total number of claims, out-patient (#).	287	258	278	283	301
27. Total payments, in-patient (\$).	1,102,540	123,692	269,963	363,153	76,981
28. Total payments, out-patient (\$).	36,260	22,567	18,432	167,588	60,159
29. Average payment, in-patient (\$).	9,933.00	1,995.00	4,426.00	5,857.00	1,540.00
30. Average payment, out-patient (\$).	126.00	87.00	66.00	592.00	200.00
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	6,000	4,000	3,000	5,342	6,000
32. Total payments (\$).	424,000	67,000	172,000	473,460	446,000
33. Average payment per service (\$).	70.16	16.37	54.30	88.63	74.33

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	35	26	33	not available	31
35. Number of services provided (#).	11,000	10,000	11,000	not available	not available
36. Total payments (\$).	389,000	409,000	419,000	not available	329,000
37. Average payment per service (\$).	35.06	39.82	37.76	not available	not available

Endnotes

1. New Methodology for 2002-2003. Operating costs only; does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.
2. Excludes inactive physicians.
3. Total salaried and fee-for-service.
4. Fee-for-service only.

Prince Edward Island

Introduction

The Ministry of Health and Social Services is a very large and complex system of integrated services that protect, maintain and improve the health and well being of Prince Edward Islanders. The continued sustainability of the system is a primary concern. Spending on health and social services has grown rapidly in recent years to 42 percent of the total provincial government program expenditures. The availability of health professionals is also affecting our ability to sustain services.

The high rate of chronic conditions in our province are a concern: conditions such as cardiovascular disease, cancer, diabetes and mental illness. Wellness initiatives will help Islanders increase their acceptance of responsibility for their health and to reach their full health potential. This will be achieved through community partnerships to promote healthy lifestyles and to reduce risk factors for chronic disease, and through increased access to primary health services that support disease prevention and management.

Recruitment, retention and human resource planning will remain a priority to ensure an adequate supply and appropriate mix of health and social service professionals to meet changing needs. Retention initiatives are supported by comprehensive workplace wellness programs that promote organizational excellence, positive personal health practices and safe, positive workplaces.

In fall 2004, the provincial government took necessary steps to renew and sustain programs in a planned and orderly fashion through the program renewal process. Adding more money to maintain and enhance programs was no longer an option to spiralling program costs. Instead, it was important to find better uses of the resources available. This process involved developing profiles of programs and consulting with employees to evaluate programs, which were then reviewed by the departmental management team. As a result of program renewal, there is a much clearer picture of what programs are working well and which ones are not.

In April 2005, it was announced in the budget speech that the four regional health authorities and the Provincial Health Services Authority would be brought together as one system under the Department of Health. To ensure a strong community voice in health care, community hospital boards will be established to oversee, manage and plan for community hospitals. A separate Department of Social Services and Seniors will be created. It will be dedicated to social services, children and meeting the special needs of our growing seniors population. This reorganization will result in cost savings of \$9 million each year.

Overview of the Health and Social Services System

Prince Edward Island 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*. Many other health and social services are funded in whole, or in part, by the provincial government. The system includes a wide range of integrated health and social services such as acute care, addictions, mental health, social assistance and housing services. In addition, some specialty services such as cardiac surgery and neurotrauma services are offered in two referral hospitals within the purview of the Provincial Health Services Authority.

In December 2002, the Prince Edward Island health system underwent restructuring. The Provincial Health Services Agency (PHSA) was created to administer all acute care hospital services including cancer treatment, mental health and addictions within two referral hospitals. The Eastern Kings and Southern Kings Regional Health Authorities were merged to form the Kings Regional Health Authority.

Facilities

Prince Edward Island has two referral hospitals and five community hospitals, with a combined total of 463 beds. Along with nine government manors/facilities that house 558 (plus 10 respite) long-term care nursing beds, Islanders have access to an additional 389 (plus 11 temporary beds) in nine private nursing homes. The system also operates several addictions and mental health facilities, 1,146 seniors' housing units and 468 family housing units.

Construction of a new \$50 million health facility, the Prince County Hospital, was completed and opened in April 2004 in Summerside. Computed Tomography (CT) scanning and a wide range of diagnostic imaging services are available at the referral hospitals. A new linear accelerator and Magnetic Resonance Imaging (MRI) services are now operating. In 2004, a renewal committee began plans to upgrade the 22-year-old Queen Elizabeth Hospital.

Human Resources

The public sector health and social services workforce has approximately 4,000 employees. Physician recruitment is ongoing to address vacancies in the physician complement in this province, although enticing new physicians to the province and retaining the appropriate number of required physicians to meet the needs of Islanders is challenging. These challenges are being met by developing a long-term physician resource plan, by providing salary options to new graduates and existing physicians, and with more communication with Island students and Residents through the Medical Education Program.

The new Physician Master Agreement, effective April 1, 2004 until March 31, 2007, ensures Prince Edward Island remains competitive with other jurisdictions so that Islanders can continue to access a quality health care system. It provides for economic increases of 2 percent in the first year, 2.5 percent in the second year, and 3 percent in the final year. Also, the government will invest an additional \$2.1 million, to be implemented over three years, to address areas that will make the health system more competitive so that it can maintain services and increase the success of recruitment and retention efforts for physicians.

Three family physicians and five specialist physicians were recruited to Prince Edward Island last year and another 55 physicians were recruited to provide temporary locum services.

The Registered Nurse Recruitment and Retention Strategy was renewed in 2004 with a few minor modifications for a number of incentives to recruit and retain registered nurses to our health system including, but not limited to: sponsorship; relocation assistance; nursing refresher assistance; student nurse summer employment; and an ongoing commitment to recruitment resources. In fiscal year 2004-2005, there were 32 sponsorships for students in their third year of study. Approximately 86 new registered nurses were brought into the health and social services system between April 1, 2004 and March 31, 2005.

Structure

The system includes the Department of Health and Social Services, the PHSA and four regional health authorities, which are governed by the Regional Health Boards. The Department works with the regional health authorities and the PHSA to establish system goals and objectives, develop policy and outcome standards and allocate resources. The regional health authorities plan and deliver primary health care and social services. The PHSA is responsible for delivering acute care services across Prince Edward Island.

Financial Resources

During the past 10 years, provincial net spending on health and social services increased from \$270 million to more than \$412 million in 2004-2005, an average increase of about 5 percent per year. Increased costs are due to inflation, population growth, new technologies and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 32 percent; Social Services, 20 percent; Long-Term Care, 11 percent; Physician Services, 14 percent; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 23 percent.

In 2004-2005, funding for drug programs increased by \$1.2 million. Drug coverage was further expanded through new financial assistance for medications to treat rheumatoid arthritis and Crohn's disease. The Remicade and Embrel Program became available in fall 2004. It provides financial assistance to qualified patients using Remicade for the treatment of severe rheumatoid arthritis, severe Crohn's disease, or fistulizing Crohn's disease, and qualified patients using Embrel for the treatment of severe rheumatoid arthritis. New funding of up to \$200 per month was introduced to help with the cost of home oxygen equipment and supplies and an additional \$1.8 million was allocated for blood services.

Increased funding was made available to identify speech and language difficulties in young children and make early interventions. Over 7,000 students were vaccinated against whooping cough and \$262,000 was invested to immunize children against meningitis.

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruiting and retaining skilled employees are expected to be a challenge throughout the labour market in coming years due to a major demographic shift. The effect of this trend is

being felt first in the health sector, which is labour intensive and depends on a specialized workforce, and particularly in less populated areas such as Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases and the supply of available health care graduates declines. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

The demand for services is increasing in almost every area for a variety of reasons, including population growth, the availability of new drugs and technology and increasing public expectations. Residents are asking for more doctors, nurses, drugs, technology and family services. They want access to care in their own communities. They are also concerned about waitlists for services. While rising expectations are creating pressure to increase spending on acute care, they are severely limiting the ability of the system to innovate and shift resources to other areas of need.

Increasing public expectation is a very critical issue. Demand alone cannot drive the system. The public must become more informed about reasonable access and the need for real changes in the way services are delivered, particularly in primary health services.

Appropriate access to primary health services

There is growing evidence that investments in primary health services have a great impact on health and sustainability. Primary health services are those that people access first and most often, such as family physician services, public health nursing, screening programs, addiction services and community mental health services.

Personal health practices

People's capacity to accept responsibility for their health is influenced by social and economic conditions. Comprehensive strategies are needed

to address these conditions. It is critical that the health system increase its capacity to work with others to help individuals, families and communities accept responsibility for, and achieve, good health.

Aging population

As baby boomers age, we will experience the biggest demographic shift in history. It is expected that the proportion of the population aged 65 and over in Prince Edward Island will increase from 13 percent today to 15 percent in 2011 and to 27 percent in 2036. This will affect the health system in several ways. The incidence of diseases such as cancer, heart disease, diabetes and dementia is expected to increase. Demand is expected to rise for acute care, long-term care, home care, mental health and other services. This issue becomes more critical when we consider that the health care workforce will be aging at the same time, there will be fewer family members to support their aging parents, and the amount of resources required to sustain services for seniors could negatively affect other government services that support health. It is critical that the health system be prepared to meet these changing needs.

Disease prevention and management

Many diseases are preventable. For example, meningitis can be prevented through vaccination. The spread of sexually transmitted diseases can be prevented through responsible sexual behaviour. Many chronic conditions are also preventable. Risk factors for cardiovascular disease and cancer can be reduced or eliminated through education and supports that result in a change in lifestyle.

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid 1970s, compared with 45 cases per month in the mid 1990s. It is projected that this number will grow to 65 cases per month in 2006. There is clear and undisputable evidence that effective blood sugar control can prevent or delay the onset of serious complications from diabetes,

such as heart disease, blindness and kidney disease, which have enormous human and financial costs. The prevalence of cancer and diabetes in this province is expected to increase significantly as the population ages. It is imperative that our system step up its efforts to help Islanders prevent, delay and manage these conditions.

Staff worked in partnership with cancer survivors and community organizations to introduce *Partners Taking Action: a Cancer Control Strategy for Prince Edward Island 2004 - 2015*; released in October 2004. Through the Strategy for Healthy Living, we continue to work with communities to make healthy living the norm in our province.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Hospital Care Insurance Plan, under the authority of the Minister of Health and Social Services, is the vehicle for delivering hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988), which insures services as defined under section 2 of the *Canada Health Act*.

Under Part I of the *Hospital and Diagnostic Services Insurance Act*, it is the function of the Minister, and the Minister has the power, to:

- ☐ ensure the development and maintenance throughout the province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;
- ☐ approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;
- ☐ approve or disapprove all grants to hospitals for construction and maintenance;
- ☐ establish and operate, alone or in cooperation with one or more organizations, institutes for training hospital and related personnel;
- ☐ conduct surveys and research programs and to obtain statistics for its purposes;

- approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations; and
- subject to the approval of the Lieutenant Governor in Council, to do all other acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

In addition to the duties and powers enumerated in Part I of the Act, it is the function of the Minister, and the Minister has power, to:

- administer the plan of hospital care insurance established by this Act and the Regulations;
- determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance and to make retroactive adjustments with hospitals for under payment or over payment for insured services according to the cost as determined in accordance with the Act and the Regulations;
- receive and disburse all monies pertaining to the plan of hospital care insurance;
- approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance;
- enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons;
- prescribe forms necessary or desirable to carry out the intent and purposes of the Act;
- appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon;
- appoint medical practitioners with the duty and power to examine and obtain information from medical and other hospital records, including patients' charts with medical records and nurses' notes, reports and accounts of patients who are receiving or have received insured services;

- appoint inspectors with the duty and power to inspect and examine books, accounts and records of employers and collectors to obtain information related to the hospital and insurance plan;
- withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;
- act as a central purchasing agent to purchase drugs, biologicals or related preparations for all hospitals in the province; to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the province; and to withhold or reduce payments under the Act to a hospital that does not comply with regulations relating to purchasing drugs, biologicals or related preparations; and
- supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under the Act to a hospital that does not comply with the regulations relating to using such aids and procedures.

The Health Ministry, through the Department, has the responsibility for the overall efficiency and effectiveness of the provincial health system.

Specifically, the Department is responsible for:

- setting overall directions and priorities;
- developing policies and strategies, legislation, provincial standards and measures;
- monitoring provincial health status;
- monitoring and ensuring that the PHSA and the four regional health authorities comply with regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the PHSA and the four regional health authorities;
- improving the quality and management of a comprehensive province wide health information system;
- ensuring access to high quality health services;
- addressing emerging health issues and examining new technology before implementation; and
- directly administering certain services and programs.

The PHSA and four regional health authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and hire physicians, nurses and other health related workers.

Their responsibilities include:

- ☐ assessing the health needs of residents in their regions;
- ☐ providing for the input and advice of their residents;
- ☐ allocating and managing resources, setting priorities, hiring staff and making the best use of available resources;
- ☐ consulting with other organizations involved in the health field;
- ☐ developing policies, standards and measures;
- ☐ planning and coordinating, with the Department and other Authorities, the delivery of the full range of health services;
- ☐ promoting health and wellness in their communities;
- ☐ making information available to residents on choices about health and health services;
- ☐ ensuring reasonable access to health services; and
- ☐ monitoring, evaluating and reporting on performance to residents and to the Ministry.

In 2004, all four regions were granted an accreditation status. Queens, Kings and West Prince were granted Accreditation with Report, requiring follow-up and reporting back to Canadian Council on Health Services Accreditation (CCHSA), and East Prince was granted Accreditation with Focus Visit. In February 2005, East Prince prepared a progress report addressing specific issues identified in the report.

The PHSA has received a full three-year accreditation, but CCHSA will conduct a focused visit in June 2005 and will require a follow-up report in December on other key recommendations made by the survey team.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on 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.

The PHSA and four regional health authorities are required under section 24 of the *Health and Community Services Act* to submit an annual report in the fall to the Minister of Health and Social Services. The Minister has the authority to request other information, as deemed necessary, on the operations of the regional health authorities and their delivery of health services in their areas of jurisdiction. Regional health authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The provincial Auditor General conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department.

Each regional health authority has the responsibility to engage its own public accounting firm to conduct annual financial statement audits. The audited financial statements are provided to the Ministry and the Department of the Provincial Treasury. The reports are presented at public meetings held annually within each region. Audited statements are also presented to the Legislative Assembly and included within the published Public Accounts of the Province of Prince Edward Island.

The provincial Auditor General, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program specific basis with respect to the operations of the Department, as well as the PHSA and each of the four regional health authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include:

- ☐ 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.

As of March 2005, there were seven acute care facilities participating in the Province's insurance plan. In addition to 423 acute care beds, these facilities house 20 rehabilitative beds and 20 day surgery beds, as defined under the *Hospitals Act* (1988), for a total of 463 beds.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988). Amendments were passed in 1996. Changes were made to include the physician resource planning process.

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The number of practitioners who billed the Insurance Plan as of March 31, 2005, was 190.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the 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 not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health.

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, 2005, no physicians had opted out of the Health Care Insurance Plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care 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-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.

New codes for MRI services, and several other codes, were developed through the negotiation

process between the Department and the Medical Society of Prince Edward Island.

The process to add a physician service to the list of insured services involves negotiation between the Department and the Medical Society.

2.3 Insured Surgical-Dental Services

Dental services are not insured in the Health Care Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two 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.

A surgical-dental service (post-operative removal of mandibular wires in an office setting) has been added as a result of negotiations between the Dental Association and the Department.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Plan include:

- ☐ services that persons are eligible for under other provincial or federal legislation;
- ☐ mileage or travel, unless approved by the Department;
- ☐ advice or prescriptions by telephone, except anticoagulant therapy supervision;
- ☐ examinations required in connection with employment, insurance, education, etc.;
- ☐ group examinations, immunizations or inoculations, unless prior approval is received from the Department;
- ☐ 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;
- ☐ physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
- ☐ 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 the Department; and
- ☐ any other services that the Department may, upon the recommendation of the negotiation process between the Department and the Medical Society, declare non-insured.

Provincial hospital services not covered by the Hospital Services 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 the Department.

The process to de-insure services by the Health Care Insurance Plan is done in collaboration with the Medical Society and the Department.

All Island residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Board of Prince Edward Island 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 to monitor usage and service concerns.

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations, section 3, define eligibility for the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island 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 Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island 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.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Forces, Royal Canadian Mounted Police (RCMP), inmates of federal penitentiaries and those eligible for certain services under other government programs, such as Workers' Compensation or the Department of Veterans Affairs' programs.

Ineligible residents may become eligible in certain circumstances. Members of the Canadian Forces or RCMP 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 parolees.

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

3.2 Registration Requirements

New or returning residents must apply for health coverage by completing a registration application from the Department. 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. Renewal of coverage takes place every five years and residents are notified by mail six weeks before renewal.

The number of residents registered for the Health Care Insurance Plan in Prince Edward Island as of March 31, 2005, was 143,261.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There were 42 Kosovar refugees registered for Medicare as of March 31, 2005.

4.0 Portability

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island 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

Persons absent each year for winter vacations and similar situations involving regular absences must reside in Prince Edward Island 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 5.(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the province for up to 182 days in a 12-month period, where the

absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the province under the above circumstances must notify the Registration Department before leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

The payment rate currently ranges from \$717 at the community hospitals to \$724 at Prince County Hospital and \$919 at the Queen Elizabeth Hospital per day for hospital stays. The standard inter-provincial out-patient rate is \$158. The methodology used to derive these rates is as if the patient had the services provided in Prince Edward Island.

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 Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

Insured residents may be temporarily out of the country for a 12-month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

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

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

The amount paid for insured emergency services outside Canada in 2004-2005 was \$112,023.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency, out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a Prince Edward Island physician. Full coverage may be provided for (Prince Edward Island insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department 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 hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The new Prince County Hospital in Summerside was completed and occupied in April 2004.

Ambulance Services

The Department has renewed agreements with each of the five private ambulance operators in the province to ensure the provision of emergency and non-emergency ground ambulance services on a 24-hour, seven day per week basis. The Department provides operating subsidies to operators who deliver service as per the requirements and standards contained within these agreements.

The Out-of-Province Medical Transport Support Program subsidizes the user fee for patients who

require ground ambulance services to access specialized medical care outside the province.

Accessibility – New Initiatives

There is activity underway with Health Infostructure Atlantic to further develop an Electronic Health Record within Atlantic Canada. The major focuses of these activities include the overall Electronic Health Record, Health Surveillance and Telehealth activities.

5.3 Access to Insured Physician and Surgical-Dental Services

Physician services are accessible throughout the province except for specialties where there are vacancies. Recruitment processes have been undertaken for family physicians, anaesthetists, radiologists, radiation and medical oncologists, psychiatrists, and a pathologist and plastic surgeon.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and government to represent their interests in the process.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Most physicians 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 growing and seem to be the preference for new graduates. Currently almost 50 percent of physicians are compensated under salary or sessional payments.

5.5 Payments to Hospitals

The PHSA and three regional health authorities are responsible for delivering hospital services in the province under the *Health and Community Services Act*. The financial (budgetary) requirements are established annually through

consultation with the Department and are subject to approval by the Legislative Assembly through the annual budget process.

Payments (advances) to PHSA and the regional health authorities 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 acknowledged the federal contributions provided through the Canada Health Transfer in its 2004-2005 Annual Budget and related budget documents and its 2003-2004 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not an insured service, except for the insured chronic care beds noted in section 2.1. Extended care services are provided through the four regional health authorities of the Health and Social Services system.

Nursing Home Intermediate Care and Adult Residential Care Services

Nursing home services are available on approval from regional admission and placement committees for placement into public manors and licensed private nursing homes. There are currently 18 long-term care facilities in the

province, nine public manors and nine licensed private nursing homes, with a total of 968 beds, including respite and temporary beds. Nursing home admission is for individuals who require 24-hour registered nurse (nursing care) supervision and care management. The standardized Seniors Assessment Screening Tool is used to determine service needs of residents for all admissions to nursing homes. Payment for long-term care is the responsibility of the individual. When a resident of a facility or someone coming into a facility does not have the financial resources to pay for their own care, they can apply for financial assistance under the *Social Assistance Act Regulations*, Part II. The Province subsidizes 72 percent of residents in nursing homes. The federal government subsidizes approximately 8.7 percent of nursing home residents through Veterans Affairs Canada. The remaining 18.4 percent finance their own care.

In addition to nursing home facilities, there are 38 licensed community care facilities in Prince Edward Island. As of March 31, 2005, the total number of licensed community care facility beds was 938. A Community Care Facility is a privately operated, licensed establishment with five or more residents. These facilities provide semi-dependent seniors and semi-dependent physically and mentally challenged adults with accommodation, housekeeping, supervision of daily living activities, meals and personal care assistance for grooming and hygiene. Care needs are assessed using the Seniors Assessment Screening Tool and are at Level 1, 2 or 3. Residents are eligible to apply for financial assistance under the *Social Assistance Act Regulations*, Part I. It should be noted that payment to community care is the responsibility of the individual. Clients lacking adequate financial resources may apply for financial assistance under the *Prince Edward Island Social Assistance Act*.

Home Care Services

Home Care and Support provides assessment and care planning to medically stable individuals, and defined groups of individuals with specialized needs, who, without the support of the formal

system, are at risk of being unable to stay in their own home, or are unable to return to their own home from a hospital or other care setting. Services provided through Home Care and Support include nursing, personal care, respite, occupational and physical therapies, adult protection, palliative care, home and community-based dialysis, assessment for nursing home placement and community support. The Senior's Assessment Screening Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment, which is generally waived for palliative care clients.

Ambulatory Health Care Services

Prince Edward Island has public Adult Day Programs that provide services such as recreation, education and socialization for dependent elders. Individuals who require this service are assessed by regional Home Care staff. The overall purpose of adult day programs, is to allow clients to remain in their homes as long as possible, provide respite for care givers, monitor client's health and provide social interaction. There are Adult Day Programs in all four health regions.

The Prince Edward Island Dialysis Program is a community-based service that operates under the medical direction and supervision of the Nephrology team at the Queen Elizabeth II Health Sciences Centre in Halifax.

There are five hemodialysis clinics in the province. This is a publically funded service. Prince Edward Island also offers a hemodialysis service to out-of-province/country visitors from the existing clinic locations. The provision of this service is based on the capacity within the clinics and the availability of human resources to provide this treatment at the time of the request. Cost of the service is covered through reciprocal billing if from another Canadian jurisdiction and by the visitor if from out of Canada.

Insured Hospital Services Within Own Province or Territory					
Registered Persons	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	138,205	140,001	141,031	142,022	143,261
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	7	7	7	7	7
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	7	7	7	7	7
3. Payments (\$):					
a. acute care	106,774,200	109,128,000	115,697,000	121,944,000	125,118,252
b. chronic care	not applicable	900	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	106,774,200	109,128,900	115,697,000	121,944,000	125,118,252
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments (\$):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	101	101	97	96	98
b. specialists	75	75	92	94	96
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	176	176	189	190	194
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	861,112	816,197	716,597	783,632	787,557
b. specialists	409,917	358,600	362,619	397,916	410,378
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,271,029	1,174,797	1,079,216	1,181,548	1,197,935
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	15,800,000	16,588,900	16,537,250	16,234,598	16,502,193
b. specialists	17,200,000	15,559,600	16,446,970	17,054,737	17,921,200
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	33,000,000	32,148,500	32,984,220	33,289,335	34,423,393
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	18.00	20.00	23.00	21.00	21.00
b. specialists	42.00	43.00	45.00	43.00	44.00
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	26.00	27.00	31.00	28.00	29.00
13. Number of services provided through <u>all payment methods</u> (#):					
a. medical	152,796	107,683	96,152	111,896	111,043
b. surgical	143,940	140,020	150,036	162,577	169,954
c. diagnostic	113,181	110,897	116,431	123,443	129,381
d. other	861,112	816,197 ¹	716,597 ¹	783,632 ¹	787,557 ¹
e. total	1,271,029	1,174,797	1,079,216	1,181,548	1,197,935
14. Total payments to physicians paid through <u>all payment methods</u> (\$):					
a. medical	6,500,000	5,061,000	4,892,997	4,845,230	4,937,461
b. surgical	8,900,000	8,703,600	9,509,720	9,880,089	10,095,966
c. diagnostic	1,800,000	1,795,000	2,044,253	2,329,418	2,887,773
d. other	15,800,000 ¹	16,588,900 ¹	16,537,250 ¹	16,234,598 ¹	16,502,193 ¹
e. total	33,000,000	32,148,500	32,984,220	33,289,335	34,423,393
15. Average payment per service, <u>all payment methods</u> (\$):					
a. medical	43.00	47.00	51.00	43.00	44.00
b. surgical	62.00	62.00	63.00	61.00	59.00
c. diagnostic	15.00	16.00	18.00	19.00	22.00
d. other	not applicable	20.00	23.00	21.00	21.00
e. all services	26.00	27.00	31.00	28.00	29.00

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	1,903	2,220	2,059	2,006	2,163
17. Total number of claims, out-patient (#).	14,839	17,572	16,790	15,638	14,368
18. Total payments, in-patient (\$).	10,127,380	9,417,000	11,713,751	14,208,471	15,325,267
19. Total payments, out-patient (\$).	2,380,567	2,930,100	2,879,064	2,578,895	2,667,968
20. Average payment, in-patient (\$).	5,322.00	4,242.00	5,689.00	7,083.00	7,085.00
21. Average payment, out-patient (\$).	160.00	167.00	171.00	165.00	186.00
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	46,832	67,435	48,369	45,255	48,928
23. Total payments (\$).	3,370,102	3,871,900	3,778,171	3,795,244	4,122,725
24. Average payment per service (\$).	72.00	57.00	78.00	84.00	84.00

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	30	26	23	37	30
26. Total number of claims, out-patient (#).	112	85	152	130	93
27. Total payments, in-patient (\$).	54,180	123,127	79,577	155,922	95,719
28. Total payments, out-patient (\$).	43,494	13,702	25,954	24,366	16,304
29. Average payment, in-patient (\$).	1,806.00	4,736.00	3,459.00	4,214.00	3,191.00
30. Average payment, out-patient (\$).	388.00	161.00	171.00	187.00	175.00
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	728	677	521	706	627
32. Total payments (\$).	57,365	33,995	30,076	37,100	21,849
33. Average payment per service (\$).	79.00	50.00	58.00	53.00	35.00

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	2	2	2	2	2
35. Number of services provided (#).	145	176	312	393	410
36. Total payments (\$).	53,100	60,989	88,443	90,851	96,490
37. Average payment per service (\$).	366.00	347.00	283.00	231.00	235.00

Endnotes

1. Includes general practitioners.

Nova Scotia

Introduction

The management of day-to-day health services delivery in Nova Scotia is the responsibility of the Province's nine District Health Authorities (DHAs) and the IWK Health Centre (Women and Children's Tertiary Care Hospital). These DHAs were created under the *Health Authorities Act*, which came into effect on January 1, 2001. The passage of this Act brought Nova Scotia closer to its goal of developing an affordable, high-quality, sustainable health care system.

Under the *Health Authorities Act*, the DHAs are required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. They are also required to submit annual reports, which provide updates on implementing DHA business plans. These provisions ensure greater financial accountability. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

Pursuant to the *Provincial Finance Act* (2000) and government policies and guidelines, the Department of Health is required to release annual accountability reports outlining outcomes against its business plan for that fiscal year. The 2004-2005 accountability report will be available in late 2005.

Nova Scotia continues to be committed to delivering medically necessary services that are consistent with the principles of the *Canada Health Act*.

The spending of Nova Scotia's 2004-2005 health-care dollars is consistent with commitments in

Your Health Matters – a report released by the Department of Health in March 2003 outlining its multi-year plan for better health care. This plan focuses on health promotion, more doctors and nurses, shorter waitlists, seniors' care and health services within communities. This report can be viewed at:

www.gov.ns.ca/health/your_health_matters.htm

As part of the commitments contained in *Your Health Matters*, Nova Scotia publishes annual reports on progress made, which accounts for how the year's activities matched plans. It reports specifically on issues such as quality, access and efficiency, and progress in primary or community-based health care, home care and drug coverage. The report for 2004-2005, *Working Together Toward Better Care: Ministers' Report to Nova Scotians* can be viewed at:

www.gov.ns.ca/health/reports.htm

Additional information related to health care in Nova Scotia may be obtained from the Department of Health website at:

www.gov.ns.ca/health

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 Plan (HSI) and the Medical Services Insurance Plan (MSI). The Department of Health administers the MSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958.

The MSI is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Medavie Blue Care (formerly called Atlantic Blue Cross), under the legislation previously mentioned (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32 and 35).

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. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Medavie¹ Blue Cross Care, by virtue of the 1992 Memorandum of Agreement, is mandated to:

- ☐ determine the eligibility of providers participating in the Plan;
- ☐ plan and conduct information and education programs necessary to ensure that all persons and providers are informed of their entitlements and responsibilities under the Plan;
- ☐ make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable; and
- ☐ develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfill its mandate.

1.2 Reporting Relationship

Medavie Blue Cross Care is required to submit to the Province, no later than the 20th day of each month, monthly expenditure reports, including details determined by the Province. Within 30 days of the end of the fiscal quarter, Medavie Blue Cross Care is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. Medavie Blue Cross Care is required

to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc. that are charged to the MSI Plan. Reports prepared by Medavie Blue Cross Care are forwarded to the respective Insured Program areas of the Department of Health for review and follow-up.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the *Hospital Insurance Regulations*, which relate to this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health, their annual budget estimates and their monthly reports of actual revenues and expenditures.

1.3 Audit of Accounts

The Auditor General's office audits all expenditures of the Department of Health, including Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Medavie Blue Cross Care. No official audit is performed on Medicare payments; however, this has been recommended by the Auditor General's office.

All long-term care facilities, home care and home support agencies are now required to provide the Department with annual audited financial statements.

Under section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health by July 1st each year, an audited financial statement for the preceding fiscal year.

The Report of the Auditor General of Nova Scotia, tabled on May 27, 2005, contained audits with respect to:

- ☐ Nova Scotia Hospital Information System (NSHIS) project, and
- ☐ Department of Health Performance Indicators.

1 Medavie is the new name adopted by Blue Cross in March 2005 in the Atlantic provinces. The name is a combination of the English and French words for "medical to life" and therefore works in both official languages.

1.4 Designated Agency

Medavie Blue Cross Care administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement with the Department of Health. Medavie Blue Cross Care receives written authorization from the Department for the physicians to whom it may make payments. The rates of pay and specific amounts depend on the physician contract negotiated between Doctors Nova Scotia and the Department of Health.

There is no legislation governing the role of Medavie Blue Cross Care. Medavie Blue Cross Care abides by the terms and conditions of the 1992 contract and its payment mechanism. Under this contract, Medavie Blue Cross Care is required to submit to the Province:

- ☐ annual audited financial statements;
- ☐ detailed line-by-line full-time equivalent counts on budget requests for which the Department actually approves staffing levels;
- ☐ line-by-line budgets showing salary, benefits, travel, postage, etc.; and
- ☐ a copy of the annual report.

All Medavie Blue Cross Care system development for MSI and Pharmacare is controlled through a joint committee. All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Nine DHAs and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in- and out-patients in Nova Scotia in a total of 35 facilities².

Accreditation is not mandatory, but all facilities are accredited at a facility or district level. The enabling legislation that provides for insured

hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958. *Hospital Insurance Regulations* were made pursuant to the *Health Services and Insurance Act*.

In-patient services include:

- ☐ accommodation and meals at the standard ward level;
- ☐ necessary nursing services;
- ☐ laboratory, radiological and other diagnostic procedures;
- ☐ drugs, biologicals and related preparations, when administered in a hospital;
- ☐ routine surgical supplies;
- ☐ use of operating room, case room and anaesthetic facilities;
- ☐ use of radiotherapy and physiotherapy services, where available; and
- ☐ blood or therapeutic blood fractions.

Out-patient services include:

- ☐ laboratory and radiological examinations;
- ☐ diagnostic procedures involving the use of radio-pharmaceuticals;
- ☐ 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 other than medical services provided by and within the Nova Scotia Hearing and Speech Clinics;
- ☐ ultrasonic diagnostic procedures;
- ☐ home parenteral nutrition; and
- ☐ haemodialysis and peritoneal dialysis.

In order to add a new hospital service to the list of insured hospital services, DHAs are required to submit a New and/or Expanded Program

2 The number of facilities reported in other documents may differ from the 35 facilities reported here as a result of differences in defining the term "facility".

Proposal to the Department of Health. This process is carried out annually by request through the business planning process. A Department-developed process format is forwarded to the DHAs for their guidance. A Department working group reviews and prioritizes all requests received. Based on available funding, a number of top priorities may be approved by the Minister of Health.

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*.

The *Health Services and Insurance Act* was amended in 2002-2003 to include section 13B stating that: "Effective November 1, 2002, any agreement between a provider and a hospital, or predecessors to a hospital, stipulating compensation for the provision of insured professional services, for the provider undertaking to be on-call for the provision of such services or for the provider to relocate or maintain a presence in proximity to a hospital, excepting agreements to which the Minister and the Society are a party, is null and void and no compensation is payable pursuant to the agreement, including compensation otherwise payable for termination of the agreement."

Under the *Health Services and Insurance Act*, persons who can provide insured physician services include:

- ☐ general practitioners, who are persons who engage in the general practice of medicine;
- ☐ physicians, who are not specialists within the meaning of the clause; and
- ☐ specialists, who are physicians and are recognized as specialists by the appropriate licensing body of the jurisdiction in which he or she practises.

Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment

under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2004-2005, 2,167 physicians and 25 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2004, no physicians had opted out.

Insured services are those medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern. There are no limitations on medically necessary insured services.

No new large-scale services were added to the list of insured physician services in 2004-2005. On a quarterly, ongoing basis, new specific fee codes are approved that represent enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a committee structure. Physicians wishing to have a new fee code recognized or established must first present their cases to *Doctors Nova Scotia*, which puts a suggested value on the proposed new fee.

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from *Doctors Nova Scotia* and the Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Medavie Blue Cross Care is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

Under the Nova Scotia *Health Services and Insurance Act*, a dentist is defined as a person lawfully entitled to practice dentistry in a place where such practice is carried on by that person.

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2004, no dentists had opted out. In 2004-2005, 25 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are listed in the *Insured Dental Services Tariff Regulations*. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of a surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Requests for an addition to the list of surgical-dental services are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health to add a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

In 2004-2005, a number of services were added on a pilot basis, effective February 15, 2005. "Other extraction services (routine extractions) at public expense were approved for the following groups of patients, 1.) cardiac patients, 2.) transplant patients, 3.) immunocompromised patients and 4.) radiation patients. Routine extractions for these patients will be provided at public expense when and only when, the following criteria have been met. These patients must be 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 and not paid at public expense. It is critical/vital to the claims approval process that the dental treatment plans include the name of the Medical Specialist providing the care and that he/she has indicated in writing in the patient's medical treatment plan that the routine dental extractions are required prior to performing the medical treatment/procedure." This approval is for an initial period of 12 months.

MSI will conduct a retrospective audit on these cases after one year. Because these services will not be covered by government regulation, this approval may be rescinded after the audit process.

Other newly approved services include coverage for all precancerous or cancerous dental surgical biopsies.

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;
- ☐ surgery for sex reassignment;
- ☐ 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, except because of medical necessity; and
- ☐ services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:

- ☐ those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;
- ☐ mileage, travelling or detention time;

- ☐ telephone advice or telephone renewal of prescriptions;
- ☐ examinations required by third parties;
- ☐ group immunizations or inoculations unless approved by the Department;
- ☐ preparation of certificates or reports;
- ☐ testimony in court;
- ☐ services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty;
- ☐ cosmetic surgery;
- ☐ acupuncture;
- ☐ reversal of sterilization; and
- ☐ in vitro fertilization.

Major third-party agencies purchasing medically necessary health services in Nova Scotia include Workers Compensation, the Canadian Armed Forces and the Royal Canadian Mounted Police (RCMP).

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as foldable intraocular lens or a fiberglass cast can be purchased, it is required to fully inform patients about the cost. They are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

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

The de-insurance of insured physician services is accomplished through a negotiation process between Doctors Nova Scotia and Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, 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 process applies to dental and hospital 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* 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.

A person is 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 Citizenship and Immigration Canada.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI 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 Citizenship and Immigration Canada.

Members of the RCMP, members of the Canadian Forces, federal inmates and members of the North Atlantic Treaty Organization (NATO) are ineligible for MSI coverage. When their status changes, they immediately become eligible for provincial Medicare.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Once eligibility has been determined, an application form is generated. The applicant (and spouse if applicable) must sign the form before it can be processed. The applicant must indicate on the application the name and mailing address of a witness. The witness must be a Nova Scotia resident who can confirm the information on the application. The applicant must include proof of Canadian citizenship or provide a copy of an acceptable immigration document.

When the application has been approved, health cards will be issued to each family member listed. Each health card number is unique and is issued for the lifetime of the applicant. Health cards expire every four years. The health card number also acts as the primary health record identifier for all health service encounters in Nova Scotia for the life of the recipient. Proof of eligibility for insured services is required before residents are eligible to receive insured services. Renewal notices are sent to most cardholders three months before the expiry date of the current health card. Upon return of a signed renewal notice, MSI will issue a new health card.

There is no legislation in Nova Scotia forcing residents of the province to apply for MSI. There may be residents of Nova Scotia who, therefore, are not members of the health insurance plan.

In 2004-2005, there were 961,089 residents registered with the health insurance plan.

3.3 Other Categories of Individual

The following persons may also be eligible for insured health care services in Nova Scotia, once they meet the specific eligibility criteria for their situations:

Immigrants: Persons moving from another country to live permanently in Nova Scotia, are eligible for health care on the date of arrival. They must possess a landed immigrant document. These individuals, formerly called “landed

immigrants”, are now referred to as “Permanent Residents”.

Convention Refugees and Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied within Canada for Permanent Resident status, will be eligible on the date of application for Permanent Resident status - provided they possess a letter from the Immigration Department stating that they have applied for Permanent Residence.

Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied outside Canada for Permanent Resident status, will be eligible on the date of arrival - provided they possess a letter from the Immigration Department stating that they have applied for Permanent Residence.

In 2004-2005, there were 20,168 Permanent Residents registered with the health care insurance plan.

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, providing 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, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia, which is indicated on their health cards. 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 him/her - or their dependents.

In 2004-2005, there were 558 individuals with Employment Authorizations covered under the health care insurance plan.

Study Permits: Persons moving to Nova Scotia from another country, 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, except 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 2004-2005, there were 830 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either a work permit or study permit.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to 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 as per the Eligibility and Portability Agreement. Students, and their dependants,

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 full-time students. 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, territory or country. 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 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. The total amounts paid by the plan in 2004-2005, for in- and out-patient hospital services received in other provinces and territories were: \$15,795,451 for out-of-province, in-patient services and \$6,107,316 for out-of-province, out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

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. Ordinarily, to be eligible for coverage, residents must not be outside the country for more than six months in a calendar year. In order to be covered, procedures of a non-emergency nature must have prior approval before they will be covered by MSI.

Students and their dependants who are temporarily absent from Nova Scotia and in full-time 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/research) outside Canada which does not exceed 24 months, are still covered by MSI; providing the person has already met the residency requirements.

Emergency out-of-country services are 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. The total amount spent in 2004-2005 for insured in-patient services provided outside Canada was \$678,205.

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 Director 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.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions. There are no user charges or extra charges under the plan.

Nova Scotia continually reviews access situations across Canada to ensure that it is not falling behind. In areas where improvement is deemed necessary, depending on the Province's financial situation, extra funding is generally allocated to that area. The Department of Health accepted the recommendations of the Provincial Osteoporosis Committee report, which included placing new bone density units in Sydney and Yarmouth and operating the Truro unit at full capacity.

In fiscal year 2004-2005:

- \$7M was added to the Capital District budget to address the issue of ever-increasing orthopedic waitlists.
- Funding was announced for the purchase of four Magnet Resonance Imaging (MRI) machines to be located in four rural areas: Antigonish, New Glasgow, Kentville and Yarmouth. A replacement MRI was also approved for Capital Health in Halifax. These new machines will be operational in early 2006.
- Capital Health also received approval and funding to establish a Positron Emission Tomography Program (PET) to be operational in 2007.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to emphasize the provision of sustainable, quality health care services to its citizens. In April 2004, the Nova Scotia Department of Health filled the newly created position of Chief Health Human Resources officer to co-ordinate health human resources planning in the province. This is another step in ensuring that the supply of health

care professionals in Nova Scotia is sufficient, has the right mix of health professionals, and has the right geographical distribution.

According to Statistics Canada's 2003 Canadian Community Health Survey (CCHS), more Nova Scotians have access to a regular family doctor than any other jurisdiction in Canada.

Approximately 95 percent of Nova Scotians have a regular family doctor, which is well above the national average of 85.8 percent.

In 2004-2005, there were a total of 2,167 physicians operating in Nova Scotia – 51 more than in the previous year. This includes 905 general practitioners and 1,235 specialists. As in previous years, all were participating in the health insurance plan.

A five-year incentive program is offered in 21 rural communities to recruit doctors. The program provides an annual bonus for each completed year of service, moving expenses, continuing medical education funding and guaranteed minimum billing (income) for the year.

Other provincial programs include: start-up contracts for family doctors, alternative funding payment plans, a debt assistance program, and a physician recruitment office that maintains a recruitment website and co-ordinates site visits, advertising, and c.v. distribution within the province.

Nova Scotia also has a nursing strategy, which was introduced in 2001. It is a multi-year plan that provides a comprehensive and coordinated approach to enhancing the quality of work life for nurses, retaining experienced nurses in the system, and creating an environment in which recruitment efforts will be successful. Nova Scotia invests approximately \$10 million annually on the strategy and on training more nurses.

Nova Scotia has a Telehealth Network (NSTHN), which connects DHAs and the IWK Health Centre with a sophisticated videoconferencing communications network. The network allows patients in rural areas to consult with specialists in large health centres. The NSTHN enhances access to health services closer to home for patients and their families. The NSTHN also provides health professionals across Nova Scotia

with access to educational opportunities without leaving their communities. 2,700 sessions were provided over the network in 2004-2005.

On October 7, 2005, Nova Scotia officially launched its wait times website. (see: www.gov.ns.ca/health/waittimes/default.htm).

This site provides Nova Scotians with information to help them, and their health-care providers, make decisions about their testing and treatment options. It provides provincial health-care wait times for tests, treatments and services by the various choice locations in Nova Scotia.

Nova Scotia has made numerous announcements regarding the allocation of new medical equipment to reduce wait times and increase the access to health services. The following are some examples:

- On December 3, 2004, Nova Scotia's Health Minister announced that \$15 million is being provided to purchase newer and more advanced medical equipment throughout the province. In February 2003, the First Ministers' Accord on Health Care Renewal included a commitment from the federal government to provide Nova Scotia with funding for diagnostic medical equipment. This year, Nova Scotia received \$15 million as part of that fund. The following is a link to a detailed breakdown of what equipment this \$15 million was used to purchase and where the purchased equipment is to be located within Nova Scotia:
www.gov.ns.ca/heal/mediaroom/docs/equipment.pdf
- On December 13, 2004, Nova Scotia announced the purchase of four new MRI machines to be located in Kentville, Antigonish, Yarmouth, and New Glasgow. See the following link for the press release:
www.gov.ns.ca/news/details.asp?id=20041213003
- On October 13, 2005, Nova Scotia announced further investment in medical equipment from the federal fund announced in February 2003. Including these investments, a total of \$54.7 million has been invested through the fund to purchase capital equipment and in specialized

technical training in Nova Scotia. See the following link for the press release:
www.gov.ns.ca/news/details.asp?id=20051013001

5.3 Access to Insured Physician and Surgical-Dental Services

In 2004-2005, 2,167 physicians and 25 dentists actively provided insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions, such as block funding and personal services contracts, have enhanced recruitment.

The Province has increased the capacity for medical education, coordinates ongoing recruitment activities and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the province.

5.4 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 and the Nova Scotia Department of Health. Doctors Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from Doctors Nova Scotia and the Department of Health negotiate the total funding and other terms and conditions. The current master agreement is effective from April 1, 2004 through March 31, 2008. The agreement lays out what the medical services unit value will be for physician services and addresses other issues such as Canadian Medical Protective Association, membership benefits, emergency department payment, on-call funding, specific fee adjustments, dispute resolution processes, and other process or consultation issues.

Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of

alternative funding arrangements in place in Nova Scotia.

Over the past seven years, we have seen a significant shift toward alternative funding. In the 1997-1998 fiscal year, about nine percent of our doctors were paid solely through alternative funding. Today, approximately 60 or 30 percent of physicians are remunerated through alternative funding. They can be broken down into three groups:

- 1) Academic Specialists (these physicians are mainly located in Halifax; i.e. QEII and IWK). Most of the Academic Specialist groups are on alternate funding arrangements with the exception of Urology and Ophthalmology;
- 2) District Specialists (Obstetrics/Gynecology, Anaesthesiology, Pediatrics); and
- 3) General Practice (including General Practice/Nurse Practitioner Contracts).

There are also a number of physicians who receive a portion of their remuneration through alternative funding. These alternative funding mechanisms include Sessional, Psychiatry, Remote Practice, Facility On-Call and Emergency Room funding. In total, approximately 60 percent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms.

In 2004-2005, total payments to physicians for insured services in Nova Scotia were \$464,685,571. The Department paid an additional \$5,866,887 for insured physician services provided to Nova Scotia residents outside the province, but within Canada.

Payment rates for dental services in the province are negotiated between the Department of Health and the Nova Scotia Dental Association and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement, which was reached in April 2004, expires on March 31, 2008.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine DHAs, the IWK Health Centre and other non-DHA

organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* was given Royal Assent on June 8, 2000. The Act instituted the nine DHAs that replaced the former regional health boards. This change came into effect in January 2001, under the *District Health Authorities General Regulations*. The implementation of community health boards under the *Community Health Boards' Member Selection Regulations* was effective April 2001. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

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 to hospitals for insured hospital services.

In 2004-2005, there were 2,891 hospital beds in Nova Scotia (3.0 beds per 1,000 population). Department of Health direct expenditures for insured hospital services operating costs were increased to \$1.13 billion.

6.0 Recognition Given to Federal Transfers

In Nova Scotia, the *Health Services and Insurance Act*, RS Chapter 197 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 (CHT) as well as other federal funds through press releases and media coverage.

The Government of Nova Scotia also recognized the federal contribution under the CHT in various

published documents including the following documents released in 2004-2005:

- Public Accounts 2004-2005; and
- Budget Estimates 2004-2005.

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care Services:

The Department of Health has implemented significant changes to the way long-term care is funded and how residents pay for long-term care. These and other program changes were launched on January 1, 2005, to promote independence, fairness, equity, and choice for people who require long-term care.

Residents who live in nursing homes, residential care facilities, and community-based options under the Department of Health's mandate are no longer required to pay for their health care costs. As well, residents no longer have to use their assets to pay for their long-term care accommodation costs. For more information please see: www.gov.ns.ca/health/ccs/ltc.htm

Home Care Services:

Continuing Care Services currently includes home care, long-term care and adult protection services

Broad-based, provincially funded home care services were introduced in Nova Scotia in 1995. Home care is part of the continuum of services available through the Department of Health's Continuing Care Branch. Home care services are available to Nova Scotians of all ages and help individuals reach and maintain their maximum level of health and prolong independent community living. Home care can be provided to people who are chronically ill, disabled, convalescent or to individuals with an acute illness. Services can delay admissions to long-term care facilities or hospitals as well as facilitate early release from an acute care facility. The

health care and support services available to individuals in the community through home care include nursing care, assistance with personal care, aid with home support activities, home oxygen services and respite. Both chronic services over the longer term and short-term acute services are provided through home care.

The Nova Scotia Department of Health has implemented a Single Entry Access to its Continuing Care services. Nova Scotians connect with continuing care through a single toll-free number.

The Continuing Care Branch has undertaken a strategic planning process. This plan will guide future investments in continuing care services for the next five to ten years.

Other Extended Health Services:

❑ **Nova Scotia Seniors' Pharmacare Program –**

This provincial drug insurance plan helps seniors manage their prescription drug costs. Eligible persons include all residents aged 65 years or older and who do not have prescription drug coverage through Veterans Affairs Canada, First Nations and Indian Health, or a private drug plan. The program provides access to prescription drugs, and diabetic and ostomy supplies listed as benefits in the Nova Scotia Formulary. Persons using this program are responsible for user charges of 33 percent of the total cost to a maximum of \$30 for each drug and supply with an annual maximum of \$390. General information regarding Pharmacare can be found at:

www.gov.ns.ca/health/pharmacare/default.htm

❑ **Special Funding for Drugs for Specific**

Disease States - The Province provides special funding for drug therapies for a few specific disease states including cystic fibrosis, diabetes insipidus, cancer and growth hormone deficiency. There are no user charges for this coverage. General information regarding Drug Programs and Funding can be found at:

www.gov.ns.ca/health/pharmacare/default.htm

❑ **Emergency Health Services** - Pre-hospital Emergency Care - Emergency Health Services Nova Scotia (EHS) is responsible for the continual development, implementation, monitoring and evaluation of pre-hospital emergency health services in Nova Scotia. EHS integrates various pre-hospital services and programs into one system to meet the needs of Nova Scotians. These services include: EHS ground ambulance system, EHS LifeFlight (the provincial air medical transport system), EHS Communications Centre, Medical Oversight (Management and Direction), the EHS NS Trauma Program, EHS Atlantic Health Training and Simulation Centre and the EHS Medical First Response program. This integrated province-wide system has been rated in the top 10 percent of systems in North America. Residents in Nova Scotia are levied a user charge of \$120, to be transported to hospital by ambulance (regardless of distance). There is no charge for transport from hospital to hospital.

❑ **Children's Oral Health Program**

(COHP) - This program has two components: 1) the Insured Services Treatment component provides diagnostic, preventative and restorative services; and 2) the Public Health Services component provides prevention-oriented activities through the application of public health initiatives. Children are eligible for services up to the end of the month in which they turn 10 years of age. All eligible children are entitled to one dental examination and two radiographs per year.

❑ **Special Dental Plans** - The program covers all dental services required, including prosthetics and orthodontics required by persons diagnosed as having a cleft palate craniofacial disorder; in-hospital dental services provided to the severely mentally challenged who, because of their condition, require the services to be provided in hospital; and a full range of diagnostic, preventive and restorative procedures to residents of the Nova Scotia School for the Blind. There are no user charges for these services. Eligible residents

include the following: 1) patients registered with the Cleft Palate Cranofacial Clinic at the IWK Health Centre; 2) registered students at the School for the Blind; and 3) patients with a signed statement to the effect that they are severely mentally challenged and require hospitalization for dental treatment.

- **Community Mental Health Program** - All of the DHAs and the IWK Health Centre offer acute psychiatric treatment. Services are provided across the life span of a person. Specialized services are offered and are in-patient, day treatment, and community-based (e.g. forensic, eating disorders, psychogeriatrics and psychosocial rehabilitation). There are early intervention programs for children with Autism Spectrum Disorder (0-6 yrs). Intensive Community Based Treatment teams in two DHAs and one provincial Mental Health residential/rehabilitation program for children and youth exists to enhance the continuum of mental health services. Youth Forensic services, including a treatment program for Sexually Aggressive Youth, exist under the authority of the IWK Health Centre. There are no user charges for these services. They are available to all residents in the province.
- **Nova Scotia Addiction Services** - A range of treatment and rehabilitation options are provided, including withdrawal management (detoxification and treatment orientation) programs and community-based structured treatment, out-patient and extended care services. Treatment options are tailored to individual needs and are based on an ongoing assessment. Short-term and long-term treatment goals are identified with each client. Programs and services may be available on a residential, day or out-patient basis, and may include individual, group and/or family programming. Targeted programming is offered where appropriate and may include programming for adolescents, women, families or impaired drivers. There are no user charges for these services except for the program for Driving While Impaired Offenders.
- **Optometric Benefit** - This benefit provides insurance for visual analysis carried out by optometrists. Vision analysis is defined as: "...an examination that includes the determination of: 1) the refractive status of the eye; 2) the presence of any observed abnormality in the visual system, and all necessary tests and prescriptions connected with such determination." Coverage is limited to one routine vision analysis every two years for those under 10 years of age and those 65 and over. Those between 10 and 65 are not covered for routine analyses, but are covered where medical need is indicated.
- **Prosthetic Services** - All insured residents of the province are eligible for financial assistance in acquiring and replacing standard arm and leg prostheses prescribed by a qualified physician and repairs on such prostheses as required. Patients are responsible for all costs over and above stated coverage.
- **Interpreter Service Program** - This program guarantees equal access to government services, offered to the general public, to eligible deaf and hard of hearing residents of Nova Scotia.
- **Speech and Language Pathology Program** - The service options of this program include: 1) one-to-one therapy; 2) small-group therapy; and 3) consultations (e.g. classroom, day-cares, developmental preschools, and residential facilities for individuals with special needs). The Nova Scotia Hearing and Speech Centres provide specialized services such as dysphagia (swallowing) programs and pervasive developmental delay programs at limited locations in the province. There are no user charges. Eligible persons include children from birth to school age and individuals when they leave school through their adult lifespan. Provincial school boards service children in the public school system.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	947,963	953,385	955,475	956,820	961,089

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	35	35	35	35	35
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	35	35	35	35	35
3. Payments (\$): ¹					
a. acute care	877,019,426	926,797,569	1,021,934,504	1,095,584,706	1,133,215,533
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	877,019,426	926,797,569	1,021,934,504	1,095,584,706	1,133,215,533
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	1	1	1	1	0
b. diagnostic imaging facilities	0	0	0	0	1
c. total	1	1	1	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	109	81	83	38	0
b. diagnostic imaging facilities	0	0	0	0	not available
c. total	0	0	0	38	not available
6. Payments (\$):					
a. surgical facilities	14,627	10,926	11,714	5,531	0
b. diagnostic imaging facilities	0	0	0	0	not available
c. total	0	0	0	5,531	not available

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	920	865	875	904	905
b. specialists	1,067	1,128	1,142	1,198	1,235
c. other	0	10	9	14	27
d. total	1,987	2,003	2,026	2,116	2,167
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	4,498,232	4,521,991	4,563,449	4,629,753	4,706,554
b. specialists	1,645,535	1,650,685	1,677,973	1,924,079	1,629,835
c. other	3,951	2,999	2,512	7,098	16,993
d. total	6,147,718	6,175,675	6,243,934	6,560,930	6,353,382
11. Total payments to physicians paid through <u>fee-for-service</u> (\$): ²					
a. general practitioners	102,332,556	102,555,964	113,507,874	120,455,816	124,586,294
b. specialists	117,891,477	118,414,434	127,688,914	133,964,947	121,524,641
c. other	175,890	162,779	165,984	250,201	613,173
d. total	220,399,923	221,133,176	241,362,772	254,670,965	246,724,107
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	22.75	22.68	24.87	26.02	26.47
b. specialists	71.64	71.74	76.10	69.63	74.56
c. other	44.52	54.28	66.08	35.25	36.08
d. all services	35.85	35.81	38.66	38.82	38.83
13. Number of services provided through <u>all payment methods</u> (#): ³					
a. medical	5,457,153	5,462,682	6,458,299	6,572,716	6,617,895
b. surgical	985,321	1,009,997	1,096,509	1,117,739	1,127,319
c. diagnostic	1,121,296	1,124,792	1,144,383	1,191,588	1,233,665
d. other	291,352	308,326	324,081	317,419	311,328
e. total	6,147,718	7,905,797	9,023,272	9,199,462	9,290,207
14. Total payments to physicians paid through <u>all payment methods</u> (\$): ^{2,3}					
a. medical	239,036,017	244,049,190	270,161,897	293,468,260	326,249,500
b. surgical	77,328,861	80,867,051	91,426,158	96,065,557	89,265,514
c. diagnostic	25,385,064	26,262,276	28,530,589	37,191,400	46,256,529
d. other	7,287,248	8,015,345	8,210,021	7,275,169	2,914,029
e. total	349,037,190	359,193,862	398,328,665	434,000,386	464,685,571
15. Average payment per service, <u>all payment methods</u> (\$): ³					
a. medical	29.40	29.18	41.83	44.65	49.30
b. surgical	68.53	68.49	83.38	85.95	79.18
c. diagnostic	57.21	58.97	24.93	31.21	37.50
d. other	47.78	53.58	25.33	22.92	9.36
e. all services	35.85	35.81	44.14	47.18	50.02

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	2,520	2,050	2,300	2,368	2,335
17. Total number of claims, out-patient (#).	32,859	30,749	34,425	32,968	34,166
18. Total payments, in-patient (\$).	9,961,995	8,536,691	12,685,659	15,859,930	15,795,451
19. Total payments, out-patient (\$).	4,171,365	4,009,667	4,447,816	4,303,236	6,107,316
20. Average payment, in-patient (\$).	3,953.17	4,115.45	5,515.50	6,697.61	6,764.65
21. Average payment, out-patient (\$).	126.94	130.39	129.20	130.58	178.75
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	180,299	179,833	187,390	180,897	188,118
23. Total payments (\$).	4,766,189	5,078,794	5,562,125	5,747,516	5,866,887
24. Average payment per service (\$).	26.43	28.24	29.68	31.77	31.19

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	not available	not available	not available	not available	not available
26. Total number of claims, out-patient (#).	not applicable	not applicable	not applicable	not applicable	not applicable
27. Total payments, in-patient (\$).	735,834	1,000,023	938,092	623,896	678,205
28. Total payments, out-patient (\$).	not applicable	not applicable	not applicable	not applicable	not applicable
29. Average payment, in-patient (\$).	not available	not available	not available	not available	not available
30. Average payment, out-patient (\$).	not applicable	not applicable	not applicable	not applicable	not applicable
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	2,541	2,421	2,748	2,667	3,111
32. Total payments (\$).	98,461	109,484	121,780	120,977	151,175
33. Average payment per service (\$).	38.75	45.22	44.32	45.36	48.59

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	39	35	36	28	25
35. Number of services provided (#).	6,853	4,497	5,188	3,780	4,343
36. Total payments (\$).	998,692	884,506	939,004	904,283	995,966
37. Average payment per service (\$).	144.27	196.69	181.00	239.23	229.33

Endnotes

1. Payments are made to acute care facilities and District Health Authorities only.
2. Discrepancies may exist between data presented here and the Nova Scotia Annual Statistical Tables due to methodological differences.
3. Fee-for-service and alternate funded programs.

New Brunswick

Introduction

New Brunswick's ongoing commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility in health care services – the principles that form the foundation of the *Canada Health Act* – was reaffirmed in the publication of New Brunswick's first Provincial Health Plan, during the 2004-2005 fiscal year.

On June 6, 2004, the Hon. Elvy Robichaud, Minister of Health and Wellness, tabled a document entitled *Healthy Futures: Securing New Brunswick's Health Care System*. This document set out a four-year plan to ensure the long-term stability of New Brunswick's publicly-funded and administered health care system by improving the overall health and well-being of New Brunswickers and providing health services in a sustainable and affordable manner.

The Provincial Health Plan sets key goals, principles, strategies and priorities that will guide health care investments and improvements. It set out a vision of a single, integrated, patient-focused, community-based health services system, accessible to all New Brunswickers in both official languages and managed in a fiscally sustainable manner. It sets out strategies to improve health care services through new investments in health promotion, primary health care, recruitment and retention of health human resources, and enhanced accountability and evidence-based decision making.

The goals set out in the Provincial Health Plan are in line with the priorities agreed to by First

Ministers in the *10-Year Plan to Strengthen Health Care*. The New Brunswick plan includes initiatives to improve patient access to health care services, provide access to needed drug therapies, increase the supply of valued health professionals, and promote wellness and healthy living.

A number of initiatives to implement aspects of the Provincial Health Plan were undertaken during the 2004-2005 fiscal year:

- on July 7, 2004, Minister Robichaud announced that 25 new Medicare billing numbers would be added to the provincial Medicare system to enhance opportunities to recruit and retain physicians within the provincial health system;
- improvements to hospital facilities in Fredericton, Moncton, Bathurst, Campbellton and the Upper St. John River Valley, all designed to improve access to important health care services in those communities; and
- the addition of 32 new staff to the province's ground-breaking Extra-Mural Program, to provide improved delivery of a variety of health care services in home settings throughout the province.

The Department also released the second edition of the *New Brunswick Health Care Report Card*, a document designed to help New Brunswickers measure their own health and the health of the provincial health care system. The report found a high rate of satisfaction among New Brunswickers who have received care in a hospital, and a high percentage of citizens with access to a family physician.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the health care insurance plan is known as the Medical Services Plan. The public authority responsible for operating and administering the plan is the Minister of Health and Wellness, whose authority rests under the

Medical Services Payment Act and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured and the uninsured services. The legislation also stipulates the type of agreements the provincial authority may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner; how the amounts to be paid for entitled services will be determined; how assessment of accounts for entitled services may be made; and confidentiality and privacy issues as they relate to the administration of the Act.

The Minister of Health and Wellness is responsible for establishing a medical services plan that identifies beneficiaries, which services are and are not covered, and the amounts to be paid for entitled services. Under the Plan, the Minister assesses and audits physician billings through inspectors appointed by him or her and through a professional review committee as defined in sections 24(1) to 33 of the *Medical Services Payment Act* and Regulations. The Minister also has the authority to recover the cost of entitled services from a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Department of Health and Wellness has a mandate 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*, which came into force on April 1, 2002, sets out the relationship between the eight Regional Health Authorities (RHAs) and the Department. Under the Act, RHAs must prepare regional health and business plans that are in harmony with the Provincial Health Plan developed by the Department. The business and affairs of the RHA are to be controlled and managed by a board of

directors, appointed or elected in accordance with the Act and its regulations. The chief executive officer of each RHA reports to the Deputy Minister of Health and Wellness. Under sections 7(1) and 7(2) of the Act, the Minister of Health and Wellness shall establish an accountability framework, drafted in consultation with RHAs, to specify the responsibilities that each party has to the other in the provincial health system.

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 of Health and Wellness. For 2004-2005, all financial transactions of the Department were subject to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report to identify errors and control weaknesses. The Auditor General also conducts management reviews on programs as he or she sees fit and follows up on prior years' audits. During 2004-2005, the Auditor General reported on the Prescription Drug Program and on the program evaluation function in the Government of New Brunswick, which included the Department.

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*. The Comptroller's internal audit objectives cover Appropriations Audit, Information Systems Audit, Statutory Audits and Value-For-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited and the audit objectives. During 2004-2005, the

Office of the Comptroller continued to gather risk assessment data on programs offered by the Department and reviewed common services in the Department and other selected departments.

Department of Health and Wellness Internal Audit Branch

The Department's Internal Audit Branch was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The Branch also performs program audits to report on the efficiency, effectiveness and economy of programs in meeting departmental objectives. For 2004-2005, the Internal Audit Branch audited the administration agreement with Blue Cross/Medavie for the Prescription Drug Program; provided advice on the Extra-Mural vehicle fleet program and Extra-Mural Program driver training and education; evaluated the Telecare contract and the HIV/AIDS Information line contract; audited Vocational Rehabilitation for Disabled Persons (VRDP) claims; evaluated the Department's financial management reporting system; coordinated audits with the Auditor General and the Canadian Blood Agency; assisted on the Ambulance Services program privatization; and compiled a database of legislative requirements for future audits.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, 1973, and section 9 of *Regulation 84-167* and the *Hospital Act*, assented to on May 20, 1992, and its *Regulation 92-84*.

There are eight RHAs, established under the authority of the *Regional Health Authorities Act*.

Each RHA includes a regional hospital facility and a number of smaller facilities, all of which provide insured services for both in- and out-patients. Each RHA has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

Under *Regulation 84-167* of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured hospital services:

In-patient services in a hospital facility operated by an approved regional health authority as follows:

- ☐ accommodation and meals at the standard ward level;
- ☐ necessary nursing service;
- ☐ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability;
- ☐ drugs, biologicals and related preparations, as provided for under Schedule 2;
- ☐ 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 therefore from the RHA.

Out-patient services in a hospital facility operated by an approved RHA as follows:

- ☐ laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner or nurse practitioner, when approved facilities are available;
- ☐ laboratory and diagnostic procedures, together with the necessary interpretations, where approved facilities are available, when performed for the purpose of a mammography screening service that has

been approved by the Minister of Health and Wellness;

- the hospital component of available out-patient services when prescribed by a medical practitioner or nurse practitioner and provided in an out-patient facility of an approved RHA for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability, excluding the following services:
 - the provision of any proprietary medicines;
 - the provision of medications for the patient to take home;
 - diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;
 - visits solely for the administration of drugs, vaccines, sera or biological products; and
 - any out-patient service that is an entitled service under the *Medical Services Payment Act*.

2.2 Insured Physician Services

The enabling legislation providing for insured physician services is the *Medical Services Payment Act*.

The Act was given Royal Assent on December 6, 1968. *Regulation 84-20* was filed on February 13, 1984. *Regulation 93-143* was filed on July 26, 1993. *Regulation 96-113* was filed on November 29, 1996, since repealed and replaced with 2002-53 filed on June 28, 2005, and Schedule 4 (surgical-dental services) *Regulation 84-20* was filed on April 13, 1999.

No changes, pertaining to physician services, to this Act and regulations were introduced during 2004-2005.

The New Brunswick Medical Services Plan covers physicians who provide medically required services. The conditions that a physician must meet to participate in the New Brunswick Medical Services Plan are:

- to maintain current licensure with the New Brunswick College of Physicians and Surgeons;
- to maintain membership in the New Brunswick Medical Society;

- to hold privileges in a RHA; and
- to have signed the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's Medical Services Plan during March 31, 2005, was 1,527.

Physicians in New Brunswick have the option to opt out totally or for selected services. Totally opted-out practitioners are not paid directly by Medicare for the services they render and must bill patients directly in all cases. Patients are not entitled to reimbursement from Medicare.

The selective opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. Opted-in physicians wishing to opt out for a service must first obtain the patient's agreement to be treated on an opted-out basis, after which they may bill the patient directly for the service. In these cases, the following procedure must be adhered to in every instance. The physician must advise the patient in advance and:

- The charges must not exceed the Medicare tariff. The practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged to the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare.
- If the charges will be in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:
 - they are opting out and charging fees above the Medicare tariff;
 - in accepting service under these conditions, the beneficiary waives all rights to Medicare reimbursement; and
 - the patient is entitled to seek services from another practitioner who participates in the Medical Services Plan.

The physician must obtain a signed waiver from the patient on the specified form and forward that form to Medicare.

As of March 31, 2005, no physicians rendering health care services had elected to completely opt out of the New Brunswick Medical Services Plan.

The range of entitled services under Medicare includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital facility. The range of non-entitled services is set out under Schedule 2, *Regulation 84-20, Medical Services Payment Act*. No new services were de-insured during 2004-2005.

An individual, a physician or the Department 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 usually based on conformity to “medically necessary” and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and 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.

2.3 Insured Surgical-Dental Services

Schedule 4 of *Regulation 84-20* (filed June 23, 1998, under the *Medical Services Payment Act*) identifies the insured surgical-dental services that can be provided by a qualified dental practitioner in a hospital, if 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.

The conditions that a dental practitioner must meet to participate in the medical plan are maintaining current registration with the New Brunswick Dental Society and completing the Participating Physician’s Agreement (included in the New Brunswick Medicare Dental registration form).

As of March 31, 2005, there were 14 dentists registered with the plan.

Dentists have the same opting-out provision as previously explained for physicians and must follow the same guidelines. The Department has no data for the number of non-enrolled dental practitioners in New Brunswick.

New Brunswick expanded the role of Oral Maxillofacial Surgeons in New Brunswick by amending the *Medical Services Payment Act* and Regulations to provide payment for entitled services when they admit and discharge patients and perform physical examinations. The range of services and procedures was expanded and includes those done in an out-patient setting.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include the following:

- ☐ patent medicines;
- ☐ 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.

There are no specific policies or guidelines, other than the Act and regulations, to ensure that charges for uninsured medical goods and services (i.e. enhanced medical goods and services such as intra-ocular lenses, fibreglass casts, etc.), provided in conjunction with an insured health service, do not compromise reasonable access to insured services.

Uninsured Physician and Surgical-Dental Services

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 services under Medicare, namely:

- ☐ elective surgery or other services for cosmetic purposes;
- ☐ correction of inverted nipple;
- ☐ breast augmentation;
- ☐ otoplasty for persons over the age of 18;
- ☐ removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
- ☐ abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;
- ☐ surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in removing the cataract itself, due to the existence of an illness or other complication;
- ☐ medicines, drugs, materials, surgical supplies or prosthetic devices;
- ☐ vaccines, serums, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;
- ☐ 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;
- ☐ 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 travel, employment, emigration, insurance purposes, or at the request of any third party;
- ☐ services provided by medical practitioners to members of their immediate family;
- ☐ psychoanalysis;
- ☐ electrocardiogram (ECG) where not performed by a specialist in internal medicine or paediatrics;
- ☐ laboratory procedures not included as part of an examination or consultation fee;
- ☐ refractions;
- ☐ services provided within the province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;
- ☐ the fitting and supplying of eyeglasses or contact lenses;
- ☐ transsexual surgery;
- ☐ radiology services provided in the province by a private radiology clinic;
- ☐ acupuncture;
- ☐ complete medical examinations when performed for a periodic check-up and not for medically necessary purposes;
- ☐ circumcision of the newborn;
- ☐ reversal of vasectomies;
- ☐ second and subsequent injections for impotence;
- ☐ reversal of tubal ligations;
- ☐ intrauterine insemination;
- ☐ gastric stapling or gastric by-pass; and
- ☐ venipuncture in order to take 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.

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 change 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 of Health and Wellness 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.

No medical or surgical-dental services were removed from the insured service list in 2004-2005.

3.0 Universality

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and its *Regulation 84-20*, define eligibility for the health care insurance plan in New Brunswick.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status 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.

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.

Residents who are ineligible for Medicare coverage include:

- ☐ regular members of the Canadian Armed Forces;
- ☐ members of the Royal Canadian Mounted Police (RCMP);
- ☐ inmates of federal prisons;
- ☐ persons moving to New Brunswick as 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 (e.g. a Student Authorization).

Provisions to become eligible for Medicare coverage include:

- ☐ non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to, or in a common-law relationship with, an eligible New Brunswick resident.

Provisions when status changes include:

- ☐ persons who have been discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided that they are residing in New Brunswick at the time, these persons are eligible for coverage on the date of their release. They must complete an application, provide the official date of release and provide proof of citizenship.

3.2 Registration Requirements

A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependents under the age of 19, on a form provided by Medicare for this purpose, or be registered by a person acting on his or her behalf.

Upon approval of the application, the beneficiary and dependents are registered and a Medicare card with an expiry date is issued to the beneficiary and each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two or three months before the expiry date of the Medicare card or cards. A beneficiary who wishes to remain eligible to receive entitled services is required to

confirm the information on the Notice of Expiry, to make any changes as appropriate and return the form to Medicare. Upon receiving the completed form, the file is updated and new card(s) are issued bearing a revised expiry date.

Currently in New Brunswick, only those individuals deemed eligible are registered.

All family members (the beneficiary, spouse and dependents under the age of 19) are required to register as a family unit. Residents who are co-habiting, but not legally married, are eligible to register as a family unit if they so request.

Residents may opt out of Medicare coverage if they choose. They are asked to provide written confirmation of their intention. This information is added to their files and benefits are terminated.

3.3 Other Categories of Individual

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, or living in a common-law relationship with, an eligible New Brunswick resident and still possess a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period to obtain eligibility for Medicare coverage in New Brunswick. Coverage commences the first day of the third month following the month of arrival.

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*, sections 3(4) and 3(5).

Students in full-time attendance at a university or other approved educational institution who leave New Brunswick to further their education in another province are granted coverage for a 12-month period that is renewable provided that they do the following:

- ☐ provide proof of enrollment;
- ☐ contact Medicare once every 12-month period to retain their eligibility;
- ☐ do not establish residence outside New Brunswick; and
- ☐ do not receive health coverage in another province.

Residents temporarily employed in another province or territory are granted coverage for up to 12 months provided that they do the following:

- ☐ do not establish residence in another province;
- ☐ do not receive coverage in another province; and
- ☐ intend to return to New Brunswick.

If absent longer than 12 months, residents should apply for coverage in the province or territory where they are employed and should be entitled to receive coverage there on the first day of the thirteenth month.

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

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*, sections 3 (4) and 3 (5).

Students: Those in full-time attendance at a university or other approved educational institution, who leave New Brunswick to further their education in another country, will be granted coverage for a 12-month period that is renewable, provided that they do the following:

- ☐ provide proof of enrollment;
- ☐ contact Medicare once every 12-month period to retain their eligibility;
- ☐ do not establish permanent residence outside New Brunswick; and
- ☐ do not receive health coverage elsewhere.

Temporary Workers: Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12-month period, provided they do not establish residence outside Canada. Any absence over 182 days, whether it be for work purposes or vacation, would require the Director's approval. This approval can only be up to 12 months in duration and will only be granted once every three years. Families of workers temporarily employed outside Canada will continue to be covered, provided that they reside in New Brunswick.

Exception for Temporary Workers: Mobile workers are residents whose employment requires them to travel frequently outside the province. Certain guidelines must be met to receive Mobile Worker designation. These are as follows:

- ☐ applications must be submitted in writing;
- ☐ documentation is required as proof of Mobile Worker status (e.g. a letter from an employer or photocopy of an Immigration Permit);
- ☐ the worker's permanent residence must remain in New Brunswick;
- ☐ the worker must return to New Brunswick during their off-time; and
- ☐ the Mobile Worker designation is assigned for a maximum of two years, after which the resident must re-apply and re-submit documentation to confirm his or her status.

Contract Workers: Any New Brunswick resident accepting an out-of-country employment contract must supply the following information and documentation:

- ☐ letter of request from the New Brunswick resident with his or her signature, detailing his or her absence, including Medicare number, New Brunswick address, date of departure, destination and forwarding address, reason for absence and date of return; and
- ☐ copy of the contractual agreement between employee and employer that defines a start date and end date of employment.

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

New Brunswick Medicare covers out-of-country medical and hospital services for emergency out-patients and resulting in-patient services only. Medicare pays New Brunswick rates for physician services associated with the emergency interventions. The associated facility rates, paid in Canadian funds, are as follows: in-patient services \$100 per day; out-patient services \$50 per visit.

Medicare will cover out-of-country services that are not available in Canada on a prior approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost.

4.4 Prior Approval Requirement

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

- ☐ the required service, or equivalent or alternate service, must be unavailable in Canada;
- ☐ it 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 services 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 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.

The following are considered exemptions under the out-of-country coverage policy:

- ☐ haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the interprovincial rate of \$220 per session; and
- ☐ allergy testing for environmental sensitivity: all tests sent outside the country will be paid at a maximum rate of \$50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required to refer patients to psychiatric hospitals and addiction centres outside the province, 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 of Health and Wellness.

5.0 Accessibility

5.1 Access to Insured Health Services

New Brunswick charges no user fees for insured health services as defined by the *Canada Health Act*. Therefore, all residents of New Brunswick have equal access to these services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds for each RHA.

All facilities that provide insured services in accordance with the *Canada Health Act* have appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2005, there were nine Computed Tomography (CT) scanners operating in New Brunswick – one in each of the eight RHAs, with a second unit operating in RHA 2. The Province also has two mobile Magnetic Resonance Imaging (MRI) units operating and three fixed-site MRI systems.

5.3 Access to Insured Physician and Surgical-Dental Services

A total of 694 general or family practitioners, 802 specialists, eight dentists and six orthodontists provided insured services in New Brunswick in 2004-2005.

In fiscal year 2004-2005, the Department continued to work on its recruitment and retention strategy, aimed at attracting newly licensed family practitioners and specialists. This strategy, announced in 1999-2000, included a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities; the provision of location grants of \$25,000 for family practitioners and \$40,000 for specialists willing to practice in under-served areas of the province; and the purchase of five additional seats at the University of Sherbrooke's medical school, which began in September 2002. The recruitment and retention strategy also provides for increased government involvement in post-graduate training of family physicians; the maintenance of 300 weeks in summer rural preceptorship training for medical students; and moving physician remuneration toward relative parity with other Atlantic provinces.

In February 2004, the Minister of Health and Wellness announced a two-year collaborative practice project to improve access to primary health care services. The pilot project will increase

patient access by adding the services of nurses and nurse practitioners to physician's offices. A total of five office sites, three in Edmundston, one in Bathurst and one in Moncton have been selected. The project will continue until March 2006.

5.4 Physician Compensation

Fiscal year 2004-2005 marked the third year of an agreement with fee-for-service physicians that provides for a 15 percent increase in fees over a three-year period (2002-2003 to 2004-2005). Discussions were held during the year with the New Brunswick Medical Society to implement the initiatives contained in that agreement.

There is no formal negotiation process for dental practitioners in New Brunswick.

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143 and 96-113.

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

5.5 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 Services Act*, which governs the financing of hospitals. The *Regional Health Authorities Act*, which provides for the delivery and administration of health services in defined geographic areas within the province, came into force on April 1, 2002.

There were no changes during the 2004-2005 fiscal year affecting the hospital payment process.

The Department uses two components to distribute available funding to New Brunswick's eight RHAs.

The main component is a "Current Service Level" (CSL) base. This component addresses five main patient-care delivered services as follows:

- ☐ tertiary services (cardiac, dialysis, oncology);
- ☐ psychiatric services (psychiatric units and facilities);

- ☐ dedicated programs (e.g. addictions services);
- ☐ community-based services (Extra-Mural Program; health service centres); and
- ☐ general patient care.

Added to this are non-patient care support services (e.g. general administration, laundry, food services, energy).

The CSL approach establishes base budgets for the eight RHAs for the above-noted programs and services, with measures for population and service volumes. The base budgets are then adjusted annually for inflation and other factors such as centrally negotiated salary rates.

The population-based funding distribution formula, which was enhanced during fiscal year 2000-2001, was still in use in fiscal year 2004-2005. This methodology attempts to predict the appropriate distribution of available funding for the RHAs based on demographic characteristics and current market share of patient volumes, with cases measured by "Resource Intensity Weights." Currently, this methodology is more suitable to in-patient volumes because of a lack of case grouping and weighting methodologies for out-patient volumes, especially tertiary out-patient services (e.g. oncology and haemodialysis).

The current budget process may extend over more than one fiscal year and includes several steps. By January of each year, RHAs are to provide the Department with their utilization data and revenue projections for the following fiscal year, as well as their actual utilization data and revenue figures for the first nine months of the current fiscal year. This information, along with the audited financial statements from the previous two fiscal years, are used to evaluate the expected funding level for each RHA.

Budget amendments are provided during the year to allow for adjustments to applicable programs and services on either recurring or non-recurring bases. The "year-end settlement process" reconciles the total annual approved budget for each RHA to its audited financial statements and reconciles budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

New Brunswick routinely recognizes the federal role regarding its contributions under the Canada Health Transfer (CHT) in public documentation presented through legislative and administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on March 28, 2005;
- the Public Accounts presented by the Minister of Finance on December 21, 2004; and
- the Main Estimates presented by the Minister of Finance on March 28, 2005.

New Brunswick does not produce promotional documentation on its insured medical and hospital benefits.

7.0 Extended Health Care Services

The New Brunswick Long-Term Care program, a non-insured service, was transferred to the Department of Family and Community Services on April 1, 2000. Nursing home care, also a non-insured service, is offered through the Nursing Home Services program of the Department of Family and Community Services. Other adult residential care services and facilities are available through a variety of agencies and funding sources within the province.

Residential and Extended Care Services

Nursing homes are private, not-for-profit organizations, except for one facility that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities¹ are, for the most part, private and not-for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open and close residential facilities. Clients are admitted after going through the same evaluation process used for nursing home admissions.

Public housing units are available for low-income elderly persons. Admission criteria are based on age and the applicant's financial situation. The Victorian Order of Nurses offers support services to some units.

Ambulatory Health Care

In New Brunswick, ambulatory health care includes services provided in hospital emergency rooms, day or night care in hospitals and in clinics if it is available in hospitals, health centres and Community Health Centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also known as the hospital-at-home program, is an active treatment program of acute, palliative and long-term health care and rehabilitation services provided in community settings (an individual's home, a nursing home or public school). Since 1996, this program has been delivered by New Brunswick's eight RHAs. Service providers include nurses, social workers, dietitians, respiratory therapists, physiotherapists, occupational therapists and speech language pathologists. These services, although not covered by the *Canada Health Act*, are considered an insured service under the provincial Hospital Services Plan.

1 Adult Residential Facilities include Special Care Homes and Community Residences.

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). [Quebec Department of Health and Social Services]

Quebec's health insurance plan, the Régime d'assurance maladie du Québec, is administered by the Régie de l'assurance maladie du Québec [Quebec Health Insurance Board] (RAMQ), a public body established by the provincial government and reporting to the Minister of Health and Social Services.

1.2 Reporting

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

1.3 Audit of Accounts

Both plans (the Quebec Hospital Insurance Plan and the Quebec Health Insurance Plan) are operated on a non-profit basis. All books and accounts are audited by the Auditor General of Quebec.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient services include: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anesthetic facilities; medications, prosthetic and orthotic devices that can be integrated with the human body; biologicals and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital staff.

Out-patient services include: 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 services covered by insurance are: mechanical, hormonal or chemical contraception services; surgical sterilization services (including tubal ligation or vasectomy); reanastomosis of the fallopian tubes or vas deferens; and ablation of a tooth or root when the health status of the person makes hospital services necessary.

The MSSS administers an ambulance transportation program that is free-of-charge to persons aged 65 or older.

In addition to basic insured health services, the RAMQ also covers the following, with some limitations, for certain residents of Quebec, as defined by the *Health Insurance Act*, and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability; external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for

people with a visual or auditory disability; and permanent ostomy appliances.

Since January 1, 1997, in terms of drug insurance, the RAMQ covers, over and above its regular clientele (employment assistance recipients and persons 65 years of age or older), individuals who do not have access to a private drug insurance plan. The drug insurance plan covers 3.25 million insured persons.

2.2 Insured Medical Services

The services insured under this plan include medical and surgical services that are provided by physicians and are required from a medical standpoint.

2.3 Insured Surgical-Dental Services

Services insured under this plan include oral surgery performed in a hospital centre or university institution determined by regulation, by dental surgeons and specialists in oral and maxillo-facial surgery.

2.4 Uninsured Hospital, Medical and Surgical-Dental Services

Uninsured hospital services include: plastic surgery; in vitro fertilization; a private or semi-private room at the patient's request; televisions; telephones; drugs and biologics ordered after discharge from hospital; and services for which the patient is covered 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 cure or prevention of illness;
- ☐ psychoanalysis of any kind, unless such service is rendered in an institution authorized for this purpose by the Minister of Health and Social Services;
- ☐ any service rendered solely for aesthetic purposes;
- ☐ any refractive surgery, except in cases where there is documented failure in astigmatism of more than 3.00 diopters or for anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn;
- ☐ any consultation by telecommunication or by correspondence;
- ☐ any service rendered 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 examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes;
- ☐ any service rendered by a professional on the basis of an agreement or a contract with an employer, an association or an organization;
- ☐ any adjustment of eye glasses or contact lenses;
- ☐ any surgical ablation of a tooth or tooth fragment performed by a physician, except where the service is provided in a hospital in certain cases;
- ☐ all acupuncture procedures;
- ☐ injection of sclerosing substances and the examination done at that time;
- ☐ mammography used for screening purposes, unless this service is delivered on a doctor's orders in a place designated by the Minister, in either case, to a recipient who is 35 years of age or older, on condition that such an examination has not been performed on the recipient in the previous year;
- ☐ thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in humans, unless these services are rendered in a hospital centre;
- ☐ ultrasonography, unless this service is rendered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose;
- ☐ any radiological or anesthetic service provided by a physician if required with a view to

providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of a radiology service, if required by a person other than a physician or dentist;

- any sex-reassignment surgical service, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and
- any services that are not associated with a pathology and that are rendered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim card, for colour blindness or a refraction problem, in order to provide or renew a prescription for eyeglasses or contact lenses.

3.0 Universality

3.1 Eligibility

Registration with the hospital insurance plan is not required. Registration with the RAMQ or proof of residence is sufficient to establish eligibility. All persons who reside or stay in Quebec must be registered with the RAMQ to be eligible under the health insurance plan.

3.2 Registration Requirements

Registration with the hospital insurance plan is not required. Registration with the RAMQ or proof of residence is sufficient to establish eligibility.

3.3 Other Categories of Individual

Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police (RCMP) and inmates of federal penitentiaries are not covered by the Plan. No premium payment exists.

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 receiving last resort financial assistance are eligible upon registration. Members of the Canadian Forces and RCMP who have not acquired the status of Quebec resident become eligible the day they arrive, and inmates of federal penitentiaries become eligible the day they are 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* [Quebec Department of Education], 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 become eligible for the plan following a waiting period.

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 RAMQ.

4.2 Coverage During Temporary Absences Outside Quebec (in Canada)

If living outside Quebec in another province or territory for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec. In the first case, they retain it for four calendar years at most, and in the second, for two consecutive calendar years at most.

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

Persons directly employed or working on contract outside Quebec in another province or territory, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

Status as a resident of the province is also maintained by 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 and provided they notify the RAMQ of the absence.

The costs of medical services received in another province or territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the RAMQ for such services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when the specialized services provided are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 between the Centre de santé Témiscamingue [Témiscamingue Health Centre] and North Bay.

Costs of hospital services received in another province or territory of Canada are paid in accordance with the terms and conditions of the interprovincial agreement on reciprocal billing regarding hospital insurance agreed on by the provinces and territories of Canada. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or the costs of expensive procedures are paid at approved interprovincial/territorial rates. However, since November 1, 1995, Quebec reimburses a maximum of \$450 per day of hospitalization when an Outaouais resident is hospitalized in an Ottawa hospital for non-urgent care or services available in the Outaouais.

Insured persons who leave Quebec to settle in another province or territory of Canada are covered for up to three months after leaving the province.

4.3 Coverage During Temporary Absences Outside Quebec (outside Canada)

Students, unpaid trainees, Quebec government officials posted abroad and employees of non-profit organizations working in international aid or cooperation programs recognized by the MSSS must contact the RAMQ to ascertain their eligibility. If the RAMQ recognizes them as having special status, they receive full reimbursement of hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

Persons directly employed or working on contract outside Canada, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

As of September 1, 1996, hospital services provided outside Canada in case of emergency or sudden illness are reimbursed by the RAMQ, usually in Canadian funds, to a maximum of \$100(CDN) per day if the patient was hospitalized (including in the case of day surgery) or to a maximum of \$50(CDN) per day for out-patient services.

However, hemodialysis treatments are covered to a maximum of \$220(CDN) per treatment. In such cases, the RAMQ provides reimbursement for the associated professional services. The services must be dispensed in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the RAMQ to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. The cost of all services insured in the province are reimbursed at the Quebec

rate, usually in Canadian funds, when they are incurred abroad.

Coverage is discontinued as of the day of departure for insured residents who move permanently to another country.

4.4 Prior Approval Requirement

Insured persons requiring medical services in hospitals abroad, in cases where those services are not available in Quebec or elsewhere in Canada, are reimbursed 100 percent if prior consent has been given for medical and hospital services that meet certain conditions. Consent is not given by the Plan's officials if the medical service in question is available in Quebec or elsewhere in Canada.

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. There is no extra-billing by Quebec physicians.

5.2 Access to Insured Hospital Services

On March 31, 2005, Quebec had 118 institutions operating as hospital centres for a clientele suffering from acute illnesses. There were 21,675 beds for persons requiring care for acute physical or psychiatric ailments allotted to these institutions. From April 1, 2003 to March 31, 2004, Quebec hospital institutions had nearly 705,255 admissions for short stays (including births) and close to 296,680 registrations for day surgeries. These hospitalizations and registrations accounted for more than 5,155,000 patient days.

Improved telephone access to care: The Info-Santé telephone line will be centralized in each of the 15 regions where it exists, and a new Info-Social line will be developed in all regions. An

Info-médicament line and a public health branch advisory module will be incorporated into Info-Santé. The plan is to have one communication centre in each region and to link all of these centres into a network, as well as to make them accessible to the general public through a single number composed of three digits.

Restructuring of the health network:

In November 2003, Quebec announced the implementation of local service networks covering all of Quebec. At the heart of each local network is a new local authority, the health and social services centre. These centres are the result of the merger of the public institutions whose mission it was to provide CLSC (local community service centre) services, residential and long-term care, and, in most cases, neighbourhood hospital services. The health and social services centres also provide the people in their territory with access to other medical services, general and specialized hospital services, and social services. To do so, they have to enter into service agreements with other health sector organizations. The linking of services within a territory forms the local services network. Thus, the aim of integrated local health and social services networks is to make all the stakeholders in a given territory collectively responsible for the health and well-being of the people in that territory.

New projects for seniors: In order to respect the wishes of frail seniors who want to remain in their homes as long as possible, the MSSS has funded new projects that offer innovative ways to deliver services directly to these persons. The second phase of the *Pour un nouveau partenariat au service des aînés* [A New Partnership for Seniors] initiative includes 10 projects, funded for a total of \$3,096,977 on an annual basis. Last year, 12 projects benefited from a recurring envelope of \$4,213,077. All of these projects are evaluated after a few years and the best are reproduced elsewhere in Quebec. The hope of the MSSS is that, one day, spots in long-term care hospitals (CHSLD) will be limited to the few patients who cannot live outside such facilities.

Management of waiting lists: In October 2003, the MSSS began publishing waiting lists for each hospital on its website. It now provides physicians and institutions with a computerized service access management system (SGAS). This tool is based on the concept of “access within a clinically acceptable period,” as defined by committees of medical experts in certain fields. Once applied uniformly throughout the province of Quebec, these guidelines will ensure that all patients, regardless of their place of origin, will be treated under the same criteria. Once implemented, this system will supply the data for the new waiting lists site and will enable the concerned patients and professionals to obtain appropriate, reliable and up-to-date information on the activities of hospital centres and waiting periods for various services.

5.3 Access to Insured Medical and Surgical-Dental Services

Primary care: In 2003-2004, family medicine groups (FMGs) were established. These groups work closely with the CLSCs and other network resources to provide services such as health assessment, case management and follow-up, diagnosis, treatment of acute and chronic problems, and disease prevention. Their services are available 24 hours a day, seven days a week.

Quebec now has 103 FMGs. A new FMG has been accredited in the Mauricie region. The number of such groups has gone from 21 to 103 within two years.

The Conseil médical du Québec has established a committee to develop the concept of the physician/population ratio because interprovincial comparisons suggest that Quebec has an adequate number of physicians.

5.4 Physician Compensation

Physicians are remunerated in accordance with the negotiated fee schedule. Physicians who have

withdrawn from the health insurance plan are paid directly by the patient according to the fee schedule after the patient has collected from the RAMQ. Non-participating physicians are paid directly by their patients according to the amount charged.

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient. The Minister may also provide for a different rate of compensation for general practitioners and medical specialists during the first years of practice, depending on the territory or the activity involved. These provisions are preceded by consultation with the organizations representing the professional groups.

While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals withdraw from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and non-participating professionals practise outside the plan and neither they nor their patients are reimbursed by the RAMQ.

In 2004-2005, the RAMQ paid an amount estimated at \$3,279.7 million to doctors in the province, while the amount for medical services outside the province reached an estimated \$9.5 million.

5.5 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 2004-2005 to institutions operating as hospital centres for insured health services provided to persons living in Quebec were more than \$7.1 billion. Payments to hospital centres outside Quebec were approximately \$92.3 million.

7.0 Extended Health Care Services

Intermediate care, adult residential care and home care services are available. Admission is coordinated on a regional level and based on a single assessment tool. The CLSCs receive individuals, evaluate their care requirements, and either arrange for provision of services such as day care centre programs or home care, or refer them to the appropriate agencies.

The MSSS offers some home care services, including nursing care and assistance, homemaker services and medical supervision.

Residential facilities and long-term care units in acute-care hospitals focus on maintaining their clients' autonomy and functional abilities by providing them with a variety of programs and services, including health care services.

Publication of the first report on the health status of the Quebec population: The report, entitled, *Produire la santé*, is published in accordance with the provisions of the *Public Health Act*. This report asserts that certain risk factors are common to the most frequently encountered health problems. These risk factors—poverty, as well as certain physical and social environments and individual behaviours—are avoidable risks. Instead of focussing exclusively on health care, the report notes that concrete initiatives are needed to address a broader range of health determinants.

Ontario

Introduction

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 Care (MOHLTC), Ontario's health care system was supported by over \$31.5 billion¹ (including capital) in spending for 2004-2005.

MOHLTC is responsible for providing services to the Ontario public through such programs as:

- ☐ health insurance;
- ☐ drug benefits;
- ☐ assistive devices;
- ☐ mental health services;
- ☐ home care;
- ☐ community support services;
- ☐ public health; and
- ☐ health promotion and disease prevention.

MOHLTC also regulates and funds hospitals and long-term care homes (nursing homes and homes for the aged); operates psychiatric hospitals and medical laboratories; and funds and regulates or directly operates emergency health services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by MOHLTC. OHIP is established 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 in hospitals and health facilities and by physicians and other health care practitioners.

1.2 Reporting Relationship

OHIP is administered by MOHLTC.

1.3 Audit of Accounts

MOHLTC is audited annually by the Office of the Auditor General. The Auditor General's 2005 Annual Report was released on December 6, 2005.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2004-2005 Public Accounts of Ontario were released on September 27, 2005.

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 and Regulation 552* under that Act.

Insured in-patient hospital services include medically required:

- ☐ use of operating rooms, obstetrical delivery rooms and anaesthetic facilities;
- ☐ necessary nursing services;
- ☐ laboratory, radiological and other diagnostic procedures;
- ☐ 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;

¹ Source: Ontario Public Accounts 2004-2005

- use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- use of diet counselling services;
- use of the operating room, anesthetic facilities, surgical supplies, necessary nursing service, and supplying of drugs, biologicals and related preparations (subject to some exceptions);
- provision of equipment, supplies and medication to haemophiliac patients for use at home;
- cyclosporine to transplant patients;
- zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
- biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
- drugs for treating cystic fibrosis and thalassemia;
- erythropoietins to patients with anaemia of end-stage renal disease;
- alglucerase to patients with Gaucher disease;
- clozapine to patients with treatment-resistant schizophrenia;
- the administration of a rabies vaccine; and
- herceptin (trastuzumab) – for early breast cancer (stages 1, 2 and 3), as well as late-stage breast cancer (metastatic); navelbine (Vinorelbine) – for lung cancer; and, taxotere (docetaxel) – for prostate cancer.

In 2004-2005, there were 152 public hospital corporations (excluding specialty hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care homes) staffed and in operation in Ontario. This includes 135 acute care hospital corporations, 13 chronic care hospitals and four general and special rehabilitation units. Hospitals are categorized by major activity, although they provide a mix of services. For example, many acute care hospitals offer chronic care services. A number of designated chronic care facilities also offer rehabilitation.

When insured physician services are provided in licensed facilities outside hospitals and where the total cost paid for these insured services is not included in the physician fees paid under the *Health Insurance Act*, MOHLTC provides funding through the payment of facility fees under the *Independent Health Facilities Act* (IHFA). Facility fees cover the cost of the premises, equipment, supplies and personnel used to render an insured service. Under the IHFA, patient charges for facility fees are prohibited.

Facility fees are charged to the government only by facilities that are licensed under the IHFA. Examples of facilities that are licensed under the IHFA include surgical/treatment facilities (e.g. those providing abortions, cataract surgery, dialysis and non-cosmetic plastic surgery) and diagnostic facilities (e.g. those providing x-ray, ultrasound, nuclear medicine, sleep studies and pulmonary function studies). New facilities are ordinarily established through a request for proposals process based on an assessment of need for the service.

2.2 Insured Physician Services

Insured physician services are prescribed under the *Health Insurance Act* and regulations under that Act.

Under subsection 37.1(1) of *Regulation 552* of the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary; contained in the Schedule of Benefits; and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits. Physicians provide primary health care services as well as medical, surgical and diagnostic services. Services are provided in a variety of settings, including private physician offices, community health centres, hospitals, mental health facilities, independent health facilities, walk-in clinics and long-term care homes.

In general terms, insured physician services include:

- ☐ diagnosis and treatment of medical disabilities and conditions;
- ☐ medical examinations and tests;
- ☐ surgical procedures;
- ☐ maternity care;
- ☐ anaesthesia;
- ☐ radiology and laboratory services in approved facilities; and
- ☐ immunizations, injections and tests.

The Schedule of Benefits 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.

During 2004-2005, physicians could submit claims for all insured services rendered to insured persons directly to OHIP, in accordance with section 15 of the *Health Insurance Act*, or they could bill the insured person, as specified in section 15 of the Act (see also Part II of the *Commitment to the Future of Medicare Act*). Physicians who do not bill OHIP directly are commonly referred to as having “opted-out”. When a physician has opted out, the physician bills the patient (not exceeding the amount payable for the service under the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. However, opting out is no longer generally allowed following proclamation of the *Commitment to the Future of Medicare Act* on September 23, 2004.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario.

There were approximately 22,000 physicians who submitted claims to OHIP in 2004-2005.

2.3 Insured Surgical-Dental Services

Insured surgical-dental services are prescribed under section 16 and the Dental Schedule of Benefits under *Regulation 552* of the *Health*

Insurance Act. These services, for which hospitalization is medically necessary, include the following:

- ☐ repair of traumatic injuries;
- ☐ surgical incisions;
- ☐ excision of tumours and cysts;
- ☐ treatment of fractures;
- ☐ homeografts;
- ☐ implants;
- ☐ plastic reconstructions; and
- ☐ all other prescribed dental procedures.

Approximately 345 dentists and dental/oral surgeons provided insured surgical-dental services in Ontario in 2004-2005.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services prescribed by and rendered in accordance with the *Health Insurance Act* and regulations under that Act are insured. Section 24 of *Regulation 552* details those services that are specifically prescribed as uninsured.

Uninsured hospital services include:

- ☐ additional charges for preferred accommodation unless prescribed by a physician, oral-maxillofacial surgeon or midwife;
- ☐ telephones and televisions;
- ☐ charges for private-duty nursing;
- ☐ cosmetic surgery under most circumstances;
- ☐ provision of medications for patients to take home from hospital, with certain exceptions; and
- ☐ in-province, out-patient hospital visits solely for administering drugs, subject to certain exceptions.

Uninsured physician services include:

- ☐ services that are not medically necessary;
- ☐ toll charges for long-distance telephone calls;
- ☐ the preparation or provision of a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;

- ☐ advice given by telephone at the request of the insured person or the person's representative;
- ☐ an interview or case conference (in limited circumstances);
- ☐ the preparation and transfer of records at the insured person's request;
- ☐ a service that is received wholly or partly for producing or completing a document or transmitting information to a "third party" in specified circumstances;
- ☐ the production or completion of a document or transmitting information to any person other than the insured person in specified circumstances;
- ☐ provision of a prescription when no concomitant insured service is rendered;
- ☐ cosmetic surgery (in most circumstances);
- ☐ acupuncture procedures;
- ☐ psychological testing; and
- ☐ research, experimental and survey programs.

Effective September 23, 2004, Part II of the *Commitment to the Future of Medicare Act* (CFMA) prohibits physicians from charging patients or accepting payments from patients for more than the amount payable by OHIP for the insured service. The CFMA also prohibits payment or accepting payment to obtain preferred access to an insured service. Before the CFMA, the *Health Insurance Act* and the *Health Care Accessibility Act* prohibited physicians from charging patients or accepting payments from patients for more than the amount payable by OHIP for the insured service.

3.0 Universality

3.1 Eligibility

To be considered a resident of Ontario for the purpose of obtaining Ontario health insurance coverage, a person must:

- ☐ hold Canadian citizenship or an immigration status as prescribed in *Regulation 552*;

- ☐ make his or her permanent and principal home in Ontario;
- ☐ be physically present in Ontario for at least 153 days in any 12-month period; and
- ☐ in most cases, new and returning residents applying for health coverage must also be physically present in Ontario for 153 of the first 183 days following the date they establish residency in Ontario (a person cannot be away from the province for more than 30 days in the first six months of residency).

With certain exceptions in which the waiting period is waived, residents of Ontario, as defined in *Regulation 552* of the *Health Insurance Act*, are eligible for Ontario health coverage subject to a three-month waiting period. MOHLTC will determine whether or not an individual is subject to the three-month waiting period at the time of their application for health coverage. Those who are exempt from the three-month waiting period include Convention Refugees and Protected Persons, newborn babies born in Ontario and insured residents from another province or territory who move to Ontario and immediately become residents of approved charitable homes, homes for the aged or nursing homes in Ontario.

Individuals who are not eligible for Ontario health insurance coverage include those who do not meet the definition of a resident as described above or those who hold an immigration status that is not set out in *Regulation 552* including refugee claimants (who are not Convention Refugees) and visitors to the province. Other individuals such as federal penitentiary inmates, Canadian Forces and Royal Canadian Mounted Police personnel are also not given Ontario health insurance coverage if they have health insurance coverage under a federal health care plan.

Persons who were previously ineligible for Ontario health insurance coverage but whose status and/or residency situation has changed (e.g. change in immigration status or release from a federal penitentiary) may be eligible, upon application, subject to the requirements of *Regulation 552*.

When it is determined that a person is not eligible or no longer eligible for OHIP coverage, a request may be made to the General Manager of OHIP to review MOHLTC's decision. Anyone may request that the General Manager review the determination of their OHIP eligibility simply by making the request in writing.

3.2 Registration Requirements

Every resident of Ontario who seeks Ontario health coverage is required to register with MOHLTC.

A health card is issued to eligible residents on applying to the General Manager of OHIP, pursuant to sections 2 and 3 of *Regulation 552*. Eligible persons should apply for coverage upon establishing their permanent and principal home in the province. Registration is done through local OHIP offices. Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide MOHLTC with original documents to prove their Canadian citizenship or eligible immigration status, their residency in Ontario and their identity. Eligible applicants over the age of 15.5 are also generally required to have their photographs and signatures captured for their photo health cards.

Each photo health card has a card renewal/expiry date in the bottom right-hand corner of the card. MOHLTC mails renewal notices to registrants several weeks before the card's renewal date.

MOHLTC is the sole payer for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for the cost of any insured service that is covered by OHIP.

Approximately 12.39 million Ontario residents were registered with OHIP and held valid and active health cards as of April 1, 2005.

3.3 Other Categories of Individual

MOHLTC provides health insurance coverage to residents of Ontario other than just Canadian

citizens and Permanent Residents/Landed Immigrants. These residents are required to provide acceptable documentation to support their eligible immigration status, their residency in Ontario, and their identity in the same manner as Canadian citizen or Permanent Resident/Landed Immigrant applicants.

The individuals listed below who are ordinarily resident in Ontario will be eligible for Ontario health insurance coverage in accordance with *Regulation 552* and prevailing MOHLTC policy. Clients applying for coverage under any of these categories should contact their local OHIP office for further details.

Applicants for Permanent Residence/

Applicants for Landing – These are persons who are being processed for Permanent Resident/Landed Immigrant status by Citizenship and Immigration Canada (CIC) and have met CIC's medical requirements.

Convention Refugees and Protected Persons –

The federal Immigration and Refugee Board designates a person as a Convention Refugee when that person has been found to fear persecution in his or her country of origin because of race, religion, nationality, political opinion or membership in a social group. CIC may also determine that a person is a Protected Person under the terms of the *Immigration and Refugee Protection Act* if returning to their country of origin would pose a substantial risk to the person's life or to torture or to cruel and unusual punishment.

Holders of Temporary Resident

Permits/Minister's Permits – Temporary Resident Permits/Minister's Permits are documents that indicate that the holder has not immediately met CIC's requirements to remain permanently in Canada. Holders of a Temporary Resident Permit/Minister's Permit with a case type of 80 (adoption only), 86, 87, 88 or 89 are typically being processed towards Permanent Resident status and are eligible for Ontario health coverage for the duration of their permit if they will be residing in Ontario. Holders of a Temporary Resident Permit/Minister's Permit with

a case type of 80 (except adoption), 81, 84, 85, 90, 91, 92, 93, 94, 95 and 96 are typically refused applicants for Permanent Resident status on medical or criminal grounds or are merely visiting for a short period of time and are not eligible for Ontario health coverage.

Clergy, Foreign Workers and their

Accompanying Family Members – An eligible foreign clergy is a person who is sponsored by a religious organization or denomination and has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer located in Ontario and has been issued a Work Permit/Employment Authorization by CIC that names the Canadian employer, states the person's prospective occupation, and has been issued for a period of at least six months.

Spouses, same sex partners and/or dependant children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker are also eligible for Ontario health coverage if the member of the clergy or the foreign worker is to be employed in Ontario for at least three consecutive years and if the family member will be ordinarily a resident of Ontario.

Live-in Caregivers – Live-in Caregivers are persons who have been issued a Work Permit/Employment Authorization under the Live-in Caregivers in Canada Program (LCP) or the former Foreign Domestic Movement (FDM) administered by CIC. An eligible Live-in Caregiver is a person who holds a valid LCP or FDM Work Permit/Employment Authorization issued by CIC and who is ordinarily a resident of Ontario. The Work Permit/Employment Authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers.

Migrant Farm Workers – Migrant farm workers are persons who have been issued a Work Permit/Employment Authorization under the Caribbean, Commonwealth and Mexican

Seasonal Agriculture Workers Program administered by CIC. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period.

3.4 Premiums

There are no premiums payable as a condition of obtaining coverage.

4.0 Portability

4.1 Minimum Waiting Period

In accordance with subsection 3(3) of *Regulation 552* under the *Health Insurance Act* (HIA) and MOHLTC policy, individuals who move to Ontario are entitled to OHIP coverage beginning three months after establishing residency in the province, unless listed as an exception in section 3(4).

4.2 Coverage During Temporary Absences in Canada

Out-of-province services are covered under sections 28, 30(1) and 32 of *Regulation 552* of the *Health Insurance Act*.

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability; therefore, insured residents who are outside Ontario could temporarily use their Ontario health cards to obtain insured health services.

An insured person who leaves Ontario temporarily to travel within Canada without establishing residency in another province or territory will continue to be covered by OHIP for a period of up to 12 months.

An insured person who seeks or accepts employment in another province or territory will 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.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health 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 MOHLTC with documentation from their educational institution confirming registration as a full-time student. Family members 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.

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Interprovincial Health Insurance Agreements Coordinating Committee.

In addition, section 28 of *Regulation 552* of the *Health Insurance Act* sets out payment for insured hospital services outside Ontario but within Canada that are not billed through the reciprocal arrangements.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services. Ontario residents who may be required to pay for doctors' services received in Quebec can submit their receipts to MOHLTC for repayment.

4.3 Coverage During Extended Temporary Absences Outside Canada

Health insurance coverage for insured Ontario residents during extended absences outside Canada is governed by sections 28.1 through 29 (inclusive) and section 31 of *Regulation 552* of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1(4), 1.1(5) and 1.1(6) of *Regulation 552* of the *Health Insurance Act*, MOHLTC may provide insured Ontario residents with continuous Ontario health coverage during absences outside Canada of longer than 212 days (seven months) in a 12-month period.

Residents are required to apply to MOHLTC for this coverage before their departure and must provide a document explaining the reason for their absence outside Canada. In accordance with the regulations and MOHLTC policy, most applicants must also have been present 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 MOHLTC will provide a person with continuous Ontario health coverage during an extended absence outside Canada varies depending on the reason for the absence. Please refer to the information below for further details:

Reason	OHIP Coverage
Study	Duration of a full-time accredited academic program (unlimited)
Work	Five-year terms
Missionary Work	Duration of missionary activities (unlimited)
Vacation/Other	Up to two years in a lifetime

Family members may also qualify for continuous Ontario health coverage while accompanying the primary applicant on an extended absence

outside Canada and should contact their local OHIP office for details.

Out-of-country services are covered under sections 28.1 to 28.6 inclusive, and sections 29 and 31 of *Regulation 552* of the *Health Insurance Act*.

Effective September 1, 1995, out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- ☐ a maximum \$400(CDN) for in-patient services;
- ☐ a maximum \$50(CDN) for out-patient services (except dialysis); and
- ☐ a maximum \$210(CDN) per dialysis treatment.

During 2004-2005, emergency medically necessary out-of-country physician and other eligible practitioner services were reimbursed at the Ontario rates detailed in regulation under the *Health Insurance Act* or the amount billed, whichever is less. Charges for medically necessary emergency or out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed or approved hospital or licensed health facility. Medically necessary out-of-country laboratory services when done on an emergency basis by a physician are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less, and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

In 2004-2005, payments for out-of-country emergency in-patient and out-patient insured hospital and medical services amounted to \$46.1 million.

4.4 Prior Approval Requirement

As set out in section 28.4 of *Regulation 552* of the *Health Insurance Act*, prior approval from MOHLTC is required for payment for non-emergency services provided outside Canada. Where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or

cause irreversible tissue damage, the patient may be entitled to full funding for out-of-country health services.

Under section 28.5 of *Regulation 552* of the *Health Insurance Act*, laboratory tests performed outside Canada are paid for, with prior approval from MOHLTC, if the following conditions are met:

- ☐ the kind of service or test is not performed in Ontario;
- ☐ the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person;
- ☐ the service or test is not experimental; and
- ☐ the service or test is not performed for research purposes.

In 2004-2005, total payments for prior-approved treatment outside Canada were \$39.3 million.

There is no formal prior-approval process for services provided to Ontario residents outside the province but within Canada. The Interprovincial Agreement on Eligibility and Portability includes a schedule for high-cost services.

5.0 Accessibility

5.1 Access to Insured Health Services

All insured hospital, physician and surgical-dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured hospital and physician services, as defined in the *Health Insurance Act*.

Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations because the person is not insured.

Accessibility to insured health care services is protected under the *Commitment to the Future of Medicare Act* (CFMA). This Act prohibits any person or any entity from charging more, or

accepting payment or other benefit for more than the amount payable by OHIP. In addition, the CFMA also prohibits physicians, practitioners and hospitals from refusing to provide an insured service if an insured person chooses not to pay for an uninsured service. The Act further prohibits any person or entity from paying, conferring or receiving any benefit in exchange for preferred access to an insured service.

MOHLTC implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to MOHLTC a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 2004-2005, there were 152 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 7,025,267 acute patient days, 2,102,449 chronic patient days and 743,590 rehabilitation patient days delivered by public hospitals.

Priority services are designated highly specialized hospital-based services that deal with life-threatening conditions. These services are often high-cost and rapidly growing, which makes access of concern. Generally, these services are managed provincially on a time-limited basis.

Priority services include:

- ☐ selected cardiovascular services;
- ☐ selected cancer services;
- ☐ end-stage renal disease; and
- ☐ selected organ transplants.

5.3 Access to Insured Physician and Surgical-Dental Services

Initiatives

Underserviced Area Program (UAP)

UAP is one of a number of supports that MOHLTC provides to help communities across the province access needed health care services. UAP provides a variety of integrated initiatives aimed at attracting and retaining health care providers. In order to be eligible for the UAP's recruitment and retention benefits, a community must be designated as underserviced.

UAP works closely with underserviced communities to identify their need for health human resources. It provides financial incentives and practice supports, and enables community access to physician services by funding locums and outreach clinics.

Currently, there are 139 communities in Ontario designated as underserviced for general/family practitioners and 14 northern Ontario communities designated as underserviced for medical specialists.

Northern Physician Retention Initiative (NPRI)

NPRI provides eligible family practitioners and specialists who maintain practices in northern Ontario for at least four years with a retention incentive as well as access to funding for continuing medical education.

Northern Health Travel Grant Program (NHTGP)

NHTGP helps defray transportation costs for residents of northern Ontario who must travel long distances to access insured non-emergency hospital and specialist medical services that are not locally available, and also promotes using

specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.

Primary Health Care

During 2004-2005, Ontario continued to align its new and existing primary care delivery models to help improve and expand access to primary care for all Ontarians by including elements such as 24-hour seven days a week access through telephone health advisory services, increased after-hours coverage and preventive care initiatives. There were approximately 2.9 million patients rostered to physicians in the primary care models that have these features.

New agreements were negotiated and signed for Health Service Organizations, Primary Care Networks, Rural and Northern Physician Groups and a number of other family physician groups working in high-needs practices.

As part of transforming its health care system, Ontario committed to establish 150 Family Health Teams by 2007-2008 to further facilitate physicians working as part of a team with other health providers with a focus on keeping patients healthy.

5.4 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Some physician payments are provided through fee-for-service arrangements. Remuneration is based on the Schedule of Benefits under the *Health Insurance Act*. Other physician payment models may include Alternate Payment Plans and new funding arrangements for physicians in Academic Health Science Centres (AHSCs).

Family physicians paid solely on a fee-for-service basis represents 49 percent of Ontario's registered family physicians. The remaining family physicians in Ontario receive funding through one of the primary care initiatives such as Family Health Networks, Family Health Groups and models for physicians in AHSCs where funding

may include any combination of capitation, salary, special payments and bonuses.

MOHLTC negotiates payment rates and other changes to the Schedule of Benefits with the Ontario Medical Association. A new Physician Services Agreement with the Ontario Medical Association was negotiated for a four-year term, from April 2004 to March 2008. The Agreement provided for an across-the-board fee increase of 2 percent for specialists and 2.5 percent for general practitioners/family physicians, effective April 1, 2004. Further increases in specific fee codes are scheduled for implementation on various dates from October 1, 2005, through to January 1, 2008.

The Agreement eliminated payment thresholds effective April 1, 2005. This Agreement expands access to care in rural communities by introducing new funding to support hospital-based specialists in the north; enhances care for seniors by introducing new on-call fees in long-term care homes, home care and palliative care; supports hospital care by expanding hospital on-call coverage and in-hospital care fees for specialists and by introducing new fees for family doctors caring for their own patients in emergency departments; supports health promotion and disease prevention by introducing special fees for managing specific chronic diseases; and makes quality of life improvements for physicians such as expanding pregnancy and parental leave benefits.

Under the Agreement, the parties have committed to begin meeting in April 2007, to undertake a performance review of the degree to which the objectives under the Agreement have been met.

With respect to insured surgical-dental services, MOHLTC negotiates changes to the Schedule of Benefits for Dental Services with the Ontario Dental Association. In 2002-2003, MOHLTC and the Ontario Dental Association agreed on a new multi-year funding agreement for dental services which became effective on April 1, 2003, and will end on March 31, 2007.

5.5 Payments to Hospitals

Hospitals submit Hospital Annual Planning Brief Submissions (HAPS) that are the result of broad consultations within the facilities (e.g. all levels of staff, unions, physicians and board) and within the community and region. HAPS are based on a multi-year budget and provide a corresponding multi-year planning forecast. MOHLTC staff reviews this planning document and negotiates specific performance indicators with individual hospitals. MOHLTC's review is conducted by regional staff, specialized program staff and senior management. The review follows standard guidelines and may involve extensive discussions and clarification with the facility.

Transfer payments to hospitals are based on historical global allocations and multi-year incremental increases that incorporate population growth and anticipated service demands within the available provincial budget.

The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority services and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

MOHLTC is beginning to measure hospital performance through six key indicators: total margin, current ratio, relative total length of stay, relative acute length of stay, relative risk of re-admission, and total weighted cases.

In addition, specialized methodologies are used for incremental funding for specific policy and program initiatives (i.e. Nursing Enhancements, 60-hour postpartum guarantee length of stay). Funding for hospital operations was over \$11.8 billion for 2004-2005 (based on public accounts).

MOHLTC reviews chronic care co-payment regulations and rates annually, taking into account changes in the Consumer Price Index, Old Age Security, Guaranteed Income Supplement and Guaranteed Annual Income Supplement each year, and determines whether revisions to the regulations and rates are appropriate.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2004-2005 publications.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care

MOHLTC funds 600 long-term care homes and over 74,800 beds. MOHLTC also conducts the compliance monitoring program for long-term care homes, which includes monitoring resident health and well-being, safety, security, environmental and dietary services to determine compliance with legislation, regulations and standards. MOHLTC receives and monitors the implementation of corrective action plans to achieve compliance, where necessary.

7.2 Home Care

Ontario home and community care programs provide a range of services that support independent community living. These services are available through Community Care Access Centres (CCAC) and Community Support Service (CSS) agencies.

CCACs provide simplified access for eligible Ontario residents of all ages to community-based health care, support services and end-of-life care in the community. CCACs assess individual care needs, eligibility for services and arrange for nursing and other professional services and personal support services. CCACs assess and determine eligibility for professional and personal support services for children in school and in-home schooling. CCACs also provide information and referral services to other long-term care

community services and are responsible for admission to long-term care homes, convalescent care and selected adult day programs. CCACs manage the Requests for Proposal (RFPs) process for purchased client services.

Community Support Service (CSS) agencies provide support services that include personal support, homemaking, attendant care, adult day programs, caregiver support, meal services, home maintenance and escorted transportation. Community support services also include acquired brain injury services and assisted living services in supportive housing. These services complement in-home and other health services and the assistance provided by family and friends.

The provincial End-of-Life Strategy helps shift care of persons in the last stages of their life from hospitals to home or another appropriate setting of their choice; enhance an interdisciplinary team approach to care; and will work toward better coordination and integration of local services. End-of-Life services are provided in home or the community by CCACs, CSS agencies and residential hospices.

7.3 Ambulatory Health Care

Community Health Centres (CHCs) are transfer payment agencies governed by a community board of directors. The name "Community Health Centre" reflects the fact that the agency is established by the community and provides programs and services in response to needs identified in that community. CHCs deliver services through inter-disciplinary teams including physicians, nurses, counsellors, dietitians and health promoters. Services include comprehensive primary care as well as group and community programs such as diabetes education, parent/child programs, community kitchens and youth outreach services. CHCs work within a population health framework that places an equal emphasis on providing comprehensive primary care, preventing illness and health promotion.

CHCs identify the priority populations that they will serve - traditionally people who have experienced barriers to access based on culture, language, literacy, age, socio-economic status, mental health status and homelessness. CHCs develop partnerships to improve access to care, promote effective service integration and build community capacity to address health risks.

Service is provided through 54 CHCs operating from more than 80 full-service sites across Ontario. Of these, 27 are in large urban centres, 14 are in smaller urban centres and 13 are in either northern or rural communities. There is no legislation specific to CHCs.

Historically, CHCs have been developed based on expressions of interest from sponsoring groups. This has resulted in an uneven distribution and some significant gaps in coverage across the province. Between 2004-2005 and 2007-2008, the government will expand the network of CHCs by adding 22 new CHCs and 27 satellite CHCs. This expansion will be targeted to communities with at-risk populations facing barriers to access. Once implemented, it is expected that many of the most critical gaps in coverage will be addressed.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	11,700,000	11,800,000	12,100,000	12,200,000	12,400,000

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	150	139	139	139	135
b. chronic care	12	11	11	11	13
c. rehabilitative care	4	4	4	4	4
d. other	3	3	3	3	3
e. total	169 ¹	157 ¹	157 ¹	157 ¹	155 ¹
3. Payments (\$):					
a. acute care	not available ²	not available ²	not available ²	not available ²	not available ²
b. chronic care	not available ²	not available ²	not available ²	not available ²	not available ²
c. rehabilitative care	not available ²	not available ²	not available ²	not available ²	not available ²
d. other	not available ²	not available ²	not available ²	not available ²	not available ²
e. total	8,700,000,000	9,200,000,000	10,300,000,000	10,300,000,000	12,300,000,000
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	not available ³	not available ³	not available ³	not available ³	not available ³
b. diagnostic imaging facilities	not available ³	not available ³	not available ³	not available ³	not available ³
c. total	not available ³	not available ³	not available ³	not available ³	not available ³
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available ³	not available ³	not available ³	not available ³	not available ³
b. diagnostic imaging facilities	not available ³	not available ³	not available ³	not available ³	not available ³
c. total	not available ³	not available ³	not available ³	not available ³	not available ³
6. Payments (\$):					
a. surgical facilities	not available ³	not available ³	not available ³	not available ³	not available ³
b. diagnostic imaging facilities	not available ³	not available ³	not available ³	not available ³	not available ³
c. total	not available ³	not available ³	not available ³	not available ³	not available ³

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	10,281	10,395	10,508	10,611	10,660
b. specialists	10,392	10,520	10,724	10,703	11,016
c. other	not available ⁴	not available ⁴	not available ⁴	not available ⁴	not available ⁴
d. total	20,673	20,915	21,232	21,314	21,676
8. Number of opted-out physicians (#):					
a. general practitioners	25	22	17	15	14
b. specialists	177	165	134	114	62
c. other	not available ⁴	not available ⁴	not available ⁴	not available ⁴	not available ⁴
d. total	202	187	151	129	76
9. Number of not participating physicians (#):					
a. general practitioners	not available ⁵	not available ⁵	not available ⁵	not available ⁵	not available ⁵
b. specialists	not available ⁵	not available ⁵	not available ⁵	not available ⁵	not available ⁵
c. other	not available ⁵	not available ⁵	not available ⁵	not available ⁵	not available ⁵
d. total	not available ⁵	not available ⁵	not available ⁵	not available ⁵	not available ⁵
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	79,700,000	77,800,000	76,800,000	78,700,000	82,111,000
b. specialists	93,600,000	99,600,000	102,300,000	103,300,000	109,340,200
c. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
d. total	173,300,000	177,400,000	179,100,000	182,000,000	191,451,200
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	1,734,100,000	1,741,400,000	1,733,200,000	1,820,200,000	1,891,180,350
b. specialists	2,824,300,000	2,936,700,000	3,065,100,000	3,152,800,000	3,420,905,268
c. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
d. total	4,558,400,000	4,678,100,000	4,798,300,000	4,973,000,000	5,312,085,618
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	21.77	22.40	22.57	23.14	23.03
b. specialists	30.19	29.50	29.96	30.52	31.29
c. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
d. all services	26.32	26.40	26.79	27.33	27.75
13. Number of services provided through <u>all payment methods</u> (#):					
a. medical	82,900,000	81,800,000	81,800,000	80,900,000	85,101,110
b. surgical	22,300,000	22,700,000	23,900,000	27,100,000	28,507,294
c. diagnostic	68,100,000	72,900,000	73,400,000	74,000,000	77,842,796
d. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
e. total	173,300,000	177,400,000	179,100,000	182,000,000	191,451,200
14. Total payments to physicians paid through <u>all payment methods</u> (\$):					
a. medical	2,699,800,000	2,731,400,000	2,742,800,000	2,818,000,000	3,010,146,244
b. surgical	670,800,000	706,800,000	735,000,000	787,700,000	841,409,580
c. diagnostic	1,187,800,000	1,239,800,000	1,320,500,000	1,367,300,000	1,460,529,794
d. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
e. total	4,558,400,000	4,678,100,000	4,798,300,000	4,973,000,000	5,312,085,618
15. Average payment per service, <u>all payment methods</u> (\$):					
a. medical	32.59	33.40	33.53	34.84	35.37
b. surgical	30.09	31.10	30.75	29.04	29.52
c. diagnostic	17.45	17.00	17.99	18.48	18.76
d. other	not available ⁶	not available ⁶	not available ⁶	not available ⁶	not available ⁶
e. all services	26.32	26.40	26.79	27.33	27.75

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	9,540	8,633	9,306	9,023	8,184
17. Total number of claims, out-patient (#).	161,882	144,831	140,692	167,143	154,460
18. Total payments, in-patient (\$).	39,900,000	36,800,000	48,500,000	63,000,000	52,000,000
19. Total payments, out-patient (\$).	22,000,000	18,000,000	16,500,000	20,000,000	23,000,000
20. Average payment, in-patient (\$).	4,182.00	4,262.70	5,211.70	6,982.00	6,353.00
21. Average payment, out-patient (\$).	136.00	124.30	117.30	119.66	129.48
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	433,463	469,146	497,880	557,720	534,179
23. Total payments (\$).	14,400,000	15,500,000	17,700,000	18,600,000	20,300,000
24. Average payment per service (\$).	33.00	33.00	35.00	33.34	38.00

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	20,503	18,542	23,295	21,458	21,710
26. Total number of claims, out-patient (#).	not available ⁷	not available ⁷	not available ⁷	not available ⁷	not available ⁷
27. Total payments, in-patient (\$).	18,800,000	19,300,000	27,200,000	32,000,000	42,466,826
28. Total payments, out-patient (\$).	not available ⁸	not available ⁸	not available ⁸	not available ⁸	not available ⁸
29. Average payment, in-patient (\$).	918.00	1,043.20	1,167.40	1,490.80	1,956.10
30. Average payment, out-patient (\$).	not available ⁹	not available ⁹	not available ⁹	not available ⁹	not available ⁹
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	179,679	157,191	200,428	180,395	179,410
32. Total payments (\$).	15,500,000	8,200,000	10,200,000	9,900,000	11,635,998
33. Average payment per service (\$).	86.00	51.90	51.00	55.10	64.86

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	357	327	319	323	335
35. Number of services provided (#).	71,660	74,000	75,600	72,900	86,000
36. Total payments (\$).	8,200,000	8,600,000	9,300,000	9,200,000	11,786,600
37. Average payment per service (\$).	115.21	116.00	123.02	126.20	137.05

Endnotes

1. Excludes the three Provincial Psychiatric Hospitals.
2. Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed. Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.
3. Data is not collected within a single system in MOHLTC.
4. All physicians are categorized as general practitioner or specialist.
5. Ontario has no non-participating physicians, only opted-out physicians who are reported under item #8.
6. All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.
7. Included in #25.
8. Included in #27.
9. Included in #29.

Manitoba

Introduction

Manitoba Health and Healthy Living provides leadership and support to protect, promote and preserve the health of all Manitobans. The Department is organized into five distinct but related functional areas: Health Accountability, Policy and Planning, Provincial Health Programs, Health Workforce, Regional Affairs and Finance. Their mandates are derived from established legislation and policy pertaining to health and wellness issues. The roles and responsibilities of Manitoba Health include policy, program and standards development, fiscal and program accountability and evaluation.

The Department of Health and Healthy Living has continued to increase its focus on activities that promote and maintain good health. To this end, a Healthy Living website has been launched, [www.gov.mb.ca/healthyliving] which provides links to information on active living, healthy eating, injury prevention and smoking cessation. In addition, there has been a province-wide expansion of the Healthy School Project that focuses on enhancing the physical, emotional and social health of students, their families, school staff and their communities.

Manitoba Health and Healthy Living continued efforts to improve access to services, reduce waiting lists and recruit and retain health care professionals. A number of primary health care initiatives were initiated, such as developing five new centres in The Pas, Flin Flon, Waterhen, Camperville and Riverton. Significant capital investments were also made in acute care facilities (e.g. Critical Services developments in

Brandon and Winnipeg's Health Sciences Centre; new acute care hospitals in Swan River and Gimli; and a renal health and dialysis unit in Garden Hill).

In support of Mental Health Renewal, implementation of the first phase of the Selkirk Mental Health Centre redevelopment began.

Manitoba's Pharmacare Program has been enhanced by adding 287 new drugs and 62 new interchangeable categories.

The Manitoba Institute for Patient Safety was established in May 2004 to promote, coordinate and stimulate research and initiatives that enhance patient safety and quality care.

Overall, a culture of accountability is being built for both the work of Manitoba Health and Healthy Living and the various stakeholders in the health care system. Clarifying roles and responsibilities of partners and expectations for performance is essential for strengthening accountability relationships. The Department signed performance agreements in 2004-2005 with all Regional Health Authorities, Cancer Care Manitoba and the Addictions Foundation of Manitoba.

Manitoba's second comparable indicators report was released that focused on healthy living and the performance and delivery of health programs and services.

www.gov.mb.ca/chc/press/top/2004/11/2004-11-29-04.html

The Role and Mission of Manitoba Health

Manitoba Health and Healthy Living is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Ministers of Health and Healthy Living. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for planning and delivering services.

Manitoba Health and Health Living's vision is healthy Manitobans through an appropriate balance of prevention and care.

It is the mission of Manitoba Health and Healthy Living to lead a publicly administered sustainable health system that meets the needs of Manitobans, and promotes their health and well-being. This is accomplished through a structure of comprehensive envelopes encompassing program, policy and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments on behalf of Manitobans for insured health benefits related to the costs of medical, hospital, personal care, pharmacare and other health services.

It is also the role of Manitoba Health and Healthy Living to foster innovation in the health care system. This is accomplished by developing mechanisms to assess and monitor quality of care, utilization and cost-effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems and alternative, less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under the *Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act¹ was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to Manitoba Health. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical and other health services referred to in acts of the Legislature or regulations there under. The Act was amended on January 1, 1999, to provide insurance for out-patient services relating to insured medical services provided in surgical facilities.

The Minister of Health is responsible for administering and operating the Plan. Under section 3(2), the minister has the power:

- ☐ to provide insurance for residents of the province in respect of the costs of hospital services, medical services and other health services, and personal care;
- ☐ to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
- ☐ to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements that the Minister considers necessary to ensure that adequate standards are maintained;
- ☐ to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the Minister considers necessary to ensure that such a consulting service is provided;
- ☐ to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals, which are required by the Government of Canada, are submitted; and
- ☐ in cases where residents do not have available medical services and other health services, to take such measures that are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents.

¹ Where reference is made to "the Act" in the text, this refers to the *Health Services Insurance Act* (1999).

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 2004-2005 fiscal year that affected the public administration of the Plan.

1.2 Reporting Relationship

Section 6 of the Act requires the Minister to have audited financial statements of the Plan 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 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 Plan 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 2004-2005 fiscal year and is contained in the *Manitoba Health Annual Report, 2004-2005*:

www.gov.mb.ca/health/ann/index.html

2.0 Comprehensiveness

2.1 Insured Hospital Services

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

As of March 31, 2005, there were 98 facilities, including one provincial psychiatric centre in Manitoba, 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 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 anesthetic facilities; and
- ☐ use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

All hospital services are added to the list of available hospital services through the health planning process.

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. Manitoba Health is sensitive to new developments in the health sciences.

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 Act.

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, registered and licensed under the *Medical Act*. As of March 31, 2005, there were 2,152 physicians on the Manitoba Health Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, 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 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. To date, no physicians have opted out of the medical plan in Manitoba.

The range of physician services insured by Manitoba Health 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, rendered to an insured person by a physician who is not excluded under the *Excluded Services Regulation* (M.R. 46/93) of the Act. During fiscal year 2004-2005, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of those covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health 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 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. As of March 31, 2005, 593 dentists were registered with Manitoba Health.

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 had opted out as of March 31, 2005.

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 will negotiate the fee with Manitoba Health.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The *Excluded Services Regulation* (M.R. 46/93) made under the 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 Manitoba Health;
- ☐ services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants;
- ☐ 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;

- ☐ in vitro fertilization;
- ☐ 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 Manitoba Health monitor compliance.

All Manitoba residents have equal 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 Manitoba Health to monitor usage and service concerns.

To de-insure services covered by Manitoba Health, 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 2004-2005.

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 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.

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."

There are currently no other waiting periods in Manitoba.

The MHSIP excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Royal Canadian Mounted Police Act*; *Veteran's Rehabilitation Act*; or under legislation of any other jurisdiction (*Excluded Services Regulations* subsection 2(2)). The excluded are residents who are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP) and federal inmates. These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Forces, the RCMP, or if an inmate of a penitentiary has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health (*Residency and Registration Regulation* (M.R. 54/93, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration card for the individual and all qualifying dependants.

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 dependant. This number is used by Manitoba Health to pay for all medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for payment of all hospital services and for the provincial drug program.

As of March 31, 2005, there were 1,169,667 residents registered with the health care insurance plan.

There is no provision for a resident to opt out of the Manitoba health plan.

3.3 Other Categories of Individual

The *Residency and Registration Regulation* (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit issued by Citizenship and Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health coverage.

As of March 31, 2005, there were 4,235 individuals on work permits covered under the MHSIP.

The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada).

No legislative amendments to the Act or the regulations in the 2004-2005 fiscal year affected universality.

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 full-time enrollment at any 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 Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba after completing their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

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 or territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical services incurred in all provinces or territories are paid through a

reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

In 2004-2005, Manitoba Health made payments of approximately \$19.7 million for hospital services and \$7.9 million for medical services provided in Canada.

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.

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health 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 Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Coverage for all these categories is subject to amounts detailed in the *Hospital Services Insurance and Administration Regulation* (M.R. 48/93). Hospital services received outside Canada due to an emergency or a sudden illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per-diem rate according to hospital size:

<input type="checkbox"/> 1-100 beds:	\$280
<input type="checkbox"/> 101-500 beds:	\$365
<input type="checkbox"/> over 500 beds:	\$570

Out-patient services are paid at a flat rate of \$100 per visit or \$215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from a specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at the equivalent Manitoba rate for similar services. Hospital services are paid at a minimum of 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the *Hospital Services Insurance and Administration Regulation*, sections 15-23).

Manitoba Health made payments of approximately \$2,754,400 for hospital care provided in hospitals outside Canada in the 2004-2005 fiscal year. In addition, Manitoba Health made payments of approximately \$824,700 for medical care outside Canada.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval by Manitoba Health is not required for services provided in other provinces or territories or for emergency care provided outside Canada. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval for coverage.

No legislative amendments to the Act or the regulations in the 2004-2005 fiscal year had an effect on portability.

5.0 Accessibility

5.1 Access to Insured Health Services

Manitoba Health 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.

In July 2001, the *Health Services Insurance Act*, the *Private Hospitals Act* and the *Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

- changes to 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
- ensuring that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

On February 10, 2004, Manitoba officially opened the expanded Health Links/Info Santé, a 35-seat, state-of-the-art call centre with a call capacity of 300,000 per year.

Manitobans now have access to vital health information and assistance in 120 languages 24-hours a day, seven days a week.

Public demand for Health Links/Info Santé has increased steadily since it began as a six station call back service in 1994. Manitobans value the service. Providing this information source relieves pressure on other areas of the health care system, particularly emergency rooms.

Through the Primary Health Care Transition Fund, multi-jurisdictional envelope funds have been made available to implement a program to manage patients with congestive heart failure. Beginning in November 2004, this 17-month initiative will evaluate the benefits of using health lines to manage patients with chronic diseases.

5.2 Access to Insured Hospital Services

All Manitobans have access to hospital services including acute care, psychiatric extended treatment, mental health, palliative, chronic, long-term assessment/rehabilitation and to personal care facilities. There has been a shift in focus from hospital beds to community services, out-patients and day surgeries, which are also insured services.

Manitoba's nursing supply has improved significantly in Winnipeg, with a more gradual improvement noted in rural and northern regions. The increased supply of nurses is primarily due to an investment in nursing education. Enrolment in nursing education programs continues to be fully subscribed. In July 2004, the Nurses Recruitment and Retention Fund implemented a Conditional Grant Program to encourage new graduates to work in rural and northern Manitoba regions (outside Winnipeg and Brandon).

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields, such as nuclear medicine, medical radiation and laboratory technology, continue to be an issue.

Manitoba currently has access to six Magnetic Resonance Imaging (MRI) machines for clinical testing. The first unit was installed in 1990 by the St. Boniface Research Foundation. In Winnipeg, there are three MRI machines located at St. Boniface General Hospital, and two located at the Health Sciences Centre. One of the MRIs at the Health Science Centre was a joint initiative with the National Research Council (NRC). The sixth and newest MRI was opened at the Brandon Regional Health Centre in June 2004. This is the first MRI machine to be located outside Winnipeg.

Manitoba has 17 Computerized Tomography (CT) scanners: three (one for paediatric patients) at the Health Sciences Centre, two at the St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Bethesda Hospital, The Pas Hospital, Selkirk

Regional Health Centre, Misericordia Health Centre, Seven Oaks, Grace and Concordia Hospitals. As well, planning is underway to establish a CT scanner at Portage District General Hospital. Two of the scanners at the Health Sciences Centre have been upgraded/replaced by 16-slice scanners. As well, there are 67 ultrasound scanners located in Winnipeg health facilities and 22 scanners in rural and northern health facilities. Bone density testing is funded by Manitoba Health on three machines, two located in Winnipeg and one in Brandon.

In November 2004 new community cancer programs were established in Deloraine and Pinawa. These new cancer programs operate in conjunction with CancerCare Manitoba and focus on prevention, early detection and screening, diagnosis and treatment, and rehabilitation. Services are delivered by health professionals specially trained in oncology and include the preparation and administration of chemotherapy.

The Manitoba Prostate Cancer Centre became operational in October 2004. It is located on the third floor of the new CancerCare building at 675 McDermott. The Prostate Centre includes a wide variety of services for Manitoba men including clinical assessment, information to help with patient decision-making, linkages with prostate cancer support groups and research conducted in the area of prostate disease.

Orthopedic hip and knee surgery was redirected from St. Boniface General Hospital to Concordia Hospital in September 2004. This Program is part of the academic program in the Faculty of Medicine, Department of Surgery. It is the first teaching program to be relocated to a community hospital. The project included the construction of two additional operating rooms and an additional 100 procedures. As well, resources have been identified to improve access to various surgical services throughout Manitoba including additional joint replacements at Concordia Hospital, Brandon Regional Health Centre and Boundary Trails Health Centre, additional cataract procedures at Pan AM Clinic and Portage District General Hospital, and the expansion of the surgical program at the Selkirk Regional Health Centre.

Expansion of pediatric dental surgery services to Beausejour Hospital and Misericordia Health Centre was initiated to reduce the waiting times for this service. Establishing a pediatric dental surgery program in Beausejour allows children to receive treatment closer to home, provides services in a local facility and cuts down on unnecessary travel time.

Manitoba is a partner in the Western Canada Waiting List Project (WCWL). The Winnipeg Regional Health Authority participated in the Child and Adolescent Mental Health tool and the General Surgery tool where standardized clinical criteria for setting priorities among patients awaiting treatment were developed. Evaluation of these tools is underway.

The Emergency Care Task Force was initiated in January 2004 to develop and oversee the implementation of recommendations for the short- and long-term improvement of emergency care in Winnipeg hospitals. Recommendations of this report are being implemented, including the opening of the Minor Injury Clinic at the Pan Am Clinic in December 2004.

Manitoba Health, in partnership with the provincial and federal governments and the First Nations, opened the first dialysis unit outside a Manitoba hospital and the first unit in a remote community in the Island Lake region in August 2004. This new renal health and treatment unit will improve access to dialysis in Northern Manitoba.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2004-2005, Manitoba Health continued to support initiatives to improve access to physicians in rural and northern areas of the province. One of the supported initiatives was a co-ordinated process to assist Regional Health Authorities with the logistics of recruiting foreign-trained physicians. The co-ordinated process is aimed at avoiding duplication of effort, while introducing future physician candidates to opportunities available in Manitoba.

The province also supports an initiative that facilitates the entry of eligible foreign medical

graduates into the physician workforce. Through the program, foreign-trained physicians can achieve conditional licensure to practice family medicine in return for agreeing to work in a sponsoring rural Regional Health Authority.

Manitoba continues to experience a small increase in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province continued to provide a financial assistance grant for students and residents. In return for financial assistance during their training, the student or resident agrees to work in Manitoba for a specific period after graduating. The program was introduced in May 2001. There are plans to expand the program to include family doctors from outside Manitoba and family doctors who have left the province and want to return. Increased enrolment in the undergraduate medical program at the University of Manitoba is under consideration and is being discussed with the Manitoba Department of Advanced Education and Training.

The Manitoba Telehealth Network under the leadership of the Winnipeg Regional Health Authority has implemented the infrastructure to link 23 Telehealth sites across the province. This modern telecommunications link means patients can be seen by specialists and medical staff can consult with each other without having to endure the expense and inconvenience of travelling from the North to Winnipeg. In September 2002, Manitoba Health launched the new Manitoba Telehealth site at St. Boniface General Hospital, officially linking its medical specialists to patients and colleagues province-wide.

5.4 Physician/Dentist Compensation

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, salaried, sessional and blended.

Fee-for-service remains the dominant method of payment for physician services. Notwithstanding, alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive either a salary

(employer-employee relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods to “top-up” the wages of physicians whose fee-for-service income may not be competitive, yet whose services remain vital to the province. As well, physicians may receive sessional payments for providing medical services, as well as stipends for on-call responsibilities.

Representatives from the Manitoba Medical Association (MMA) and Manitoba Health typically negotiate compensation agreements for physicians. Representatives from Manitoba Health and the Manitoba Dental Association (MDA) are usually involved in negotiating compensation agreements with dental surgeons, oral surgeons and periodontists.

The *Health Services Insurance Act* governs payment to both physicians and dentists/oral surgeons for insured services. There were no amendments to the *Health Services Insurance Act* (HSIA) related to physician compensation during the 2004-2005 fiscal year.

The current MDA-Manitoba Health agreement was negotiated in 2003-2004 and remains in effect for the 2004-2005 fiscal year.

Manitoba Health and the MMA agreement was negotiated and concluded in 2003-2004 and remains in effect for the 2004-2005 fiscal year.

The June 23, 2003, settlement maintained the terms of the June 2, 2002, Arbitration Agreement, including:

- the establishment of a Physician Retention Fund (\$5 million per annum over the duration of this agreement as well as the subsequent agreement);
- the continuation of the Professional Liability Insurance Fund (\$5 million per annum for 2003, 2004, 2005 and 2006);
- the continuation of the Continuing Medical Education Fund (\$1 million per annum for 2002, 2003 and 2004);
- the establishment of a Maternity/Parental Benefits Fund (\$1 million per annum for 2002, 2003 and 2004);
- a mechanism to initiate arbitration proceedings with respect to a subsequent

agreement, if notice is given by either party by January 1, 2005;

- that physicians covered by the Agreement shall refrain from stopping work or curtailing services and to continue to provide services without interruption; and
- continuation of the Grievance Arbitration procedure set forth in the March 8, 1994, Fee-For-Service Agreement between the parties.

The highlights of the June 23, 2003, Negotiated Settlement include:

- a three-year term from April 1, 2002 to March 31, 2005;
- an overall increase of 9 percent (non-compounded) to the Fee-For-Service Schedule of Benefits, as well as alternate-funded agreements/arrangements) – 3 percent effective October 1, 2002; 3 percent effective April 1, 2003; and 3 percent effective April 1, 2004;
- an additional \$10 million (\$5 million effective April 1, 2003, and \$5 million effective April 1, 2004) was applied to the schedule of benefits. Approximately \$7 million of the \$10 million has been applied to the fee tariffs for family physicians. The remaining \$3 million was used to address fee and income disparities in the other blocks of practice, such as rheumatology, physical medicine, geriatric medicine, etc.;
- an extension of maternity and parental benefits to all Manitoba physicians, including interns and residents;
- increased incentives for family doctors to provide full-service care and to maintain hospital privileges;
- the incremental cost of this increase was approximately \$38 million for fee-for-service physicians (exclusive of increases in volume). Of this amount, over 50 percent was allocated to the fee tariffs for family physicians; and
- increases to the rates for physicians under alternate funding agreements in the amount of 3 percent effective October 1, 2002; 3 percent effective April 1, 2003; and 3 percent effective April 1, 2004 (non-compounded); were also applied over and above the fee-for-service increase.

The parties initiated discussion in October 2004 towards renewing a comprehensive physician compensation agreement to be applied in the 2005-2006 fiscal year and onward.

5.5 Payments to Hospitals

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operational 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 this division, 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, the funding to be provided by the Authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request that the Minister of Health 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.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire on March 31, 2006. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, two other Regional Health Authorities have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or by the federal government. The agreements in place between the Authorities and

the health corporations do not have expiry dates. The Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by Regional Health Authorities for providing hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that 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 MHSIP 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 an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the regulations in 2004-2005 had an effect on payments to hospitals.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health Transfer (CHT) in public documents.

7.0 Extended Health Care Services

Manitoba has established community-based service programs as appropriate alternatives to hospital services. These service programs are funded by Manitoba Health through the Regional Health Authorities. The services include the following:

Personal Care Home Services

Insured personal care services are provided pursuant to the *Personal Care Services Insurance and Administration Regulation* under the *Health Services Insurance Act*. In 2005, the *Personal Care Homes Standards Regulation* and *Personal Care Homes Licensing Regulation* were enacted under the same Act, linking licensing to compliance with a range of standards designed to ensure safe, quality care. Both proprietary and non-proprietary homes are licensed by Manitoba Health. Residents of personal care homes pay a residential charge towards accommodation costs, with the cost of care funded by Manitoba Health through the Regional Health Authorities. Total Manitoba Health operating funding for personal care services delivered in licensed personal care homes and in two long-term care centres during fiscal year 2004-2005 was \$427,777,138². This funding supported the delivery of insured personal care services in a total of 9,830 personal care beds plus a total of 338 chronic care beds in two long-term care facilities. In addition, Manitoba Health provided \$19,840,549² in capital funding for approved capital projects, information technology projects, safety and security upgrades, and equipment.

Home Care Services

The Manitoba Home Care Program is the oldest comprehensive, province-wide, universal home care program in Canada. Manitoba Home Care provides effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home Care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. Home Care case co-coordinators conduct assessments and develop individual care plans, which may include self or family Managed

2 From Manitoba Health Annual Report, 2004-2005

Care, personal care assistance, household maintenance, professional health care, in-home family relief, facility-based respite care, some supplies and equipment, access to adult day programs, and/or access to support services to seniors' programs that coordinate volunteers, congregate meal programs, transportation, emergency response systems and other activities that support continued independent community living.

Mental Health and Addictions Services

All Regional Health Authorities provide community mental health services. Community Mental Health Workers provide assessment, service planning, short-term counselling interventions, rehabilitation and recovery planning, crisis intervention, community consultation and education. In addition to community Mental Health Workers, some regions have a variety of intensive and supportive programs such as Intensive Case Management, Supported Employment, Supported Housing and, in Winnipeg, the Program for Assertive Community Treatment and the Early Psychosis Prevention and Intervention Service.

Addictions services and supports are provided through provincially funded agencies, the largest being the Addictions Foundation of Manitoba; however, there are several other addictions agencies funded by Manitoba Health. These agencies work to reduce the harm associated with alcohol, other drugs and gambling through education, prevention, rehabilitation and research.

Primary Health Care

In 2003-2004, each Regional Health Authority developed and submitted a regional primary health care (PHC) operational plan to the Manitoba government. Subsequently, the Regional Health Authorities have worked with the Primary Health Care Branch to develop PHC logic models and evaluation frameworks.

The federal government's Primary Health Care Transition Fund (PHCTF) per capita grant to Manitoba has supported five foundational and 17

Regional Health Authority initiated projects. Themes include interdisciplinary training, change management, community capacity building, capital info-structure and community information technology. Evaluation is an integral component of each project and will inform and advance PHC within the province. The projects are in various stages of completion. Where applicable, they will be sustained by the Regional Health Authorities through the annual health planning process.

Primary Health Care in partnership with other jurisdictions participated in several national PHCTF initiatives. They include the Health Lines Multi-jurisdictional Collaborative, the Western Health Information Collaborative on chronic disease management, the national Canadian Nurse Practitioner Planning Network and the Official Languages Minorities Communities out of which several Manitoba Francophone community initiatives have been supported. All of these initiatives have expanded and enhanced the PHC work taking place in Manitoba.

Regulated and funded midwifery was introduced in 2000. Funded services are now provided by six of 11 Regional Health Authorities. In 2004-2005, approximately 5 percent of Manitoba births were with midwives, half of these in northern and rural regions. The Midwifery Program provides comprehensive community-based care for mothers and newborns. Midwives provide primary health care in multiple settings including home, hospital and community. They also work collaboratively with other professionals to address a broad range of health determinants. Provincial direction requires the program to focus on underserved groups. In 2004-2005, approximately 70 percent of those served were from identified priority populations.

Construction began on five new primary health care centres that will deliver community-based health programs and support timely access to health care services. The new centres are located in The Pas, Flin Flon, Waterhen, Camperville and Riverton. They will provide community residents with access to a wide range of health care services including primary health care, mental

health services, and health promotion, illness and injury prevention and education programs. These initiatives are supported out of Manitoba's PHCTF per capita grant.

In May 2004, Manitoba hosted a national conference, called Moving Primary Health Care Forward: Many Successes, More to Do. More than 900 delegates participated in interactive sessions on several topics including the determinants of health, information management and community perspectives on primary health care. Other items included group working sessions and presentations by primary health care experts from around the world. Speakers at the conference included broadcaster Rex Murphy and Roy Romanow, head of the Commission on the Future of Health Care in Canada. The conference was sponsored by Health Canada through the PHTCF.

Ambulatory Health Care Services

The *Health Services Insurance Act* includes a provision authorizing the designation of non-profit, publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#). ¹	1,149,904	1,152,982	1,156,217	1,159,784	1,169,667

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	95	96	92	92	98 ²
b. chronic care	3	3	5	5	3 ³
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not applicable	not applicable	not available	not available	not available
e. total	98	99	97	97	98
3. Payments (\$):					
a. acute care	953,834,797	1,046,407,229	1,148,652,940	1,220,253,362	1,400,448,441
b. chronic care	65,153,895	70,872,152	107,840,132	117,642,127	96,364,992
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	not applicable	not applicable	1	1	1
b. diagnostic imaging facilities	not applicable	not applicable	0	0	0
c. total	not applicable	not applicable	1	1	1
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not available	not available	not available
b. diagnostic imaging facilities	not applicable	not applicable	0	0	0
c. total	not applicable	not applicable	not available	not available	not available
6. Payments (\$):					
a. surgical facilities	not applicable	not applicable	not available	1,252,657	1,290,989
b. diagnostic imaging facilities	not applicable	not applicable	0	0	0
c. total	not applicable	not applicable	not available	1,252,657	1,290,989

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	948	not available	954	959	979
b. specialists	not available	not available	1,010	980	1,008
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not available	not available	1,964	1,939	1,987
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	6,211,011	6,244,197	6,161,451	6,224,463	6,185,333
b. specialists	8,741,628	9,198,787	9,779,269	10,044,381	10,393,068
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	14,952,639	15,442,984	15,940,720	16,268,844	16,578,401
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	132,200,004	140,703,474	143,846,209	152,393,920	167,728,376
b. specialists	199,231,274	214,392,377	221,948,290	232,153,861	248,021,396
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	331,431,278	355,095,851	365,794,499	384,547,781	415,749,772
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	21.28	22.53	23.35	24.48	27.12
b. specialists	22.79	23.31	22.70	23	24
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	22.17	22.99	22.95	24	25
13. Number of services provided through <u>all payment methods</u> (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
14. Total payments to physicians paid through <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	467,886,678	496,268,700	521,611,200	559,271,513	601,240,469
15. Average payment per service, <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	3,037	2,892	2,714	2,928	3,036
17. Total number of claims, out-patient (#).	29,217	26,479	26,059	31,100	24,057
18. Total payments, in-patient (\$).	12,152,757	11,427,627	12,918,117	16,290,426	15,393,378
19. Total payments, out-patient (\$).	4,089,018	3,776,489	3,783,059	4,369,889	3,896,789
20. Average payment, in-patient (\$).	4,001.57	3,951.50	4,759.81	5,563.67	5,070.28
21. Average payment, out-patient (\$).	139.87	142.60	145.17	140.51	161.98
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	192,272	211,464	212,795	210,294	209,152
23. Total payments (\$).	6,148,444	7,381,785	7,691,159	7,579,028	8,109,229
24. Average payment per service (\$).	31.980	34.900	36.14	36.00	39.00

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	567	557	569	418	540
26. Total number of claims, out-patient (#).	6,335	6,676	6,025	6,069	6,170
27. Total payments, in-patient (\$).	1,065,302	2,008,580	1,847,910	1,348,148	1,085,650
28. Total payments, out-patient (\$).	2,435,560	3,267,764	914,251	1,216,073	1,112,466
29. Average payment, in-patient (\$).	1,878.84	3,607.40	3,249.89	3,225.00	2,010.00
30. Average payment, out-patient (\$).	384.46	489.00	151.73	200.00	180.00
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	6,763	6,345	5,826	5,324	5,714
32. Total payments (\$).	500,757	529,029	607,066	519,782	426,937
33. Average payment per service (\$).	74.04	83.40	104.20	98.00	75.00

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	101	not available	116	102	114
35. Number of services provided (#).	3,256	3,401	3,455	3,498	3,774
36. Total payments (\$).	660,870	677,295	714,590	750,122	875,657
37. Average payment per service (\$).	202.97	199.15	206.83	214.44	232.02

Endnotes

1. The population data is based on records of residents registered with Manitoba Health as of June 1, 2004.
2. 98 submitting acute facilities includes 22 nursing stations and 2 federal hospitals.
3. Three acute facilities have been given a chronic institution submitting number: Riverview Health Centre; Deer Lodge Centre; and Brandon General Hospital.

Saskatchewan

Introduction

In 2004-2005, Saskatchewan Health continued to progress toward fulfilling our goals of:

- improved access to quality health services;
- effective health promotion and disease prevention;
- retaining, recruiting and training health providers; and
- a sustainable, efficient, accountable, quality health system.

Skilled, dedicated people are at the heart of the health system. In 2004-2005, Saskatchewan Health targeted improvements in training, workplace safety, and other human resources practices to help retain and recruit the health care workers and professionals needed to meet demand for health services. The Department also recognized the need to reduce wait times for surgeries and diagnostic imaging. Progress is being made, but further work is needed in these areas.

The year was a time of dramatic developments for publicly funded health care. Heading into the year, Saskatchewan Health set targets for continued progress on *The Action Plan for Saskatchewan Health Care*, which was released in December 2001, and looked to regional health authorities to do the same. With provincial-territorial-federal talks progressing on the future of health care, there was also hope that in future years federal funding might be partially restored to previous levels, allowing further investment in key areas. A welcome development came as a result of the negotiations – new federal money arrived for health care, with the first injection of federal funding coming immediately. While

representing only a small portion of annual health spending in Saskatchewan, the effect of \$66 million in new federal money during 2004-2005 should not be underestimated. The money was quickly directed to important initiatives to address immediate needs such as the following:

- reducing diagnostic and surgical waiting lists;
- retaining health care professionals;
- capital equipment and infrastructure;
- quality improvements; and
- investments in information technology.

Most of the new funding was passed on to health regions, where front-line health services are provided. The remainder of the funding was invested in information technology (IT) improvements for the diagnostic imaging waitlist registry, the radiology information system and other projects. The priorities agreed to by federal, provincial and territorial health ministers closely match the existing priorities of *The Action Plan for Saskatchewan Health Care*.

The following list provides a snapshot of Saskatchewan Health accomplishments in 2004-2005:

- addition of new equipment and staff resulted in increased volume of Computed Tomography (CT) scans and Magnetic Resonance Imaging (MRI) scans;
- new linear accelerators installed in Regina and Saskatoon for cancer treatment;
- \$31 million in capital construction spending, including the All Nations' Healing Hospital, which opened in Fort Qu'Appelle;
- expansion of Telehealth services to a total of 18 sites;
- renal satellite services added in North Battleford;
- introduction of a smoking ban January 1, 2005, prohibiting smoking in enclosed public places;
- addition of three new vaccines to the school-age immunization program;
- contingency planning against the threat of a global flu pandemic;
- responses to 73,549 calls to the toll-free HealthLine during 2004-2005;

- funding of \$10 million for information technology initiatives aimed at innovative improvements to health care administration; and
- introduction of the Maximum Allowable Cost policy to encourage cost-effective prescribing by doctors. This policy establishes a maximum price the Drug Plan will cover for similar drugs used to treat the same condition.

Saskatchewan Health has a mandate to support Saskatchewan residents in achieving their best possible health and well-being. We are particularly committed to changes that will improve the health care system and make it sustainable into the future. In 2004-2005, the Saskatchewan government budgeted \$2.7 billion for health care. This represented an increase of 6.9 percent or \$173 million over the previous year. The government invested 44 percent of total program spending on health care.

Saskatchewan Health works closely with its many partners in the health sector to deliver high-quality services. In Canada, both the federal and provincial governments play a major role in providing health care.

The need for continued investment in Saskatchewan's health system is clear. However, we need to achieve a balance between high public expectations for acute care services and the need to control costs and invest in long-term public health improvements. We believe in the value of primary health care as a better way to serve the people of our province, while we seek to slow the growth of health care costs. In this balanced way, we will work to ensure our health care system runs effectively and efficiently, providing high-quality care for generations to come.

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 Department of Health Act* authorizes that the Minister of Health 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 regional health authorities, 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 any health region or part of a health region 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 of Health to establish and administer a plan of medical care insurance for residents. *The Regional Health Services Act* provides the authority to establish 12 regional health authorities, replacing the former 32 district health boards.

Sections 5 and 11 of *The Cancer Foundation Act* provide for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Department of Health, regional health authorities and the Saskatchewan

Cancer Agency for 2004-2005 are outlined in *The Department of Health Act*, *The Regional Health Services Act* and *The Cancer Foundation Act*.

1.2 Reporting Relationship

The Department of Health is directly accountable, and regularly reports, to the Minister of Health on the funding and administering the funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report concerning the medical care insurance plan to the Legislative Assembly.

The Regional Health Services Act prescribes that a regional health authority shall submit to the Minister of Health:

- a report on the activities of the regional health authority; and
- a detailed, audited set of financial statements.

Section 54 of *The Regional Health Services Act* requires that the regional health authority shall submit to the Minister any reports that the Minister may request from time to time. All regional health authorities are required to submit a financial and health service plan to Saskatchewan Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report about its business and a financial statement to the Minister of Health for the fiscal year immediately preceding.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to regional health authorities, the Saskatchewan Cancer Agency and to physicians and dental surgeons for insured physician and surgical-dental services.

The Provincial Auditor may also conduct audits of regional health authority boards.

The Provincial Auditor independently determines the scope and frequency of his or her audits based on accepted professional standards.

Section 57 of *The Regional Health Services Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by the regional health authority, shall audit the accounts of a regional health authority at least once in every fiscal year. A detailed, audited set of financial statements must be submitted annually, by each regional health authority, to the Minister of Health.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated representative.

The most recent audits were for the year ended March 31, 2005.

Each regional health authority includes audited financial statements as part of its annual report. The 2004-2005 regional health authorities annual reports were tabled in the Saskatchewan Legislature July 2005.

The Saskatchewan Cancer Agency's 2004-2005 Annual Report is available on its website: www.scf.sk.ca.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Regional Health Services Act was proclaimed on August 1, 2002, to replace *The Health Districts Act* as the authority to amalgamate the existing 32 health districts into 12 regional health authorities. Section 8 of *The Regional Health Services Act* (the Act) gives the Minister the authority to provide funding to a regional health authority or a health care organization for the purpose of the Act.

Section 10 of *The Regional Health Services Act* permits the Minister to designate facilities including hospitals, special-care homes and health

centres. Section 11 allows the Minister to prescribe standards for delivering services in those facilities by regional health authorities and health care organizations that have entered into service agreements with a regional health authority.

The Act sets out new accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual operational and financial and health service plans for Ministerial approval (sections 50-51); establishing community advisory networks (section 28); and reporting critical incidents (section 58). The Minister also has the authority to establish a provincial surgical registry to help manage surgical wait times (section 12). The Minister retains authority to inquire into matters (section 59); appoint a public administrator if necessary (section 60); and approve general and staff practitioner by-laws (sections 42-44).

Funding for hospitals is included in the funding provided to regional health authorities.

As of March 31, 2005, the following facilities were providing insured hospital services to both in- and out-patients:

- ☐ 65 acute care hospitals provided in- and out-patient services; and
- ☐ one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

The Hospital Standards Act and The Hospital Standards Regulations (1980) established minimum standards for care and certain administrative requirements for hospitals.

With the passage of *The Regional Health Services Act*, Saskatchewan plans to incorporate those provisions relating to hospital organization and program standards under the new Act; thereby, allowing for the repeal of *The Hospital Standards Act* and *The Hospital Standards Regulations* (1980).

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;
- ☐ radiotherapy 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.

The Action Plan for Saskatchewan Health Care establishes new hospital categories and outlines a standard array of services that should be available in each hospital. Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals.

One of the elements of the Action Plan is to provide reliable, predictable hospital services, so people know what they can expect 24 hours a day, 365 days a year. 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.

This service delivery framework will ensure quality, predictable hospital services and help guide decisions about where to invest new funds.

Regional health authorities have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available health professional funding 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. The process is initiated by a regional health authority and, depending on the specific service request, it could include consultations involving several branches within Saskatchewan Health as well as external stakeholder groups such as health regions, 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. Amendments were made in April and October 2004, to the Physician Payment Schedule of *The Saskatchewan Medical Care Insurance Payment Regulations* (1994) in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services, changes in payment levels for selected services, and definition or assessment rule revisions to existing selected services with significant monetary impact. All new fee items for physicians can be found in the Physician's Newsletter:

- ❑ www.health.gov.sk.ca/ic_pub_2005oct1_pps.html
- ❑ www.health.gov.sk.ca/ic_pub_2005apr1_pps.html

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra-billing for insured services.

As of March 31, 2005, there were 1,685 physicians licensed to practice in the province and eligible to participate in the medical care insurance plan.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, must fully

opt out of all insured physician services. The "opted-out" 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, 2005, there were no "opted-out" physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Department 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*.

There were approximately 3,100 different insured physician services as of March 31, 2005.

A process of formal discussion 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 (modernization) with significant monetary impact. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service or significant revisions occur to the Physician Payment Schedule, a regulatory amendment is made to the Physician Payment Schedule.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan. As of March 31, 2005, 84 dental specialists were providing such services.

Amendments were made in April 2003, to The Saskatchewan Medical Insurance Branch Payment Schedule for Insured Services Provided by a Dentist. Those amendments provided for changes in payment levels for selected services.

Dentists may opt out or not participate in the Medical Services Plan, but if doing so, must opt-out of all insured surgical-dental services. The 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 “opted-out” dentists in Saskatchewan as of March 31, 2005.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- ☐ oral surgery required in hospital as a result of trauma;
- ☐ treatment for infants with cleft palate;
- ☐ hospital-based dental care to support medical/surgical care (e.g. extractions when medically necessary); and
- ☐ surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation 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.

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;
- ☐ 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 a regional health authority;
- ☐ services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
- ☐ non-emergency cataract and non-emergency diagnostic imaging services provided outside Saskatchewan without prior written approval;
- ☐ 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 or are not required to be performed in a hospital; and
- ☐ services covered by the Saskatchewan Workers' Compensation Board.

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. Compliance is periodically monitored through consultation with regional health authorities, physicians and dentists. There are no charges allowed in Saskatchewan for medically necessary 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. Compliance is monitored through consultations with regional health authorities, physicians and dentists.

Insured hospital services could be de-insured by the government if they were determined to be no longer medically necessary. The process is based on discussions among regional health authorities, practitioners and officials from the Department of Health.

Insured surgical-dental services could be de-insured if they were determined not to be medically

necessary or if they were not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if they were determined not to be medically required. The process is based on consultations with the Saskatchewan Medical Association and 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.

No health services were de-insured in 2004-2005.

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. The penalty provisions in section 11 of the Act (Duty to Register) were increased from \$25 to \$50,000 for giving false information or withholding information necessary for registering an individual.

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 of establishing 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 eligible for insured health services in Saskatchewan:

- ☐ members of the Canadian Forces and the Royal Canadian Mounted Police (RCMP), federal inmates and 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 and the RCMP, 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).

3.2 Registration Requirements

The following process is used to issue a health services card and to document that a person is eligible for insured health services:

- ☐ every resident, other than a dependent child under 18 years, is required to register;
- ☐ registration should take place immediately following the establishment of residency in Saskatchewan;
- ☐ registration can be carried out either in person in Regina or by mail;
- ☐ each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and

- ❑ cards are renewed every three years. (Current cards expire in December 2008.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 and over living in the parental home or on their own must self-register.

The number of persons registered for health services in Saskatchewan on June 30, 2004, was 1,018,057.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, student permit or Minister's permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with an employment/student permit, Minister's permit or permanent resident, that is, landed immigrant, record.

On June 30, 2004, there were 5,059 such temporary residents registered with Saskatchewan Health.

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. There were no changes to the in-Canada temporary absence provisions in 2004-2005.

Continued coverage during a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- employment of up to 12 months (no documentation required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health 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.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates. The reciprocal arrangement for physician services applies to every province except Quebec.

Payments/reimbursement to Quebec physicians, for services to Saskatchewan residents, are made at Saskatchewan rates (Saskatchewan Physician Payment Schedule). However, the physician fees may be paid at Quebec rates with prior approval. In recent years, the out-of-province reciprocal hospital per diem billing rates have increased significantly.

In 2004-2005, expenditures for insured physician services in other provinces were \$19.87 million. Insured hospital services in other provinces were \$39.81 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* describe the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on the expiration of the approved period as follows:

- ☐ education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- ☐ employment of up to 24 months (written confirmation from the employer is required); and
- ☐ vacation and travel of up to 12 months.

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* was amended in 2004-2005 to provide 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 Department of Health 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.

In 2004-2005, \$730,800 was paid for in-patient hospital services and \$252,000 was spent on out-

patient hospital services outside Canada. In 2004-2005, expenditures for insured physician services outside Canada were \$510,600.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical out-of-province care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received 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 and problem gambling services; and
- ☐ cataract surgery services, bone densitometry (outside of hospitals) and non-urgent MRI, because Saskatchewan Health does not normally cover these services out-of-province.

Before the Department of Health funds non-urgent services for a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

- ☐ 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 from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

- Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric and chiropractic out-of-country services; therefore, prior approval is required.

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.

The Saskatchewan Human Rights Code prohibits discrimination in providing public services, which include insured health services on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2005, Saskatchewan had 3,073 staffed hospital beds in 65 acute care hospitals, including 2,505 acute care beds, 240 psychiatric beds and 328 other beds. The Wascana Rehabilitation Centre had 48 rehabilitation beds and 205 extended care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

Keeping and attracting key health providers, such as nurses, to provide insured hospital services continues to be a top priority for Saskatchewan Health. Tracking the actual number of people who work in the health professions can be difficult because people move and change jobs, hours of work or even careers.

One way to measure our health care workforce is to count how many providers are registered in the province. The professional regulatory bodies in

Saskatchewan do this every year. Much of this information is reported to the Canadian Institute for Health Information (CIHI), allowing comparisons with other provinces.

According to the Saskatchewan Registered Nurses Association's (SRNA) 2004 annual report there are 8,932 active members on the roster. Compared to the previous year, this is an increase of 117. A total of 917 Registered Psychiatric Nurses (RPNs) are registered in the province. Currently, 2,274 Licensed Practical Nurses (LPNs) were practicing members in 2004. As of June 30, 2005, there are 67 licensed Registered Nurses (Nurse Practitioners) RN (NPs). The general trend of nursing retention is flat with small deviations seen from year to year. The major concern is the age of nurses who will be eligible to retire over the next 5-10 years.

There are signs of progress that show nursing graduates are more enthusiastic about remaining in Saskatchewan. Over the past couple of years, our province has retained about 80 percent of graduates from our nursing education program.

The number of Registered Nurses (RN) per capita in Saskatchewan in 2003 (855 per 100,000 population) is higher than the Canadian average (760 per 100,000 population). This represents an increase from 1998 for Saskatchewan (824). There is also considerable variation in RN per population ratios across Canada, from a low of 693 per 100,000 in Ontario to a high of 1.044 in Newfoundland. (Source – *CIHI Canada's Health Care Providers 2005 Chartbook*.)

Listed below are some of the 2004-2005 initiatives implemented to improve the retention and recruitment of health care providers:

- The province invested \$11 million in retaining health care providers by providing bursary programs, safer and higher quality workplaces, continuing education, and training. This will benefit all health care providers, including nurses.
- The budget for 'return for service' nursing and allied health profession bursaries is approximately \$1.5 million.

- ❑ Bursaries are awarded to a wide range of nursing and allied health disciplines. There are now 22 types of allied health professions, eligible for bursaries and six categories in nursing, eligible for bursaries.
 - ❑ The number of new bursaries awarded to health science (non-physician) students has been increased substantially from 2001-2002 when 27 bursaries were awarded, to 2004-2005 in which 293 new bursaries were awarded.
 - ❑ 26 Primary Care Nurse Practitioner bursaries were awarded in 2004-2005.
 - ❑ A northern nursing program with 40 seats for Aboriginal students delivered through the First Nations University of Canada was continued.
 - ❑ Access to the Nursing Education Program of Saskatchewan (NEPS) has been enhanced through distance delivery. The entire first year of the program is available by distance learning. The development of a Bachelor of Science in Nursing second-degree program will begin in 2005-2006.
 - ❑ Saskatchewan Health has committed \$1.79 million – one-time funding over two years under the Quality Workplace Program to the regional health authorities for a wide variety of workplace improvement initiatives including: conflict management, transfer and lifting programs and targeted leadership development opportunities.
 - ❑ One-time funding (\$1.5-2 million) for leadership and development, continuing education and International Medical Graduates (IMGs) assessment.
 - ❑ One-time funding for northern recruitment retention initiatives of \$1 million.
 - ❑ Since 2001, Saskatchewan Health provided funding to regional health authorities to support Representative Workforce Training, development of capital improvement projects, implementation of the a variety of nursing programs targeted at Aboriginal people.
 - ❑ Saskatchewan is paying for two MRI seats, in the Northern Alberta Institute of Technology (NAIT) direct entry program – again to respond to health system needs.
 - ❑ Four cytotechnologist students passed their exams in 2005.
 - ❑ Nuclear Medicine graduates from a program purchased from the Southern Alberta Institute of Technology (SAIT), Calgary, entered the labour force for the first time. SAIT continues to accept four Saskatchewan students annually.
 - ❑ SAIT has also entered into a contract with the Province of Saskatchewan to train respiratory therapy students for the Saskatchewan market. Eight students are accepted annually. The first graduates will be available to work in Saskatchewan in 2004-2005.
 - ❑ Saskatchewan Health provided funding to explore the challenges and opportunities for entry-level staff to achieve job satisfaction and career advancement through career laddering. This project is ongoing.
- Canada's First Ministers agreed, in September 2004, to continue their work on Health Human Resources and accelerate action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals. The federal, provincial and territorial governments agreed to increase the supply of health professionals based on their assessment of the gaps and to make their action plans public, including targets for training, recruiting and retaining professionals by December 31, 2005.
- Saskatchewan has responded to the First Ministers agreements by undertaking a planning process that builds on the *Action Plan for Saskatchewan Health Care*. Saskatchewan is working to develop a plan by the end of 2005.
- Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services, Saskatchewan Health notes the following:
- ❑ MRI machines are located in Saskatoon (2) and Regina (1). Regina Qu'Appelle Regional Health Authority has received approval and is in the process of acquiring a second MRI. It is planned to be operational by the latter part of 2005-2006.
 - ❑ CT scanners are available in Saskatoon (3), Regina (3), Prince Albert (1), Swift Current (1),

Moose Jaw (1) and Yorkton (1). CT scanners in North Battleford and Lloydminster are planned to be operational in 2005-2006.

- Renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton, Swift Current and North Battleford. Another satellite unit began operating in Moose Jaw in December 2004.
- Cancer treatment services are provided by the Saskatchewan Cancer Agency's two cancer clinics, the Saskatoon Cancer Centre and the Allan Blair Cancer Centre in Regina. In calendar year 2004, approximately 4,800 new patients began treatment for cancer. Both centres provided approximately 38,600 radiation therapy treatments and 16,400 chemotherapy treatments to cancer patients in Saskatoon and Regina.
- Sixteen (16) sites are involved in the Community Oncology Program of Saskatchewan (COPS) that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon. In 2004, over 1,000 patients made approximately 6,000 visits to COPS centres for treatment.
- Approximately 73 percent of surgery services are provided in Saskatoon and Regina, where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 22 percent is provided in six mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster, with the remaining surgery performed in smaller hospitals across the province.
- Telehealth Saskatchewan links continue to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2004-2005 to improve access to insured hospital services:

- Access and use of specialized medical imaging services, including MRI, CT and bone mineral density testing has grown steadily in

Saskatchewan. In 2004-2005, approximately 16,100 MRI tests and approximately 90,650 CT tests were performed.

- Telehealth Saskatchewan has proven to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health continues to support the network. In 2004-2005, planning began for eight additional sites, which will bring the number to 26 sites. As of March 31, 2005, the Telehealth Saskatchewan network has been established at 18 sites in Saskatchewan.
- The Chronic Renal Insufficiency (CRI) Clinics that were established in the Regina Qu'Appelle and Saskatoon regions in summer 2001 continue to grow. The goals of these clinics are to delay the need for dialysis and to better prepare patients in making their treatment choices: haemodialysis, peritoneal or home dialysis or transplant. The number of patients served by these clinics surpasses the number of patients on dialysis. (During the period March 31, 2003 to December 31, 2004, the number of CRI patients grew from 350 to 813, an increase of 132 percent.)
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven sites around the province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program provides mammograms to between 34,000 and 37,000 women annually.
- The Prevention Program for Cervical Cancer is a Cancer Agency Program that has the goal of increasing participation in regular pap testing and tracking follow-up of unsatisfactory and abnormal test results. Since its launch in 2003, the program has sent out 200,000 result notices and 350,000 recall/reminder letters to approximately 325,000 women.
- The Provincial Malignant Hematology/Stem Cell Transplant Program continues to provide transplants to Saskatchewan residents. In 2004-2005, 47 patients with aggressive or advanced blood or other system cancers

received stem cell or bone marrow transplants. The program also provides teaching as a formal part of the hematology clinic rotation for residents of Internal Medicine at the University of Saskatchewan.

Capital equipment purchases by regional health authorities is consistent with the criteria established under the February 2003 Health Accord. Regional health authority acquisitions are reviewed to ensure consistency with provincial health strategies and priorities and Health Accord principles. Capital equipment acquisitions in 2003-2004 supported enhanced access to diagnostic imaging and surgical services.

Saskatchewan Health continues to place priority on promoting surgical access and improving the province's surgical system. Saskatchewan Health, with advice from the Saskatchewan Surgical Care Network (SSCN) is leading the country in implementing key surgical care system initiatives.

Saskatchewan Health has established a new Patient Assessment Process, the Surgical Patient Registry and target time frames for surgery in 10 regional health authorities performing surgery in operating rooms (Regina Qu'Appelle, Saskatoon, Five Hills, Sunrise, Prince Albert Parkland, Prairie North, Cypress, Sun Country, Heartland and Kelsey Trail).

The new Patient Assessment Process will increase consistency and fairness by standardizing the factors physicians will use to assess their patients' level of need for surgery. This will help to ensure those with the greatest need for surgery will receive it first.

The Surgical Patient Registry tracks patients needing surgery in the province. Information from this comprehensive database will allow the surgical care system to improve the management of surgical access, assist in determining system capacity and resource requirements, and reduce wait times for patients.

Target Time Frames for Surgery will allow the health regions to better monitor and track patients and to help ensure they receive care according to their level of need. In March 2004,

Target Time Frames for Surgery were announced as "performance goals" for the surgical care system.

In January 2003, the Saskatchewan surgical website was launched. Located at [www.sasksurgery.ca] this surgical access website provides important waitlist/wait-time data from the Surgical Registry, along with other information about how the surgical system works, what questions patients should ask their doctors and key contacts within the Regional Health Authorities.

Saskatchewan Health is currently working closely with members of the health regions, physicians and other health partners to maximize access to diagnostic imaging services in Saskatchewan. The focus is on improving access to diagnostic services (MRI, CT), while at the same time providing a basis for improved, sustainable health delivery in the future.

On January 31, 2005, the Minister of Health announced the establishment of a Diagnostic Imaging Network. This Network is a partnership among clinicians, service providers, regional health authorities, regulatory agencies, health training institutions, community and government that works toward the goal of ensuring equitable access to quality diagnostic imaging services in Saskatchewan. This Network will act as a provincial advisory body to assist in province-wide strategic planning and coordination of the diagnostic imaging system.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2005, there were 1,685 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 967 (57.4 percent) were family practitioners and 718 (42.6 percent) were specialists.

As of March 31, 2005, there were approximately 375 practising dentists and dental surgeons located in all major centres in Saskatchewan. Eighty-four provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2004-2005 to recruit and retain physicians whereby enhancing access to insured physician services and reducing waiting times.

Specialist Programs:

- ❑ A Specialist Physician Enhancement Training Program provides grants of up to \$80,000 per year to allow practicing specialists the opportunity to obtain additional training and requires a return service commitment.
- ❑ A Specialist Emergency Coverage Program compensates specialist physicians who make themselves available to provide emergency coverage to acute care facilities.
- ❑ The Specialist Resident Bursary Program offers 15 bursary spots per year to residents for a maximum of three years funding with a return-of-service commitment.
- ❑ The Foreign Certified Specialists' initiative implemented in 2004-2005 provides funding to ensure that these specialists are paid rates equivalent to Canadian certified specialists.

Rural and Regional Programs:

- ❑ A pilot Regional Practice Establishment Program provides grants of \$10,000 to eligible family physicians who establish a practice in a regional centre for a minimum of 18 months.
- ❑ A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- ❑ Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program, which compensates physicians providing emergency room coverage in rural areas and helps those communities with fewer than three physicians gain access to other physicians to provide weekend relief.
- ❑ The Rural Practice Establishment Grant Programs make grants of \$18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.

- ❑ The Family Medicine Resident Bursary Program provides bursaries of \$25,000 to family medicine residents to help them with medical educational expenses in return for a rural service commitment.
- ❑ The Undergraduate Medical Student Bursary Program provides an annual grant of \$15,000 to medical students who sign a return service commitment to a rural community.
- ❑ The Rural Practice Enhancement Training Program provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- ❑ The Rural Emergency Care Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program.
- ❑ The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.
- ❑ The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to help stabilize the supply of physicians in northern Saskatchewan.
- ❑ The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- ❑ The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- ❑ The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

Other Programs:

- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services Program.
- A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.
- The Parental Leave Program was developed in 2004 to provide benefits for self-employed physicians who take a maternity, paternity or adoption child care leave from clinical practice.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by section 48 of *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the government providing notice to begin discussing a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn select a third member; and
- the Board has the authority to make a decision binding on the parties.

In June 2003, a new three-year agreement (retroactive to April 1, 2003) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of 8.3 percent effective October 1, 2003, and 6 percent on April 1, 2004 and 2005. Similar increases were applied to non fee-for-service physicians.

Additional improvements include a total of \$11.2 million to bolster recruitment and retention programs and \$3 million per year for new items and modernization of the Payment Schedule.

Section 6 of *The Saskatchewan Medical Care Insurance Payment Regulations*, 1994, outlines the obligation of the Minister of Health to make payment 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, salaries, capitation arrangements 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 2004-2005 amounted to \$511.2 million: \$330.2 million for fee-for-service billings; \$20.1 million for Emergency Coverage Programs; \$141.5 million in non-fee-for-service expenditures; and \$19.4 million for Saskatchewan Medical Association programs as outlined in the agreement.

5.5 Payments to Hospitals

In 2004-2005, funding to regional health authorities was based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. Each regional health authority 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.

Regional health authorities may receive additional funds for providing specialized hospital programs (e.g. renal dialysis, specialized medical imaging services, specialized respiratory services) or for providing services to residents from other health regions.

Payments to regional health authorities for delivering services are made pursuant to section 8 of *The Regional Health Services Act*. The legislation provides the authority for the Minister of Health to make grants to regional health

authorities 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.

Regional health authorities provide an annual report on the aggregate financial results of their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in the Department of Health 2004-2005 Annual Report, the 2004-2005 Annual Budget and related budget documents, its 2004-2005 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 on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums.

7.0 Extended Health Care Services

As of March 31, 2005, the range of extended health care services provided by the provincial government included long-term residential care services for Saskatchewan residents, certain community-based health services such as home care, as well as a wide range of other health, social support, mental health, addiction treatment and drug benefit programs.

Nursing Home Intermediate Care Services

- Special-care homes provide institutional long-term care services to meet the needs of individuals, primarily with heavy care needs. Services offered include care and

accommodation, respite care, day programs, night care, palliative care and, in some instances, convalescent care. These facilities are publicly funded by Saskatchewan Health through regional health authorities and are governed by *The Housing and Special-care Homes Act* and regulations.

- Public Health Services of regional health authorities provide immunization for residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services. This applies to influenza and pneumococcal vaccines.

Home Care Services

- The Home Care Program provides an option for people with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals with palliative, acute and supportive care needs. Services include assessment and care coordination, nursing, personal care, respite care, homemaking, meals, home maintenance, therapy and volunteer services. Individualized funding is an option of the Home Care Program. It provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is governed by *The Regional Health Services Act*.

Ambulatory Health Care Services

- Saskatchewan regional health authorities provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act*.
- Regional health authorities offer podiatry services. Services include assessment, consultation and treatment. *The Chiropractic Services Regulation of The Department of Health Act* provides chiropractors and podiatrists with the ability to self-regulate their profession.

- Regina Qu'Appelle and Saskatoon regional health authorities provide a Hearing Aid Program. Services include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Hearing Aid Act* and regulations and *The Regional Health Services Act* govern these programs.
- Rehabilitation therapies, including occupational and physical therapies and speech and language pathology, are offered by the regional health authorities to help individuals of all ages improve their functional independence. Services are provided in hospitals, rehabilitation centres, long-term care facilities, community health centres, schools and private homes and include assessment, consultation and treatment. *The Regional Health Services Act* and *The Community Therapy Regulations*, which are under the authority of *The Department of Health Act*, govern these programs.
- by *The Non-profit Corporations Act* to provide services.
- Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and/or other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days. *The Adult and Youth Group Homes Regulations of The Housing and Special-care Homes Act* govern licensure of detoxification services.
- In-patient services are provided to individuals requiring intensive rehabilitative programming for their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs. *The Adult and Youth Group Homes Regulations of The Housing and Special-care Homes Act* govern licensure for in-patient services.

Long-term residential services provide maintenance and transition programs for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse prevention in a safe and supportive environment. *The Adult and Youth Group Homes Regulations of The Housing and Special-care Homes Act* govern licensure for long-term residential services.

Adult Residential Care Services – Mental Health Services

- Apartment Living Programs and Group Homes provide a continuum of support and living assistance to individuals with long-term mental illnesses. These programs are governed by *The Residential Services Act*.
- Saskatchewan Health, in partnership with the Heartland Regional Health Authority, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and is currently governed by *The Non-profit Corporations Act* (1995) and *The Co-operatives Act* (1996).

Alcohol and Drug Services

- The provision of Alcohol and Drug services generally falls under *The Regional Health Services Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the regional health authorities contract with community-based and non-profit organizations governed

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	1,021,762	1,024,788	1,024,827	1,007,753	1,018,057

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	68	66	65	66	65
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. other	0	0	0	0	0
e. total	69	67	66	67	66
3. Payments (\$):					
a. acute care	680,326,248 ¹	720,174,393 ¹	not available	811,561,671 ²	867,261,000 ²
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	38,249,010	39,656,384	not available	not available ³	not available ³
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	718,575,258	759,830,777	not available	811,561,671	867,261,000
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments (\$):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	1,016	937	936	946	967
b. specialists	593	696	700	716	718
c. other	0	0	0	0	0
d. total	1,609	1,633	1,636	1,662	1,685
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	6,873,539	6,760,156	6,631,582	6,434,620	6,397,252
b. specialists	3,250,953	3,700,801	3,637,879	3,499,069	3,573,354
c. other	0	0	0	0	0
d. total	10,124,492	10,460,957	10,269,461	9,933,689	9,970,606
11. Total payments to physicians paid through <u>fee for service</u> (\$):					
a. general practitioners	134,989,267	137,541,402	139,410,263	147,119,703	160,986,686
b. specialists	129,470,569	144,566,069	151,061,558	157,419,082	176,829,943
c. other	0	0	0	0	0
d. total	264,459,836	282,107,471	290,471,821	304,538,785	337,816,629
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	19.64	20.35	21.02	22.86	25.16
b. specialists	39.83	39.06	41.52	44.99	49.49
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	26.12	26.97	28.29	30.66	33.88
13. Number of services provided through <u>all payment methods</u> (#): ⁴					
a. medical	6,071,567 ⁵	6,017,477 ⁵	5,788,055 ⁵	5,841,196 ⁵	5,801,265 ⁵
b. surgical	787,655 ⁶	994,321 ⁶	984,405 ⁶	998,210 ⁶	1,015,900 ⁶
c. diagnostic	2,288,038 ⁷	2,262,256 ⁷	2,179,286 ⁷	2,174,220 ⁷	2,187,590 ⁷
d. other	977,232 ⁸	1,186,903 ⁸	1,317,715 ⁸	920,063 ⁸	965,851 ⁸
e. total	10,124,492	10,460,957	10,269,461	9,933,689	9,970,606
14. Total payments to physicians paid through <u>all payment methods</u> (\$): ⁴					
a. medical	151,152,270 ⁵	160,742,594 ⁵	162,032,557 ⁵	170,595,840 ⁵	192,359,771 ⁵
b. surgical	51,681,286 ⁶	56,027,014 ⁶	58,596,690 ⁶	60,515,275 ⁶	70,671,415 ⁶
c. diagnostic	43,216,810 ⁷	44,488,404 ⁷	48,355,683 ⁷	51,280,830 ⁷	57,032,791 ⁷
d. other	18,409,471 ⁸	20,849,458 ⁸	21,486,890 ⁸	22,145,286 ⁸	17,752,650 ⁸
e. total	264,459,837	282,107,470	290,471,821	304,537,231	337,816,627
15. Average payment per service, <u>all payment methods</u> (\$): ⁴					
a. medical	24.90 ⁵	26.71 ⁵	27.99 ⁵	29.21 ⁵	33.16 ⁵
b. surgical	65.61 ⁶	56.35 ⁶	59.52 ⁶	60.62 ⁶	69.57 ⁶
c. diagnostic	18.89 ⁷	19.67 ⁷	22.19 ⁷	23.59 ⁷	26.07 ⁷
d. other	18.84 ⁸	17.57 ⁸	16.31 ⁸	24.07 ⁸	18.38 ⁸
e. all services	26.12	26.97	28.29	30.66	33.88

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	4,527	4,692	4,422	4,561	4,307
17. Total number of claims, out-patient (#).	46,199	45,320	50,401	45,510	51,678
18. Total payments, in-patient (\$).	20,208,100	22,037,200	23,447,100	30,528,100	30,461,943
19. Total payments, out-patient (\$).	6,046,600	5,836,500	7,144,800	6,405,900	9,345,190
20. Average payment, in-patient (\$).	4,463.91	4,696.76	5,302.37	6,693.29	7,072.66
21. Average payment, out-patient (\$).	130.88	128.78	141.76	140.76	180.83
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	425,800	444,430	458,100	509,784	513,694
23. Total payments (\$).	13,767,600	15,520,000	16,948,900	19,477,300	19,868,600
24. Average payment per service (\$).	32.33	34.92	37.00	38.21	38.68

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	272	252	287	231	254
26. Total number of claims, out-patient (#).	1,369	1,172	1,049	875	1,002
27. Total payments, in-patient (\$).	1,039,500	1,009,400	1,891,800	728,400	730,849
28. Total payments, out-patient (\$).	377,600	375,900	359,400	373,300	251,957
29. Average payment, in-patient (\$).	3,821.69	4,005.56	6,591.64	3,153.25	2,877.36
30. Average payment, out-patient (\$).	275.82	320.73	342.61	426.63	251.45
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	not available	not available	not available	not available	not available
32. Total payments (\$).	722,400	588,100	1,129,300	583,200	510,600
33. Average payment per service (\$).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	92	94	94	94	84
35. Number of services provided (#).	19,900	18,900	18,500	18,300	19,400
36. Total payments (\$).	1,404,700	1,275,400	1,264,200	1,345,900	1,442,800
37. Average payment per service (\$).	70.59	67.48	68.34	73.55	74.37

Endnotes

1. Based on provincial government funding summaries provided to the former health districts.
2. This number includes estimated government funding to Regional Health Authorities (RHAs), based on total projected expenditures less non-government revenue, as provided to Saskatchewan Health through the RHA annual operational plans.
 - Acute care funding includes: acute care services, specialized hospital services, and in-hospital specialist services.
 - Does not include in-patient rehabilitative care, in-patient mental health, or addiction treatment services.
 - Does not include payments to Saskatchewan Cancer Agency for out-patient chemotherapy and radiation.
3. Comparable annual information is not available at this time.
4. Fee-for-service only.
5. Includes visits, hospital care, psychotherapy.
6. Includes surgeries, surgical assistance, obstetrics, anaesthesia.
7. Includes x-rays, laboratory services, diagnostics.
8. Includes surcharges, premiums, on-call physician services.

Alberta

Introduction

Alberta provides medically necessary, insured services in a public system that follows the principles of the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility. Medically necessary services include hospital and physician services and specific kinds of services provided by oral surgeons and other dental professionals.

Alberta also provides full and partial coverage for health care services not required by the *Canada Health Act*. They include:

- ☐ home care and long-term care;
- ☐ mental health services;
- ☐ dental and eyeglass benefits for recipients of the Alberta Widows' pension and their eligible dependants;
- ☐ palliative care;
- ☐ immunization programs for children;
- ☐ allied health services such as optometry (for residents under 19 and over 64 years), chiropractic and podiatry services;
- ☐ drug benefits through Alberta Blue Cross; and
- ☐ Alberta Aids to Daily Living.

Health System Governance

Alberta's health care system is defined in legislation and is governed by the Minister of Health and Wellness. The *Regional Health Authorities Act* makes regional health authorities responsible to the Minister for ensuring the provision of acute care hospital services, community and long-term care services, public health protection and promotion services and

other related services. The *Alberta Cancer Board Act* makes the Alberta Cancer Board responsible to the Minister for providing cancer care, education and research. The Alberta Mental Health Board advises the Minister on strategic and policy matters related to mental health programs and services. Alberta's health legislation can be accessed at: www.health.gov.ab.ca/about/minister/legislation.html

Significant Events in 2004-2005

Alberta's immunization programs were expanded. The provincial influenza immunization program was expanded to include infants between six and 23 months, as well as their caregivers and family members. The hepatitis A vaccination program was expanded so that high-risk groups can now receive the vaccination free of charge and Grade 9 students are now provided with the pertussis (whooping cough) vaccination.

The *Prevention of Youth Tobacco Use Amendment Act* received Royal Assent. A new definition of "public places" where youth can be charged with possession or use of tobacco came into effect on September 1, 2004. The amendment expanded the definition to include buildings such as schools and shopping malls, streets and parks.

A \$700 million investment was announced to expand capacity and improve access. This was one of the largest ever single investments in Alberta's health system with \$350 million provided to Alberta Health and Wellness and \$350 million to Alberta Infrastructure and Transportation. Alberta Health and Wellness' portion was aimed at increasing bed capacity, reducing wait times for surgery, improving care for mothers and their babies, and reducing preventable illness.

Collaborative work under the Master Agreement between the Alberta government, the regional health authorities and the Alberta Medical Association has continued. Under the agreement, three new Primary Care Networks were launched. Through Primary Care Networks physicians and a

wide range of other health care professionals use a team approach to provide patients with coordinated treatment.

New regulations are being developed under the *Health Professions Act* to ensure that health professions practice in accordance with appropriate standards and are able to work to their full scope of practice. In 2004-2005, regulations were developed under the Act to include the dental technician profession. This brings the total number of colleges regulated under the Act to 10 out of 28.

Effective October 1, 2004, health care premiums are no longer charged for Albertans 65 years of age and older, their spouses and dependants.

Premier Klein announced in January 2005 that Alberta will revamp public health care by charting a "Third Way" of health care delivery. The Third Way is about being innovative and getting on with what needs to be done. The Premier assured Albertans that a person's ability to pay will never determine their ability to access necessary health care in Alberta. More significant events are described in detail in the 2004-2005 Annual Report of the Alberta Ministry of Health and Wellness at:

www.health.gov.ab.ca/resources/publications/AR04_05/index.html

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan is publicly administered in accordance with the *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* has governed the operation of the Alberta Health Care Insurance Plan. The Minister of Health and Wellness determines what services are covered by the Alberta Health Care Insurance Plan. Alberta Health and Wellness reviews scientific literature, consults with expert advisors, and assesses policy, funding and training when considering which medical products, services or

devices will be covered under the Alberta Health Care Insurance Plan. Alberta Health and Wellness administers the plan on a non-profit basis.

Alberta Health and Wellness registers eligible Alberta residents for coverage under the plan and pays practitioners for insured services listed in the Schedule of Medical Benefits and the Schedule of Oral and Maxillofacial Surgery Benefits. Alberta Health and Wellness also provides funding to regional health authorities and provincial boards for the provision of insured hospital services.

1.2 Reporting Relationship

The Alberta Health Care Insurance Plan is fully accountable to the Minister of Health and Wellness and is managed by the Minister's departmental staff.

Under the *Government Accountability Act*, sections 13 and 14, the Minister must prepare a business plan and an annual report for each fiscal year. The Ministry's annual report documents key activities of the health care system including the Alberta Health Care Insurance Plan and provides consolidated financial statements for the previous fiscal year. It also provides information about key achievements and results in response to key performance measures and targets included in the previous year's business plan. The 2004-2005 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at:

www.health.gov.ab.ca/resources/publications/AR04_05/index.html

The Ministry also issues an annual Statistical Supplement on data related to the Alberta Health Care Insurance Plan. The Statistical Supplement can be accessed at:

www.health.gov.ab.ca/resources/publications/index.html

Under the *Government Accountability Act*, section 16, "accountable organizations" (regional health authorities and provincial health boards) must prepare and provide to the Minister a business plan and annual report for each fiscal year. In addition under the *Regional Health Authorities Act*, section 9, regional health authorities and provincial health boards must

provide to the Minister a health plan indicating how the authority will carry out its responsibilities under section 5 of the Act and how its performance will be measured.

1.3 Audit of Accounts

The Auditor General of Alberta is the auditor of all government ministries, departments, regulated funds and provincial agencies, and is responsible for assuring the public that the government's financial reporting is credible. The Auditor General reports on the adequacy of regulatory administration, management structures accounting systems and management control systems including those designed to ensure economy and efficiency. The Auditor General of Alberta audits the performance reporting, records and financial statements of the Ministry of Health and Wellness as well as regional health authorities and provincial health boards.

2.0 Comprehensiveness

2.1 Insured Hospital Services

In Alberta, regional health authorities are responsible to the Minister for ensuring the provision of insured hospital services except for cancer hospitals, which are the responsibility of the Alberta Cancer Board. The *Hospitals Act*, the *Hospitalization Benefits Regulation* (AR244/90), the *Health Care Protection Act* and the *Health Care Protection Regulation* define how insured services are provided by hospitals or designated surgical facilities. According to the legislation, the Minister must approve all hospitals and surgical facilities.

The services provided by approved hospitals in Alberta range from the most advanced levels of diagnostic and treatment services for in-patients and out-patients to the routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are defined in the *Hospitalization Benefits Regulation* (AR244/90).

The *Health Care Protection Act* in Alberta governs the provision of surgical services through non-hospital surgical facilities. Ministerial approval of a contract between the facility operator and a regional health authority is required for providing insured services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta are also required. According to the College, there are currently 53 non-hospital surgical facilities with accreditation status.

According to the *Health Care Protection Act*, Ministerial approval for a contractual agreement shall not be given unless:

- ☐ the insured surgical services are consistent with the principles of the *Canada Health Act*;
- ☐ there is a current and likely future need for the services in the geographical area;
- ☐ the proposed surgical services will not have a negative impact on the province's public health system;
- ☐ there will be an expected benefit to the public;
- ☐ the regional health authority has an acceptable business plan to pay for the services;
- ☐ the proposed agreement contains performance expectations and measures; and
- ☐ the physicians providing the services will comply with the conflict of interest and ethical requirements of the *Medical Profession Act* and by-laws.

2.2 Insured Physician Services

Insured physician services are paid for under the Alberta Health Care Insurance Plan. Only physicians who meet the requirements stated in the *Alberta Health Care Insurance Act* are allowed to provide insured services under the Alberta Health Care Insurance Plan. In addition to insured services, a number of other practitioner services are covered under the Alberta Health Care Insurance Plan. They include opticians, podiatrists, optometrists and chiropractors.

Before being registered with the Alberta Health Care Insurance Plan, a practitioner must complete the appropriate registration forms and include a copy of his or her license issued by the appropriate governing body or association, such as the College of Physicians and Surgeons of Alberta. Under section 8 of the *Alberta Health Care Insurance Act*, physicians may opt out of the Alberta Health Care Insurance Plan. As of March 31, 2005, there were no opted-out physicians in the province.

The *Medical Benefits Regulation* defines which medical services are insured. These services are documented in the Schedule of Medical Benefits, which can be accessed at:

www.health.gov.ab.ca/professionals/somb.htm

Insured physician services and any changes to the Schedule of Medical Benefits are negotiated among Alberta Health and Wellness, the Alberta Medical Association (AMA) and the regional health authorities. All changes to the Schedule of Medical Benefits require ministerial approval.

2.3 Insured Surgical-Dental Services

Alberta insures a number of medically necessary oral surgical and dental procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits available at:

www.health.gov.ab.ca/professionals/allied.htm

A dentist may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan when performed by a dentist certified as an oral or maxillofacial surgeon who meets the requirements stated in the *Alberta Health Care Insurance Act*. Services provided by denturists are covered by the Alberta Health Care Insurance Plan in addition to insured surgical dental services.

Although there is no formal agreement between dentists and Alberta Health and Wellness, the department meets with members of the Alberta Dental Association and College to discuss changes to the Schedule of Oral and Maxillofacial

Surgery Benefits. All changes to the benefit schedule require ministerial approval.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 21 of the *Alberta Health Care Insurance Regulation* defines what services are not considered to be insured services. Section 4(1) of the *Hospitalization Benefits Regulation* provides a list of uninsured hospital services.

3.0 Universality

3.1 Eligibility

Under the terms of the *Alberta Health Care Insurance Act*, all Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes the province his or her home and is ordinarily present in Alberta. 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 are landed immigrants, returning landed immigrants or returning Canadian citizens. Temporary residents may also be eligible for coverage, if they intend to remain in Alberta for 12 months and their Canada entry documents are in order.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan include:

- ☐ members of the Canadian Forces;
- ☐ members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
- ☐ persons serving a term in a federal penitentiary.

3.2 Registration Requirements

All new Alberta residents are required to register themselves and their eligible dependants with the

Alberta Health Care Insurance Plan. New residents in Alberta should apply for coverage within three months of arrival. Family members are registered on the same account for premium billing purposes. As of March 31, 2005, there were 3,210,035 Alberta residents registered with the Alberta Health Care Insurance Plan.

Improvements were made to the Alberta Health Care Insurance Plan processes for registering Albertans and issuing health cards. There are now stricter requirements for new registrations and requests for card replacement. Registrants now have to provide documentation that proves their identity, legal entitlement to be in Canada and Alberta residency. These changes will improve security and confidentiality while reducing the potential for fraud or abuse.

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorization and Minister's Permits. There were 19,628 people covered under these conditions as of March 31, 2005.

3.4 Premiums

The majority of Alberta residents are required to pay premiums. Exceptions include:

- ☐ dependants;
- ☐ individuals excluded from liability;
- ☐ seniors aged 65 and older, their spouses and dependants (effective October 1, 2004);
- ☐ individuals enrolled in special groups such as Alberta Widows' Pension or Support for Independence; and
- ☐ anyone entitled to full premium assistance.

Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to pay. Two programs help lower-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program; and the Waiver of Premiums Program. Premium assistance for seniors was available under the Alberta Seniors Benefit Program prior to October 1, 2004.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

The Alberta Health Care Insurance Plan provides the following coverage to eligible Alberta residents who temporarily leave Alberta for other parts of Canada:

- ☐ Visit/Vacation: up to 24 months coverage (requests to extend coverage for a period longer than 24 months are reviewed on a case-by-case basis);
- ☐ Work/Business/Missionary Work: up to 48 months; and
- ☐ Post-secondary Education: no limit (coverage continues until studies are completed).

Individuals who are routinely absent from Alberta every year normally need to 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 Alberta Health and Wellness that Alberta is their permanent and principal place of residence.

Alberta participates in the inter-provincial hospital and medical reciprocal agreements. These agreements were established to minimize complex billing processes and help ensure timely payments to health practitioners when they provide services to residents from other provinces/territories (Quebec does not participate in the medical reciprocal agreement). Under these agreements Alberta pays for insured services Albertans receive in other parts of Canada at the host province or territorial rates. Benefits for other allied services covered by the Alberta Health Care Insurance Plan are paid according to Alberta's rates. More information on

coverage during temporary absences outside Alberta is accessible at:

www.health.gov.ab.ca/ahcip/pdf/travel.pdf

4.3 Coverage During Temporary Absences Outside Canada

The Alberta Health Care Insurance Plan provides coverage for the first six consecutive months of temporary absence from Canada. Residents who wish to maintain coverage for a longer period may request an extension of coverage as described in section 4.2.

The maximum amount payable for out-of-country, in-patient hospital services is \$100(CDN) per day (not including day of discharge). The maximum hospital out-patient visit rate is \$50(CDN), with a limit of one visit per day. The only exception is haemodialysis, which is paid at a maximum of \$220 per visit, with a limit of one visit per day. Physician and allied health practitioner services are paid according to Alberta rates. More information on coverage during temporary absences outside Canada is accessible at:

www.health.gov.ab.ca/ahcip/pdf/travel.pdf

4.4 Prior Approval Requirement

Prior approval is not required for elective services received outside Alberta, except for alcohol and substance abuse, eating disorders and similar addictive or behavioural disorder treatment. Approval by the Minister must be received before these services can be covered.

5.0 Accessibility

5.1 Access to Insured Health Services

All Alberta residents have access to provincially funded and insured health services regardless of where they live in the province. Alberta has nine regional health authorities, the Alberta Cancer Board and the Alberta Mental Health Board that

cooperate with each other in ensuring that all Albertans have access to needed health services. There are two major metropolitan regions, Calgary Health Region and Capital Health (Edmonton), which provide provincially funded, province-wide services to Alberta residents who need tertiary-level diagnostic and treatment services.

5.2 Access to Insured Hospital Services

Alberta Health and Wellness, regional health authorities, the Alberta Cancer Board and the Alberta Mental Health Board actively participate in a health workforce planning process to ensure an adequate supply of key personnel. Health authorities are required to develop capital equipment plans as part of their annual business plan submissions to the Minister of Health and Wellness. Funding for regional health services in 2004-2005 (which includes hospitals, medical equipment and province-wide services) was \$5,385 million, an increase of \$834 million or 18.3 percent from 2003-2004. The 2004-2005 Alberta Health and Wellness Annual Report can be accessed at:

www.health.gov.ab.ca/resources/publications/ar04_05/index.html

Alberta tracks waiting time information (excluding urgent patients who are seen without delay) on the Alberta Waitlist Registry website. The registry provides information on wait times for hip and knee replacement surgery, cataract surgery, cardiac surgery and Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CT) examinations for both hospitals and community providers. The registry is accessible at:

www.health.gov.ab.ca/waitlist/waitlistpublichome.jsp

Alberta continues to improve access to health services. On June 30, 2004, an investment of \$350 million provided to Alberta Health and Wellness for health services was announced. The funding was aimed at increasing bed capacity and reducing wait times for surgery. New centralized orthopedic intake clinics were set up in Calgary,

Red Deer and Edmonton to reduce waitlists for joint replacement surgery. The clinics assess patients before surgery, allowing 1,200 additional joint replacements to be performed. Included in this funding was \$150 million for health regions to acquire medical and diagnostic imaging equipment. The addition of new machines will provide more Albertans with access to MRI and CT scans. Regions have also increased the operating hours for MRI and CT machines in an attempt to reduce waiting times. Under new access standards for cardiac surgery, some patients scheduled for coronary artery bypass grafting (open heart surgery) receive intensive home care. This reduces wait times by allowing patients to wait at home, freeing up hospital beds for additional surgeries.

5.4 Physician Compensation

Most physicians are compensated through the Alberta Health Care Insurance Plan on a traditional, volume-driven, fee-for-service basis. Alternate Relationship Plans and Primary Care Networks for specialists and family physicians offer alternative compensation models to the fee-for-service payment system and contribute to better health outcomes by supporting innovative health care delivery.

A tri-lateral agreement involving the Alberta Medical Association, Alberta Health and Wellness and regional health authorities contains provisions to improve access to physician services. Under this agreement, Alternate Relationship Plans (ARPs) have been established to enhance physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction and value for money. Also under the agreement, physicians can partner with their health regions to create Primary Care Networks that will manage 24-hour access to front-line services.

As with physicians, dentists performing oral surgical services insured under the Alberta Health Care Insurance Plan are compensated through the Plan on a volume-driven, fee-for-service basis.

Alberta Health and Wellness establishes fees through a consultation process with the Alberta Dental Association and College.

5.5 Payments to Hospitals

Most insured hospital services in Alberta are funded through a population-based funding formula for regional health authorities. Regional health authorities also receive a mental health funding grant for insured services provided in mental health hospitals and for community mental health services. The Alberta Cancer Board receives grant funding to provide insured services in cancer hospitals and pay for cancer services patients received in regional hospitals. The regional health authorities and the Alberta Cancer Board are responsible for planning the allocation of funds for insured hospital services in accordance with regional needs assessments and services plans.

6.0 Recognition Given to Federal Transfers

The consolidated financial statements in the Ministry's Annual Report recognize the federal contributions provided under the Canada Health Transfer (CHT). Measure 5.D of the Ministry's Annual Report shows the portion of health service funding that is provided by federal contributions. The 2004-2005 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at:

www.health.gov.ab.ca/resources/publications/AR04_05/ARI_05.pdf

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
1. Number as of March 31st (#).	3,007,582	3,072,384	3,124,487	3,165,157	3,210,035

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
2. Number (#):					
a. acute care	102	103	100	102	101
b. chronic care (Aux. Hospital only)	105	106	110	107	106
c. rehabilitative care	1	1	1	1	1
d. other	3	3	3	3	3
e. total	211	213	214	213	211
3. Payments (\$):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
4. Number (#):					
a. surgical facilities	not available	not available	not available	not available	not available ²
b. diagnostic imaging facilities	not available	not available	not available	not available	not available ²
c. total	not available	not available	not available	not available	not available ²
5. Number of insured hospital services provided (#):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available
6. Payments (\$):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
7. Number of participating physicians (#):					
a. general practitioners	2,659	2,746	2,841	2,937	3,026
b. specialists	2,197	2,333	2,365	2,426	2,475
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,856	5,079	5,206	5,363	5,501
8. Number of opted-out physicians (#):					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	1	0	0	0	0
c. other	0	0	0	0	0
d. total	1	0	0	0	0
10. Number of services provided through fee-for-service (#):					
a. general practitioners	15,914,666	16,132,591	16,450,512	16,924,877	17,973,020
b. specialists	11,319,078	11,710,080	12,878,411	13,119,523	13,710,640
c. other	0	0	0	0	0
d. total	27,233,744	27,842,671	29,328,923	30,044,400	31,683,660
11. Total payments to physicians paid through fee-for-service (\$):					
a. general practitioners	430,681,658	474,076,958	543,635,736	564,936,923	596,936,029
b. specialists	528,392,197	587,092,735	681,990,901	707,843,059	751,788,155
c. other	0	0	0	0	0
d. total	959,073,855	1,061,169,693	1,225,626,637	1,272,779,982	1,348,724,184
12. Average payment per fee-for-service service (\$):					
a. general practitioners	26.70	29.39	33.05	33.38	33.21
b. specialists	45.12	50.14	52.96	53.95	54.83
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	34.45	38.11	41.79	42.36	42.57
13. Number of services provided through all payment methods (#):					
a. medical	20,328,498	20,647,611	21,153,134	21,680,907	22,640,833
b. surgical	1,316,312	1,396,422	2,417,363	2,513,638	3,043,454
c. diagnostic	5,588,934	5,798,638	5,758,426	5,849,855	5,999,373
d. other	0	0	0	0	0
e. total	27,233,744	27,842,671	29,328,923	30,044,400	31,683,660
14. Total payments to physicians paid through all payment methods (\$):					
a. medical	618,596,110	684,971,654	788,450,446	816,374,918	856,868,540
b. surgical	150,223,933	164,427,152	190,259,821	196,291,136	209,890,970
c. diagnostic	190,253,812	211,770,887	246,916,370	260,113,928	281,964,674
d. other	0	0	0	0	0
e. total	959,073,855	1,061,169,693	1,225,626,637	1,272,779,982	1,348,724,184
15. Average payment per service, all payment methods (\$):					
a. medical	30.43	33.17	37.27	37.65	37.85
b. surgical	114.12	117.75	78.71	78.09	68.96
c. diagnostic	34.04	36.52	42.88	44.47	47.00
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	35.22	38.11	41.79	42.36	42.57

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
16. Total number of claims, in-patient (#).	4,656	4,205	4,275	4,651	4,550
17. Total number of claims, out-patient (#).	56,408	61,230	67,975	68,469	72,495
18. Total payments, in-patient (\$).	14,699,049	12,328,205	15,753,884	19,411,517	20,139,919
19. Total payments, out-patient (\$).	5,287,271	7,115,105	7,953,195	7,982,851	11,473,142
20. Average payment, in-patient (\$).	3,157.01	2,931.80	3,685.12	4,173.62	4,426.36
21. Average payment, out-patient (\$).	93.73	116.20	117.00	116.59	158.26
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
22. Number of services (#).	418,587	493,798	559,503	485,841	444,884
23. Total payments (\$).	12,436,188	11,998,825	13,880,981	15,139,409	15,871,755
24. Average payment per service (\$).	29.71	24.30	24.81	31.16	35.68

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
25. Total number of claims, in-patient (#).	4,151	4,457	3,698	3,319	4,266
26. Total number of claims, out-patient (#).	3,945	3,942	3,739	3,405	4,089
27. Total payments, in-patient (\$).	374,005	416,635	340,169	300,233	381,217
28. Total payments, out-patient (\$).	298,725	309,119	206,684	212,949	227,609
29. Average payment, in-patient (\$).	90.10	93.48	91.99	90.46	89.36
30. Average payment, out-patient (\$).	75.72	78.42	55.28	62.54	55.66
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
31. Number of services (#).	20,891	22,928	21,289	20,753	26,017
32. Total payments (\$).	907,010	1,043,997	976,232	963,299	1,208,422
33. Average payment per service (\$).	43.42	45.53	45.86	46.42	46.45

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005 ¹
34. Number of participating dentists (#).	232	250	234	216	216
35. Number of services provided (#).	14,708	14,585	16,759	14,802	14,658
36. Total payments (\$).	2,116,386	2,167,898	2,394,458	2,404,042	2,843,638
37. Average payment per service (\$).	143.89	148.64	142.88	162.41	194.00

Endnotes

1. These figures are considered preliminary until the release *Alberta Health Care Insurance Plan Statistical Supplement Report*.
2. These data are available from the College of Physicians and Surgeons of Alberta at www.cpsa.ab.ca/home/home.asp

British Columbia

Introduction

British Columbia has a progressive and integrated health system that includes insured services under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The health system in British Columbia relies on regional delivery and self-regulating professions to provide quality, accessible and affordable health services to all British Columbians, when and where those services are required.

British Columbia's five regional health authorities are responsible for managing and delivering a range of health services, including acute and hospital care, home and community care, mental health and addictions services, and public health strategies. These regional health authorities encompass 16 health services delivery areas and reflect British Columbia's natural patient referral patterns.

In addition to the regional health authorities, the Provincial Health Services Authority coordinates and delivers highly specialized services and facilitates coordination of province-wide initiatives. Health authorities set three-year budgets and are accountable to government through performance agreements that define expectations and performance deliverables for three fiscal years. Performance agreements also set out the major changes required in areas of service such as emergency care, surgical services, home and community care, public and preventive health and mental health.

Health care is a top priority for the Government and the people of British Columbia.

Activities for 2004-2005

Since 2001, British Columbia's health system has undergone a number of significant changes. These redesign efforts have continued throughout 2004-2005. Despite enjoying the best health status in Canada, nation-wide trends are creating unprecedented demands on British Columbia's health system. Rising rates of obesity, a lack of physical activity, injuries, tobacco use and problematic substance use all affect the health status of individuals and increase demands for health services. In addition, the province's aging population is exhibiting a high incidence of chronic illness, resulting in increased demand for more complex and expensive health services.

Significant reforms and new initiatives have continued across the health system, as the Ministry of Health works with health authorities and health professionals to build a system that meets the needs of British Columbians and is sustainable into the future.

To support health reforms and help meet rising demands for service, health funding increased in 2004-2005, allowing more surgeries and services to be delivered in British Columbia's health system than ever before.

While increased funding is beneficial, the system will not be sustainable, nor will it meet the needs of individuals, unless it is redesigned to support good health and foster improved quality. The health system of the future must provide services across the continuum of care including: services that help people stay healthy (health promotion and disease prevention); get better (intermittent use of primary, community and hospital care); manage disease or disability (chronic care); and cope with end of life (hospice/palliative care).

In 2004-2005, the Ministry introduced, continued or enhanced a number of strategies across the span of health services. These include: population health and safety; primary care; chronic disease management; Fair PharmaCare; ambulance services; community programs for mental health and addictions; hospital and surgical services; home care; assisted living;

residential care; and end-of-life care. The Ministry also continued to work on strategies that ensure an adequate supply of skilled health providers are available to deliver services across the continuum of care.

Redesign of British Columbia's health system has enhanced patient access to quality health services. As a result, the health of all British Columbians will continue to improve and the province's health system will be patient-centred, accessible and sustainable into the future.

Significant achievements in 2004-2005

Keeping People Healthy

In 2004-2005, the Ministry of Health introduced a number of health promotion and disease prevention initiatives designed to improve the health and wellness of British Columbians:

In 2004-2005, the Ministry:

- launched ActNow BC, a program that cuts across all sectors to promote healthy lifestyles, prevent disease and mobilize communities. ActNow BC provides individuals with the information, resources and support they need to make healthy lifestyle decisions;
- through *2010 Legacies Now, Expanded Action Schools!* BC sought to increase elementary students' physical activity levels and provide them with information on healthy lifestyles;
- introduced programs that identify and address hearing, vision or dental health challenges before children reach Grade 1;
- protected health through immunization programs, infectious disease control, minimizing injury prevention, monitoring and regulating water and environmental safety, enhancing reproductive health, improving food security and better managing health emergency management;
- provided \$12.75 million to expand childhood immunization programs for influenza, meningitis and chickenpox. British Columbia met a record demand for influenza

immunization by providing well over 1,000,000 doses to British Columbians during the flu season; and

- provided \$8.6 million to ensure local mosquito surveillance and control programs are in place to prevent the spread of the West Nile virus. The Ministry works with the Provincial Health Officer, the BC Centre for Disease Control, health authorities and municipal governments to address the potential outbreak of West Nile. It also implemented coordinated approaches for responding to major public health risks, emergencies or epidemics.

Increasing Access

Access has been expanded across the spectrum of care, from BC NurseLine services to heart surgery and cancer treatment.

In 2004-2005, the Ministry:

- increased health spending. The province's health spending for 2004-2005 stands at \$10.7 billion, which includes a record \$6.2 billion in funding for the province's five health authorities;
- targeted more than \$45 million in additional funding to provide 240 more heart surgeries, 2,000 more orthopaedic procedures (including hip and knee replacements, arthroscopy and spine surgeries), 500 more cataract procedures and nearly 17,000 more diagnostic procedures;
- increased elective surgical capacity. The number of elective surgeries in key areas increased in 2004-2005 from 2000-2001 including:
 - knee replacements increased by more than 65 percent;
 - hip replacements increased by more than 35 percent;
 - cataract surgeries increased by more than 20 percent;
 - angioplasties increased by more than 52 percent; and
 - reduced wait times. More than half of all surgeries are emergent and are performed immediately. As a result, fewer than 50

- percent of all surgeries were wait listed in 2004-2005. Of these:
- 10 percent are done within a week;
 - 25 percent are done in approximately two weeks;
 - 50 percent are done in just over a month;
 - 75 percent are done in just over three months;
 - 90 percent are done in less than seven months; and
 - 97 percent are done within 12 months.
- released British Columbia's first comprehensive survey of emergency room (ER) care, which revealed that 85 percent of the over 14,000 patients surveyed rated the quality of care they received in emergency rooms as good to excellent. Almost 80 percent reported waiting an hour or less to see the ER doctor;
 - provided \$20 million in new funding to improve radiation therapy services and increase access to cancer treatment. British Columbia is a leader in cancer care with some of the most favourable outcomes in North America;
 - provided \$4 million to improve access to treatment and guidance for individuals suffering from kidney disease;
 - invested \$3 million to support an increased number of women having a screening mammogram every two years;
 - provided \$6 million to strengthen access to care for rural residents by enhancing programs such as Telehealth, recruitment programs and improved ambulance services, and introducing a new rural travel assistance program to help eligible rural residents travel for medical services;
 - continued to enhance BC NurseLine services, which provide 24-hour, toll-free access to registered nurses specially educated to provide confidential health information and advice to British Columbians;
 - introduced a new monthly deductible payment option to help families better manage their prescription drug costs through Fair PharmaCare;
 - introduced a three-year plan to invest more than \$47 million to improve access to dental prevention and treatment for young children and low-income families;
 - led the National Pharmaceuticals Strategy. When implemented, the strategy will: provide all Canadians with access to catastrophic drug coverage; accelerate access to breakthrough drugs; strengthen the national evaluation of drug safety and effectiveness; and introduce national purchasing strategies so drugs and vaccines can be obtained at the best price. British Columbia will continue to lead work on the strategy in 2005-2006; and
 - increased the threshold for eligibility in the Medical Services Plan premium assistance program by \$4,000 per year. The change will reduce or eliminate monthly payments for an estimated 215,000 British Columbians.

Improving Quality of Health Services in 2004-2005

In 2004-2005, a number of important initiatives were undertaken across the health system to improve the quality of health services provided. Innovations, integrated services and the application of proven best practices in treating health conditions are leading to better health outcomes for British Columbians.

In 2004-2005, the Ministry:

- introduced Professional Quality Improvement Days (PQIDs) as a joint initiative with the British Columbia Medical Association. PQIDs provided approximately 800 physicians from across the province with an opportunity to work with health authorities and the Ministry on primary health care renewal. Over 2,000 clinicians are now involved in primary care quality improvement initiatives across the province;
- provided \$10 million for patient safety initiatives that include:

- \$6 million over three years to support the patient safety task force; and
- \$3 million for a patient safety research chair of patient safety in the University of British Columbia's medicine faculty.
- provided an additional \$30 million in funding for the Michael Smith Foundation for Health Research to be used to develop, attract and retain outstanding health scientists and researchers in the province. This funding supports research in priority areas such as health care re-engineering and innovation;
- expanded emergency response services to ensure paramedics are on site at ambulance stations 24 hours a day, in both rural and urban communities;
- published *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*, which gives health authorities a common planning model to deliver comprehensive, responsive services from prevention through harm reduction and treatment;
- enhanced mental health and addiction services across the province, including breaking ground on a 44-bed, \$17 million psychiatric acute care facility at the Royal Inland Hospital to benefit patients in the Interior;
- continued to implement a new model of home and residential care that expands options and better meets the needs of seniors. The government has added, replaced or upgraded over 4,000 residential care and assisted living units for seniors to date, and will complete 5,000 new residential care and assisted living spaces by 2008;
- expanded housing and care options to better meet the needs of seniors. As of June 2005, the government has added, replaced or upgraded more than 4,000 residential care and assisted living units. British Columbia will meet its commitment to develop 5,000 new care spaces by 2008;
- began construction of an 87-bed, multi-level care facility in the Ladysmith area, which will provide 75 complex care beds and 12 geriatric mental health beds for seniors in the area by spring 2006;
- began Phase I of the Delta View Life Enrichment Centre, which provides care for 210 residents along with a range of other health services. These beds will provide specialized residential care for seniors with both mental illnesses and complex health care needs;
- expanded end-of-life care choices, including a palliative benefits program that provides people, who choose to remain at home, with medications, medical supplies and equipment;
- invested in leading edge medical equipment, such as British Columbia's first Positron Emission Tomography Program (PET) unit at the Vancouver Cancer Centre; new Computerized Tomography (CT) scanners for Royal Columbian Hospital, Royal Jubilee Hospital, Vancouver General Hospital, Lion's Gate Hospital and Kelowna General Hospital; and a new Magnet Resonance Imaging (MRI) scanner at Children's and Women's Hospital, a mobile MRI scanner for the Kootenays and South Okanagan, and an upgraded MRI scanner at the University of British Columbia Hospital; and
- established an Electronic Health Steering Committee to accelerate developing and implementing eHealth for British Columbia. A number of projects are underway, including developing an electronic health record, which will improve efficiency and safety by enabling care providers to access clinical information, such as patient medication profiles, lab and other testing results, using web-based technology.

Investing for Future Sustainability

Making the right strategic investments now will ensure the health system is sustainable into the future. Investing in infrastructure and health human resources, independently or with funding partners, is a key priority for the government.

In 2004-2005, the Ministry:

- ❑ started construction on the new 300-bed Abbotsford Regional Hospital and Cancer Centre;
- ❑ completed the Prince George Regional Hospital redevelopment, including a new patient care building with new medical/surgical beds, improved critical care services and a new emergency department;
- ❑ redeveloped the Royal Inland Hospital in Kamloops with a new emergency department and a new medical imaging department;
- ❑ started construction on the Nanaimo Regional General Hospital expansion which will improve patient care, surgical services and maternal programs;
- ❑ completed the first phase of transforming the Ladysmith Family Practice Clinic into a primary health centre, providing individuals and families with a wider range of integrated services in their own community;
- ❑ opened the 19-storey Jim Pattison Pavilion at Vancouver General Hospital, which includes 459 new beds and modernized equipment and facilities;
- ❑ launched major improvements to the Fraser Valley Cancer Centre in Surrey and the Vancouver Cancer Centre, including the acquisition of eight new and replacement linear accelerators;
- ❑ started building a new 11-storey Academic Ambulatory Care Centre in Vancouver that will integrate patient care services with academic and research programs;
- ❑ expanded the province's medical training program by almost doubling the number of doctors in training. In September 2004, 72 more medical students than the previous year began their studies in British Columbia, bringing the total number of students in first year to 200. By 2008, there will be 904 medical students in training at any given time in British Columbia. The government also invested \$27.6 million to expand and upgrade academic space in teaching hospitals across British Columbia;
- ❑ strengthened government's relationship with physicians by reaching a new three-year working agreement. The agreement sets a framework for greater physician participation in health system issues such as increasing physician use of information technology, supporting full service family practice and laboratory reform;
- ❑ continued to increase the number of nurses practicing in British Columbia as part of the province's Nursing Strategy. In 2004-2005, an additional 321 seats were added to nursing programs, bringing the total number of new nursing seats to more than 2,100 since 2001. In addition, the province's first group of nurse practitioners graduated in May 2005, adding a new level of care to the health system; and
- ❑ entered into an agreement to improve delivery of the Medical Services Plan (MSP) and PharmaCare services to British Columbians while improving the protection and privacy of personal data.

Information on health and health services in British Columbia is available at:

www.gov.bc.ca/healthservices

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, through the Regional Health Sector budget of the Ministry of Health.

This program is responsible to the provincial government for the ongoing funding of the province's public hospitals, delivered via funding and transfer agreements with the five health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act* (section 9), and the

Hospital District Act (section 20). This entails expenditures and commitment controls for operating hospitals, providing funds for hospital construction and equipment and paying out-of-province hospital costs for qualified British Columbia residents.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health and facilitates access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). Routine administrative functions of the Medical Services Plan of the Ministry of Health are delivered by a private sector service provider. In addition to its role in managing the contract with the private provider, the Ministry is accountable for overall service delivery and retains responsibility for areas such as legislation, regulations, setting of policy, complex decisions and appeals.

The Commission's responsibilities (section 5 of the *Medicare Protection Act*) include: determining benefits; registering beneficiaries; enrolling practitioners; processing and paying practitioners' bills for benefits rendered; registering diagnostic facilities; establishing advisory committees; authorizing research and surveys related to the provision of benefits; auditing claims for payment and patterns of practice or billings submitted; and hearing appeals from practitioners and beneficiaries.

1.2 Reporting Relationship

Health authorities are required to report health information data on hospitals in their jurisdictions to the Ministry of Health. The Ministry's Performance Management and Improvement Division, reports to government through the *Ministry of Health Annual Service Plan Report*. This report compares actual results for the preceding fiscal year with the expected results identified in the service plan for that fiscal year. In accordance with the *Budget Transparency and Accountability Act*, this report, as well as the Ministry of Health Service Plan, is made public by

the minister. The Medical Services Commission reports annually to the Minister of Health in a separate financial statement.

The Ministry of Health provides extensive information in its Annual Service Plan on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting, as identified in the *Budget Transparency and Accountability Act* (2000).

The Ministry of Health plays a role in various reports including:

- Ministry Annual Report;
- Report on Health Authority Performance (annual);
- Nationally Comparable Indicators Report; and
- Provincial Health Officer's Annual Report (on the health of the population)

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- the Office of the Comptroller General's Internal Audit and Advisory Services, the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry.

The Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the audit recommendations.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Act* establishes public insurance coverage for general hospital services. Eligibility is defined by regulations, which include both a residency requirement and a waiting period. Insured hospital services are provided in facilities specified in section 1 of the *Hospital Insurance Act*. In 2004-2005, there were 92 acute care hospitals, four rehabilitation hospitals, 18 free-standing extended care hospitals and 23 diagnostic and treatment and other health centres.

Insured hospital services are provided as recommended by the attending physician, nurse practitioner or midwife. These services, and the conditions under which they are provided, are listed in the *Hospital Insurance Act Regulations*, division 5. Insured in-patient services provided by hospitals are:

- ☐ accommodation and meals at the standard or public ward level;
- ☐ necessary nursing services;
- ☐ laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability;
- ☐ clinically approved drugs, biologicals and medical supplies;
- ☐ routine surgical supplies;
- ☐ use of operating room and case room facilities;
- ☐ anaesthetic equipment and supplies;
- ☐ use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- ☐ other services approved by the Minister.

Individuals not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room

services for surgical day care and minor surgery, including applying and removing casts.

Listed hospital out-patient benefits include:

- ☐ out-patient renal dialysis treatments in designated hospitals or other approved facilities;
- ☐ diabetic day-care services in designated hospitals;
- ☐ out-patient dietetic counselling services at hospitals with qualified staff dietitians;
- ☐ psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day care and services;
- ☐ cancer therapy and cytology services;
- ☐ out-patient psoriasis treatment;
- ☐ abortion services; and
- ☐ MRI services.

Insured hospital services are provided at no charge to patients. Incremental charges for preferred medical/surgical supplies, when approved, are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

Ambulance services are provided within the province by the British Columbia Ministry of Health through the Emergency Health Services Commission, with a partial charge to the patient. Fees charged to BC residents are highly subsidized and cover only part of the cost of delivering the service.

There is no regular process to review insured hospital services. As the list of insured services included in the regulations is intended to be both comprehensive and generic and does not require routine review and updating.

2.2 Insured Physician Services

Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care practitioners, such as midwives) who are enrolled and who render benefits to a beneficiary are eligible to be paid

for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as Medical Services Plan benefits under the MPA in accordance with the *Canada Health Act*:

- ☐ medically required services provided to “beneficiaries” (residents of British Columbia) by a medical practitioner enrolled with the Medical Services Plan; and
- ☐ medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

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 insured services, they must be enrolled with the Medical Services Plan. In fiscal year 2004-2005, 8,271 physicians were enrolled with the Medical Services Plan and billed fee-for-service. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) to the health authorities. Physicians paid by these alternative mechanisms may also practice on a fee-for-service basis.

A physician may choose not to enroll or to de-enroll with the Medical Services Commission. Enrolled physicians may cancel their enrollment by giving 30 days’ written notice to the Commission. Patients are responsible for the full cost of services provided by non-enrolled physicians. As of March 31, 2005, only one physician has de-enrolled.

Enrolled physicians can elect to be paid directly by patients by giving written notice to the Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to the Medical Services Plan for reimbursement of the fee for insured services rendered. As of March 31, 2005, only six physicians had elected to be paid in this manner.

Under the Master Agreement between the government, the Medical Services Commission and the British Columbia Medical Association

(BCMA), additions, deletions, fee changes or other modifications to the payment Schedule are made by the Commission, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time while definitive listings are established.

New or revised clinical practice guidelines approved by the Medical Services Commission in 2004-2005 include:

- ☐ chronic obstructive pulmonary disease;
- ☐ clinical management of chronic hepatitis B;
- ☐ clinical management of chronic hepatitis C;
- ☐ acute otitis media (revised 2004);
- ☐ otitis media with effusion (revised 2004);
- ☐ investigation and management of iron deficiency (revised 2004);
- ☐ thyroid function tests in diagnosing and monitoring adults with thyroid disease; and
- ☐ primary care management of sleep complaints (revised 2004).

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by the Medical Services Plan when hospitalization is medically required for the safe and proper completion of surgery and when it is listed in the Dental Payment Schedule. Additions or changes to the list of insured services are managed by the Medical Services Plan on the advice of the Dental Liaison Committee. Additions and changes must be approved by the Medical Services Commission. Included as insured surgical-dental procedures are 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.

Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan may provide insured

surgical-dental services in hospital. There were 228 dentists enrolled with the Medical Services Plan and billing fee-for-service in 2004-2005. None have de-enrolled or opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial PharmaCare program. Other procedures not insured under the *Hospital Insurance Act* include:

- ☐ the services of medical personnel not employed by the hospital;
- ☐ treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
- ☐ services solely for the alteration of appearance; and
- ☐ reversal of sterilization procedures.

Uninsured hospital services also include:

- ☐ preferred accommodation at the patient's request;
- ☐ televisions, telephones and private nursing services;
- ☐ preferred medical/surgical supplies;
- ☐ dental care that could be provided in a dental office including prosthetic and orthodontic services; and
- ☐ preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan include:

- ☐ those covered by the *Workers' Compensation Act* or by other federal or provincial legislation;
- ☐ provision of non-implanted prostheses;
- ☐ orthotic devices;
- ☐ proprietary or patent medicines;
- ☐ any medical examinations that are not medically required;
- ☐ oral surgery rendered in a dentist's office;
- ☐ acupuncture;

- ☐ telephone advice unrelated to insured visits;
- ☐ reversal of sterilization procedures;
- ☐ in vitro fertilization;
- ☐ medico-legal services; and
- ☐ most cosmetic surgeries.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

The *Medicare Protection Act*, section 45 prohibits the sale or issuance of health insurance by private insurer to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for 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". The Ministry of Health responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the BCMA's Tariff Committee. No services were de-listed in 2004-2005.

3.0 Universality

3.1 Eligibility

Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry of Health's Acute Care Policy Manual.

Section 7 of the *Medicare Protection Act* defines the eligibility and enrollment of beneficiaries for insured services. Part 2 of the *Medical and Health Care Services Regulation* made under the *Medicare Protection Act* details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits. The *Medicare Protection Act*, in section 1, defines a resident as a person who is a

citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under section 2 of the *Medical and Health Care Services Regulations* to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage. The Medical Services Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

Residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enroll. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the province. Eligible residents who enroll with the Medical Services Plan are issued a CareCard.

Beneficiaries may cover their dependents, provided the dependents are residents of the province. Dependents include a spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward supported by the beneficiary, and either under the age of 19 or under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2004, was 4.18 million. Enrollment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2005, 256 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible for benefits unless they hold a work or study permit that is valid for six or more months. Individuals who are approved for refugee status and who are entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits. Holders of Minister's Permits/Temporary Resident Permits are eligible for benefits where deemed to be residents under the *Medical and Health Care Services Regulation*. A waiting period applies that consists of the balance of the month in which a person first meets the Medical Services Plan's definition of a resident, plus two months.

3.4 Premiums

Enrollment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrollment eligibility criteria. Monthly premiums for the Medical Services Plan are \$54 for one person, \$96 for a family of two, and \$108 for a family of three or more. Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident (landed immigrant) status.

There are no additional premiums for insured hospital services. However, there is a daily charge for residential care services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2005, the rates ranged from \$28.10 a day to \$67.50 a day, depending on client income. In certain circumstances where clients cannot afford to pay their assessed rate, there is a provision to waive a portion of the daily fee. Client rates are increased on January 1st of

each year by the percentage increase in the Consumer Price Index.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Coverage may be extended for a reasonable period of travel, but cannot exceed three months.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a resident.

Coverage is available to landed immigrants who have completed the waiting period. After the waiting period, coverage is also available to individuals from outside Canada who are in the province on work permits or student visas, provided the permits or visas are valid for at least six months.

4.2 Coverage During Temporary Absences in Canada

Sections 3, 4 and 5 of the *Medical and Health Care Services Regulations* define portability provisions for persons temporarily absent from British Columbia with regard to insured services. In 2004-2005, there were no amendments to the *Medical and Health Care Services Regulation* with respect to the portability provisions.

Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province or territory to bring about a high degree of liaison and cooperation concerning hospital insurance matters, and to make arrangements under which

a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year.

Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their homes in British Columbia. 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 and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). 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, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the inter-provincial and inter-territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled through inter-provincial and inter-territorial reciprocal billing procedures. In 2004-2005, the total amounts paid to other provinces and territories for both in-patient and out-patient hospital services was \$65.4 million. The amount paid to physicians in other provinces and territories was \$23.5 million.

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. Reimbursement may be made to the individual who submitted the claim – either the physician who provided the service, or the patient who received the service.

4.3 Coverage During Temporary Absences Outside Canada

The *Hospital Insurance Act Regulations*, division 4 and sections 3, 4, and 5 of the *Medical and Health Care Services Regulations* define portability of insured hospital and physician services during temporary absences outside Canada. In 2004-2005, there were no amendments to the *Medical and Health Care Services Regulation* for portability provisions.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until within one month of the earlier of the last day of the month in which the person ceased full-time attendance at that educational institution, or the last day of the sixtieth month since the date of departure from British Columbia.

Individuals who leave the province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their homes in British Columbia.

With prior authorization, coverage is provided for hospital services not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Out-patient renal dialysis treatment is available at a rate of \$220. In all other cases, including emergency or sudden illness during temporary absences from the province, in-patient hospital or daycare surgical care is paid up to \$75(CDN) per day for adults and children, and \$41(CDN) per day for newborns. Payments for insured services provided outside Canada in 2004-2005 totalled \$4.5 million to hospitals and \$2.4 million to physicians.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the inter-provincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of the Performance Management and Improvement Division (e.g. treatment for anorexia). All non-emergency procedures performed outside Canada require approval from the Commission before the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbians have reasonable access to hospital and medical care services. Beneficiaries, as defined in section 1 of the *Medicare Protection Act* and the Ministry of Health's Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, Part 4, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

The number of Registered Nurses licensed to practice in British Columbia as of December 2004 was 30,280. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2004, there were 2,162 RPNs and 5,349 LPNs licensed to practice in the province. In June 2004, the government provided a further \$3.5 million to its nursing strategy to build on successful recruitment, retention and education nursing strategies. This funding brought the government's total commitment to nursing strategies to \$62.5 million since 2001.

On August 19, 2005, the *Nurses (Registered) and Nurse Practitioners Regulation* came into effect. This regulation establishes the new College of Registered Nurses of British Columbia (CRNBC) under the *Health Professions Act* as the regulatory body for registered nurses and also enables nurse practitioners to be regulated by the new College and to practice in British Columbia. As part of this transition, the *Nurses (Registered) Act* was repealed and the Registered Nurses' Association of British Columbia was dissolved. The University of British Columbia and the University of Victoria graduated their first nurse practitioners in 2005. Many of these graduates are moving into primary health positions throughout the province. An additional Nurse Practitioner program will commence at the University of Northern British Columbia in Prince George in September 2005.

British Columbia's nursing strategies are developed and implemented annually by the Ministry of Health's Nursing Directorate through consultation with stakeholders, input from the Nursing Advisory Committee of British Columbia and a review of national trends and policies. The following priorities form the broad strategy framework:

- ☐ human resources planning for recruitment, retention and education of nurses in British Columbia;
- ☐ enhancing nursing practice environments by supporting health authorities and government to make sound nursing policy in keeping with current research and provincial, national and global trends;
- ☐ compiling nursing data to enhance the Ministry's understanding of trends and changing needs in nursing and health care; and
- ☐ promoting nursing as a career of choice to ensure the future of a quality British Columbia health care system.

Telehealth (supported by the Provincial Health Services Authority since mid-2002) continues to provide improved access to services in British Columbia. Services established through different

projects continue to be delivered. New applications are implemented on an ongoing basis. Four domains in Telehealth have been defined: Telemedicine; Telehomecare; Telelearning; and Telerriage. There is growing focus on increasing access to Telehealth in underserved Aboriginal, rural and remote communities.

In 2004-2005, there were active Telehealth programs available in approximately 20 clinical program areas including: oncology; mental health/psychiatry; maternal/fetal medicine; medical genetics; orthopedics; pharmacy; thoracic surgery; trauma; and wound care program areas. They are all applying Telehealth technology to service delivery. Services for children are available in the areas of: psychiatry; rehabilitation and development; eating disorders/nutrition; neonatology; cardiology; oncology; palliative care; physiotherapy; and speech therapy.

A provincial Telehealth Steering Committee was formed to identify and define the provincial priorities for Telehealth.

Acute care access standards are used by health authorities to redesign hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services.

In recent years, the Province has initiated changes that encourage strategic investment in capital infrastructure and innovative approaches to meeting health service delivery needs, now and in future. The Ministry of Health has introduced a longer planning cycle and has gathered better data on current capital assets to support improved decision-making and better forecasting of needs. The Ministry is working to extend the planning horizon to 10 years, which is particularly beneficial in planning for major infrastructure such as hospitals that have life-cycles encompassing several decades. It also gives health authorities more time to explore creative ways of addressing capital requirements.

The Ministry provides capital funding to health authorities for maintenance, renovation, replacement and expansion of health infrastructure that is consistent with regional and provincial priorities. In the 2004-2005 fiscal year, health authorities used Ministry funding (in some cases, in collaboration with other funding partners such as Regional Hospital Districts, foundations and auxiliaries) for purchasing equipment, building new and replacement facilities, and converting facilities to uses more consistent with current and future needs.

Among the projects recently completed or underway are:

- a new 300-bed hospital and cancer centre in Abbotsford that will provide enhanced programs and services;
- a new Academic Ambulatory Care Centre in Vancouver that will consolidate out-patient services, medical education facilities, teaching physician/specialist practice offices and related activities;
- redevelopment of Vancouver General Hospital to consolidate hospital services creating a modern and efficient environment for quality patient care and accessibility;
- redevelopment of Prince George Regional Hospital, offering a new patient care building and emergency department and improved critical care services;
- renovations to upgrade the maternity units at Kelowna, Vernon and Nelson in British Columbia's Interior; and
- a surgical expansion and creation of a palliative care suite at Lady Minto Hospital on Salt Spring Island.

In 2004-2005, the Province committed \$27.6 million for expanding and upgrading academic space in teaching hospitals around British Columbia. This will support the Province's increasing number of undergraduate and post-graduate medical students.

The 2003 First Ministers' Accord on Health Care Renewal established a \$1.5 billion national diagnostic and medical equipment fund, of which \$200.1 million was apportioned to British

Columbia for spending over three years. To March 31, 2005, health authorities have spent \$83.7 million from this fund on a wide variety of equipment for diagnostic/therapeutic and medical/surgical purposes, and to enhance comfort and safety for patients and staff.

In December 2004, the Province announced an investment of \$35 million in leading-edge medical technologies, using \$25 million of the federal funding as well as provincial capital and foundation dollars.

Funding has been designated for:

- the province's first publicly funded PET unit at the Vancouver Cancer Agency that will improve the management of cancer patients by providing accurate pre-treatment detection of cancerous tumours and by monitoring therapy response;
- new CT scanners in the Lower Mainland and Victoria that will improve cardiac care and increase provincial capacity for diagnosing heart and brain disease as well as handling trauma cases;
- a mobile MRI scanner for the Kootenays and South Okanagan and a CT scanner for Kelowna that will significantly improve access in the province's interior; and
- a Picture Archiving Communication System and a Radiology Information System for the Northern Health Authority that will enhance access to care and treatment in many small communities by allowing sharing of digital images between hospitals/regions and radiologists across the north.

The September 2004 First Ministers' Agreement committed an additional \$66 million in medical equipment funding for British Columbia. Health authorities are planning how to best use this allocation by 2007-2008.

The BC HealthGuide Program, started in 2001, has a comprehensive approach to self-care that is unique in Canada. *BC HealthGuide* information is delivered in a variety of formats:

BC HealthGuide Handbook

This handbook was delivered free to every household in British Columbia in spring 2001. It provides information on how to prevent illness, apply home treatment and determine when to see a health professional. A French version of the handbook was released in June 2004 (*Guide-santé – Colombie-Britannique*).

The *BC First Nations Health Handbook* was developed in partnership with the BC First Nations Chiefs' Health Committee, and was distributed to Aboriginal communities in January 2003. The handbook provides specific information on health services available to Aboriginal communities.

BC HealthGuide OnLine

Located at www.bchealthguide.org, this website expands on the information in the BC HealthGuide handbook with more than 35,000 medically reviewed pages covering over 3,000 detailed health topics.

BC NurseLine

BC NurseLine is a toll-free, 24 hours a day, seven days a week nursing triage and health education telephone service. Registered nurses are specially educated to use medically approved protocols to provide advice on acute and chronic health symptoms and conditions. The BC NurseLine gives people the information they need, when they need it, where they need it, and includes services for people who are deaf and hearing impaired as well as translation services in over 130 different languages. In 2004-2005, the BC NurseLine received over 331,000 calls – an increase of approximately 33 percent over the previous year.

On June 19, 2003, the pharmacist enhancement to the BC NurseLine was implemented. Callers from British Columbia can speak with a pharmacist about medication-related questions, between 5:00 pm and 9:00 am, seven days a week, 365 days per year.

From implementation of the pharmacist advice line to the end of March 2005, over 18,000 medication-related calls were transferred from the

BC NurseLine to the BC NurseLine pharmacists. Over this period, 1,700 calls were identified as being triggered by adverse drug reactions – about 9.5 percent of all medication-related calls. As a result, BC NurseLine pharmacists have submitted 484 Adverse Drug Reaction (ADRs) Reports to the British Columbia Regional ADR Centre, which have been approved for submission to Health Canada. These reports are used to monitor adverse effects that are either unexpected, serious or for newly marketed medications. The pharmacist service is responsible for over 20 percent of all ADR reports submitted to Health Canada by the British Columbia Regional ADR Centre, making it a large and integral contributor to patient safety – not only for British Columbians, but for all Canadians.

In January 2005, the BC HealthGuide Program partnered with Fraser Health on a demonstration project to explore the feasibility of leveraging the BC NurseLine platform to provide after-hours triage and support to Hospice Palliative Care (HPC) patients. Between 9 p.m. and 8 a.m. when the Fraser Health HPC nurse is on-call, patients can call BC NurseLine for after-hours support. Evaluation results will be available in fall 2005.

BC HealthFiles

The BC HealthFiles are a series of over 170 one-page, easy-to-understand fact sheets on public and environmental health and safety issues. The fact sheets are available through the province's more than 120 health units and departments and other offices, and online at: www.bchealthguide.org.

The Ministry's 2004-2005 to 2006-2007 Service Plan contained a number of objectives and strategies designed to reach the Province's goals for a sustainable health system. This includes *Priority Strategy 3: Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services*.

While most of the strategies under this objective focus on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high-quality

manner. Under this strategy, the Ministry and all five health authorities have participated in two province-wide projects to improve access to, and effectiveness of, emergency room and surgical services in hospitals across the province.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2004-2005, 4,629 enrolled general practitioners, 3,642 enrolled specialists and 228 enrolled dentists provided insured fee-for-service physician and dental-surgical services. Approximately 2,497 general practitioners and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to hire salaried physicians or contract with physicians, in order to deliver insured clinical services.

The Ministry of Health implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia.

These programs include:

- ❑ the **Rural Retention Program**, which provides eligible rural physicians (estimated at 1,200) with fee premiums and is available for visiting physicians and locums;
- ❑ the **Northern and Isolation Travel Assistance Outreach Program**, which funded an estimated 1,500 visits by family doctors and specialists to rural communities;
- ❑ the **Rural General Practitioner Locum Program**, which assisted physicians in approximately 66 small communities to attend subsidized continuing medical education and provide vacation relief;
- ❑ the **Rural Specialist Locum Program**, which provided locum support for core specialists in 17 rural communities while physician recruitment efforts were underway;
- ❑ the **Rural Education Action Plan**, which supported training physicians in rural practice

through several components, including rural practice experience for medical students and enhanced skills for practicing physicians;

- ❑ the **Isolation Allowance Fund**, which from April 1, 2004 provided funding to communities with fewer than four physicians and no hospital, and where Medical On-call/Availability Program, call-back, or Doctor of the Day payments are not available; and
- ❑ the **Rural Loan Forgiveness Program**, which decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives and pharmacists.

In November 2002, British Columbia received \$73.5 million in federal funding over four years (2002-2006) to develop sustainable improvements to primary health care (PHC) and to increase patient access to comprehensive, high-quality services in physicians' offices and community clinics - the usual first points of contact with the health care system. Since 2002, the number of new model PHC sites, providing interdisciplinary care and extended hours, has increased to nine. Regional health authorities have plans to establish up to 30 PHC sites by March 2006.

The University of British Columbia's (UBC) medical school is expanding in collaboration with the University of Northern British Columbia, the University of Victoria and British Columbia's health authorities to almost double the number of medical students. In 2002, the government announced \$134 million to build a new Life Sciences Centre at UBC in Vancouver and other distributed sites for medical programs in Prince George and Victoria. British Columbia's annual intake for medical students was 128 in 2003. The expanded program will double the number of available seats to 256 by 2007. The latest addition to the medical school expansion, the Okanagan Medical Program, will add at least another 30 first-year medical school spaces when the program begins in 2009-2010.

In addition to the medical school expansion, the government has begun a stepped expansion to post-graduate medical education. In 2004, 32

first-year residency positions were added. By 2010, the number of first-year post-graduate positions will double to 256, up from 128 in 2003.

5.4 Physician Compensation

The Province of British Columbia negotiates with the BCMA to establish the conditions, benefits and overall compensation for both fee-for-service (FFS) physicians and physicians paid under alternative payment mechanisms, including contracted, sessional and salaried physicians.

Physicians in British Columbia received significant increases in 2002, making them one of the highest compensated physician groups in Canada. Funding for physicians accounts for over \$2.5 billion or 23 percent of the health care budget in 2004-2005. In June 2004, the government and BCMA signed three Letters of Agreement pertaining to the Working Agreement, Laboratory Reform and Related Matters. The agreement reallocates \$100 million of savings to improve the quality of patient care.

The three-year contract put physician compensation increases on hold for two years. The contract expands communications between the government and physicians through a variety of committees and consultations. Financial components reallocated benefit funds, improved maternity care, provided additional funding for recruiting and retaining rural physicians and specialists, supported GPs and their role in chronic disease management, and reformed and modernized laboratories.

The Agreement covers the period April 1, 2004 to March 31, 2007, and was reached through negotiation. Compensation adjustments to the FFS, Sessional, Service and Salary rates are the subject of further negotiations with physicians for the third year of the agreement and began in October 2005. If negotiations are unsuccessful, disputed items may be sent to binding arbitration after January 2006.

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payments

Program (APP) to health authorities for contracted physicians' services. The patient is not normally involved in the payment system. Ninety-nine point nine percent of Medical Services Plan claims are submitted electronically through the Teleplan System, while the remainder are submitted on claim cards. Approximately 10 percent of physicians' compensation was distributed through the APP in 2004-2005.

The APP provides program-specific funding to British Columbia's five health authorities and the Nisga'a, which in turn, contract with physicians for their services or time through service contracts, sessional payments or as salaried physicians. Provincial agreements between the Government of British Columbia and the BCMA set the terms and conditions of physician compensation for government-funded services, including those funded by the APP. Approximately 2,497 physicians are supported, either wholly or in part, through APP funding arrangements.

5.5 Payments to Hospitals

In 2004-2005, total funding to health authorities was \$6.25 billion. These payments were for the full range of regionally delivered health care services including acute, residential, community care, public and preventive health, adult mental health and addictions programs. Health Authority funding does not include Medical Services Plan or other Ministry of Health program payments to health authorities.

Payments to out-of-province hospitals within Canada for insured services (both in- and out-patient) provided to British Columbia residents totaled \$65.4 million, while payment to hospitals outside the country totaled \$4.5 million in 2004-2005.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer is recognized and reported by the Government of

British Columbia through various government websites and provincial government documents. In 2004-2005, these documents included:

- ❑ *Public Accounts 2003/04* (tabled June 29, 2004) www.fin.gov.bc.ca/ocg/pa/03_04/PA_2004_all.pdf
- ❑ *Budget and Fiscal Plan, 2004/05 to 2006/07* (tabled February 17, 2004) www.bcbudget.gov.bc.ca/bfp/default.htm
- ❑ *Estimates, Fiscal Year Ending March 31, 2005* (tabled February 17, 2004) www.bcbudget.gov.bc.ca/est/25-26_Health_Services.html

7.0 Extended Health Care Services (EHCS)

Home and community care services provide a comprehensive range of community-based health care and support services for eligible British Columbians with acute, chronic, palliative or rehabilitative health care needs. They are provided by health authorities, either directly or through partnerships with not-for-profit or for profit service providers. The Ministry of Health is responsible for establishing legislation and broad policy for areas such as licensing, eligibility and client fees.

Services complement and supplement, but do not replace, the efforts of individuals to care for themselves, with the assistance of family, friends and community.

In-home services include home care nursing, rehabilitation, home support and palliative care. Community-based services include adult day programs, meal programs, as well as assisted living, residential care services and hospice care. Case management services, which include an assessment to determine a client's needs, are provided in both the home and community. Depending on the type of care required and an individual's income, there may be a cost associated with some services.

Eligibility for Services

To be eligible for services such as home-care nursing or physiotherapy and occupational therapy, clients must:

- ❑ be a resident of British Columbia;
- ❑ be a Canadian Citizen or have permanent resident status¹; and
- ❑ require care following discharge from an acute care hospital, care at home rather than hospitalization or care because of a terminal illness.

To be eligible for subsidized services, such as home support, assisted living, adult day care, case management, residential care services and/or palliative care services, clients must:

- ❑ be 19 years of age or older;
- ❑ have lived in British Columbia for the required period of time (local health authorities can provide up-to-date information);
- ❑ be a Canadian Citizen or have permanent resident status¹; and
- ❑ be unable to function independently because of chronic, health-related problems or have been diagnosed by a doctor with an end-stage illness.

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

Residential care facilities provide 24-hour professional nursing care and supervision in a protective, supportive environment for adults who have complex care needs and can no longer be cared for in their own homes. Residential care clients pay a daily fee based on their after-tax income. Rates are adjusted annually based on the Consumer Price Index. The legislation pertaining to residential care facilities is the *Community Care and Assisted Living Act*, the *Adult Care Regulations*, the *Hospital Act*, the *Hospital Act Regulation*, the *Hospital Insurance Act*, the *Hospital Insurance Act Regulations*, and the

¹ Landed immigrant or on a Minister's permit approved by the Ministry of Health Medical Advisory Committee.

Continuing Care Act, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

Family care homes are single family residences that provide meals, housekeeping services and assistance with daily activities for up to two clients. The cost for family care homes is the same as for residential care facilities. The legislation pertaining to family care homes is the *Continuing Care Act*, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

Adults with disabilities can also live independently in the community in publicly funded group homes. Group homes are safe, affordable, four-bed to six-bed housing projects. They offer short- and long-term accommodation, skills training, peer support and counselling. Group home clients are responsible for operating costs, such as food and rent, not associated with their care. Rental costs vary, depending on income. The legislation pertaining to group homes is the *Continuing Care Act*, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

Assisted living residences provide housing, hospitality and personal assistance services for adults who can live independently, but require regular assistance with daily activities, usually because of age, illness or disabilities. Residences typically consist of one-bedroom apartments. Services include help with bathing, grooming, dressing or mobility. Meals, housekeeping, laundry, social and recreational opportunities and a 24-hour response system are also provided. Clients pay a monthly charge based on 70 percent of their after-tax income, up to a maximum of a combination of the average market rent for housing and hospitality in a particular geographic area and the actual cost of personal care. The legislation pertaining to assisted living residences is the *Community Care and Assisted Living Act*, the *Assisted Living Regulation*, the *Continuing Care Act*, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

Hospice services provide a residential home-like setting where supportive and professional care

services are provided to British Columbians of any age who are in the end stages of a terminal illness or preparing for death. Services may include medical and nursing care, advance care planning, pain and symptom management, and psychosocial, spiritual and bereavement support. There may be a charge for some hospice services. The legislation pertaining to hospices is the *Community Care and Assisted Living Act*, the *Adult Care Regulations*, the *Hospital Act* and the *Hospital Act Regulation*.

Services for Persons with Mental Illness and Substance Use Disorders

A variety of housing alternatives are also available through health authorities for persons with mental illness and substance use disorders. Residential care facilities provide 24-hour care and intensive treatment services. Supported housing facilities provide stable and secure housing while residents receive treatment or community reintegration services in the community. In addition, individuals with mental illnesses can reside and receive life-skills support in family care homes, which are private homes operated by families or individuals who are compensated for the services provided. Depending on the type of service required and an individual's income, there may be a charge for these services. The legislation pertaining to these residential services is the *Community Care and Assisted Living Act*, the *Adult Care Regulations*, the *Continuing Care Act*, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

7.2 Home Care Services

Home care nursing and community rehabilitation services are professional services, delivered to people of all ages by registered nurses and rehabilitation therapists. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination and direct care or treatment for clients with chronic, acute, palliative or rehabilitative needs. There is no charge for these services.

Home support services help clients remain in their own homes. Home support workers provide personal assistance with daily activities, such as bathing, dressing, grooming and, in some cases, light household tasks that help maintain a safe and supportive home. Depending on an individual's income, there may be a cost associated with home support services. The legislation pertaining to home support services is the *Continuing Care Act*, the *Continuing Care Programs Regulation* and the *Continuing Care Fees Regulation*.

End-of-life care preserves clients' comfort, dignity and quality of life by relieving or controlling symptoms so those facing death, and their loved ones, can devote their energies to embracing the time they have together. Professional care givers and support staff provide supportive and compassionate care in the client's home, in hospital, hospice, an assisted living residence or a residential care facility. Depending on the type of care required and an individual's income, there may be a cost associated with some services.

A Palliative Care Benefits Program was implemented in 2001 to provide people living at home who are nearing the end of their life with approved medications for pain or symptom relief and some medical supplies and equipment, at no charge. Approved medications can be obtained through a local pharmacy.

7.3 Ambulatory Health Care Services

Adult day programs assist seniors and adults with disabilities to be independent. They provide supportive group programs and activities that give clients a chance to be more involved in their community and offer care providers a break. Services vary with each centre, but may include personal care, social activities, meals and transportation. Centres usually charge a small daily fee to assist with the cost of craft supplies, transportation and meals. The legislation pertaining to adult day programs is the *Continuing Care Act* and the *Continuing Care Programs Regulation*.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	3,804,133	3,981,617	4,019,744	4,084,463	4,182,682

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#): ¹					
a. acute care	94	94	92	92	92
b. chronic care	18	18	18	18	18
c. rehabilitative care	3	3	3	3	4
d. other	25	25	25	24	23
e. total	140	140	138	137	137
3. Payments (\$): ²					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	1	1	1	11	17
b. diagnostic imaging facilities	not available	not available	not available	0	1
c. total	1	1	1	11	18
5. Number of insured hospital services provided (#): ³					
a. surgical facilities	634	689	612	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	634	689	612	not available	not available
6. Payments (\$):					
a. surgical facilities	348,700	353,100	358,600	1,470,370	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	348,700	353,100	358,600	1,470,370	not available

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	4,359	4,430	4,471	4,573	4,629
b. specialists	3,297	3,380	3,421	3,510	3,642
c. other	0	0	0	0	0
d. total	7,656	7,810	7,892	8,083	8,271
8. Number of opted-out physicians (#):					
a. general practitioners	3	3	3	3	4
b. specialists	5	3	3	2	2
c. other	0	0	0	0	0
d. total	8	6	6	5	6
9. Number of not participating physicians (#):					
a. general practitioners	1	1	1	1	1
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	1	1	1	1	1
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	23,037,717	22,786,171	23,099,256	23,930,105	23,684,535
b. specialists	34,565,990	36,207,479	38,541,400	39,828,847	42,264,671
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	57,603,707	58,993,650	61,640,656	63,758,952	65,949,206
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	665,989,273	720,487,209	749,875,492	772,938,345	760,104,435
b. specialists	969,589,022	1,076,322,482	1,154,109,934	1,193,934,257	1,196,269,921
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,635,578,295	1,796,809,691	1,903,985,426	1,966,872,602	1,956,374,356
12. Average payment per <u>fee-or-service</u> service (\$):					
a. general practitioners	28.91	31.62	32.46	32.30	32.09
b. specialists	28.05	29.73	29.94	29.98	28.30
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all services	28.39	30.46	30.89	30.85	29.66
13. Number of services provided through <u>all payment methods</u> (#): ⁴					
a. medical	25,201,483	24,994,070	25,423,944	25,921,437	26,082,947
b. surgical	4,417,069	4,317,461	4,393,613	4,520,151	4,590,296
c. diagnostic	27,985,155	29,682,119	31,823,099	33,317,364	35,275,963
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	57,603,707	58,993,650	61,640,656	63,758,952	65,949,206
14. Total payments to physicians paid through <u>all payment methods</u> (\$): ⁴					
a. medical	942,736,513	1,025,581,421	1,068,441,470	1,093,491,339	1,101,606,113
b. surgical	252,828,480	279,710,272	296,852,610	307,627,814	313,878,348
c. diagnostic	440,013,302	491,517,998	538,691,346	565,753,449	540,889,895
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,635,578,295	1,796,809,691	1,903,985,426	1,966,872,602	1,956,374,356
15. Average payment per service, <u>all payment methods</u> (\$): ⁴					
a. medical	37.41	41.03	42.03	42.18	42.23
b. surgical	57.24	64.78	67.56	68.06	68.38
c. diagnostic	15.72	16.56	16.93	16.98	15.33
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. all services	28.39	30.46	30.89	30.85	29.66

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	8,113	8,113	7,618	7,294	7,467
17. Total number of claims, out-patient (#).	83,765	80,732	83,152	81,911	80,386
18. Total payments, in-patient (\$).	35,882,521	40,898,996	40,195,515	45,318,174	51,869,175
19. Total payments, out-patient (\$).	9,149,496	10,604,141	11,223,254	11,105,322	13,574,737
20. Average payment, in-patient (\$).	4,422.84	5,041.17	5,276.39	6,213.08	6,946.45
21. Average payment, out-patient (\$).	109.23	131.35	134.97	135.58	168.87
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	579,390	543,210	625,939	647,761	624,160
23. Total payments (\$).	18,541,081	18,934,857	22,687,705	24,151,538	23,470,331
24. Average payment per service (\$).	32.00	34.86	36.25	37.28	37.60

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	2,097	1,964	1,795	1,970	2,294
26. Total number of claims, out-patient (#).	720	637	949	611	761
27. Total payments, in-patient (\$).	6,463,676	9,246,228	2,294,341	2,365,051	3,811,717
28. Total payments, out-patient (\$).	134,789	119,928	543,969	294,712	741,617
29. Average payment, in-patient (\$).	3,082.34	4,707.86	1,278.18	1,200.53	1,661.60
30. Average payment, out-patient (\$).	187.21	188.27	573.20	482.34	974.53
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	77,973	71,940	71,377	57,093	57,172
32. Total payments (\$).	3,281,934	3,013,045	3,083,949	2,458,027	2,421,817
33. Average payment per service (\$).	42.09	41.88	43.21	43.05	42.36

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	283	275	249	243	228
35. Number of services provided (#).	55,643	43,505	36,680	36,809	38,310
36. Total payments (\$).	6,321,864	5,401,691	5,379,450	5,164,249	5,268,900
37. Average payment per service (\$).	113.61	124.16	146.66	140.30	137.53

Endnotes

For items 1-2: All data is preliminary for 2004-2005. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

1. In British Columbia, the categories under which these facilities are reported in these tables do not match those normally used in the BC Ministry of Health, but facilities have been matched as closely as possible.
 - Acute Care includes acute care in-patient facilities, acute care ambulatory facilities and psychiatric in-patient facilities
 - Chronic Care includes extended care facilities
 - Rehabilitative care includes rehabilitation facilities
 - Other includes diagnostic and treatment centres

The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the *Societies Act* because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

2. Payments to Health Authorities for the provision of the full range of regionally delivered services are as follows: \$4.59 billion in 1999-2000; \$5.20 billion in 2000-2001; \$5.62 billion in 2001-2002; \$6.06 billion in 2002-2003; and \$6.21 billion in 2003-04. Payments to Health Authorities in 2004-2005, (base and one-time payments), totalled \$6.25 billion.
3. There are approximately 49 private facilities licensed by the College of Physicians and Surgeons of British Columbia. These facilities provide mostly non-*Canada Health Act* services. Under the *Medicare Protection Act*, they are prohibited from extra-billing for any insured services. The numbers reported here reflect the number of private surgical facilities contracted with health authorities.
4. Data is available for "fee-for-service" only. Information is not available for the Alternative Payments Program. The data for 2004-2005 reflects dates of service April 1, 2004 to March 31, 2005, paid as of August 31, 2005.

Yukon

Introduction

The health care insurance plans operated by the Government of Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director, Insured Health and Hearing Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. There are no regional health boards in the Territory.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services according to the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory on uniform terms and conditions. The Minister, Department of Health and Social Services, is responsible for delivering all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 31,505 eligible persons registered with the Yukon health care plan on March 31, 2005.

Other insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program; Chronic Disease and Disability Benefits Program; Pharmacare and Extended Benefits

Programs; and the Children's Drug and Optical Program. Noninsured health service programs include Continuing Care; Community Nursing; Community Health; and Mental Health Services.

Health care initiatives in the Territory target areas such as access and availability of services, recruitment and retention of health care professionals, primary health care, systems development and alternative payment and service delivery systems. Specifically:

- in cooperation with the Province of British Columbia, Yukon produced a 384-page book designed to help Yukoners manage their health. This book was delivered to households and agencies throughout Yukon. An associated website – www.ykhealthguide.org – was linked to the book;
- primary care initiatives are proceeding that will broaden and strengthen service delivery, modernize and improve system capabilities. These initiatives include:
 - Mental Health - Synapse, a system for clinical management, has been implemented;
 - Public Health - the immunization module of iPHIS, a public health information system, has been implemented in Whitehorse and Haines Junction and is now being implemented in all other Yukon communities; and
 - Insured Health Information System - a vendor for this system has been chosen through a tendering process and detailed planning is now underway;
- work with the Yukon Medical Association to find solutions for a number of Yukon residents without a family physician;
- production of *The Report to Yukoners on Comparable Health and Health System Indicators* is the second report of its type, the first being issued in fall 2002. Overall, the report shows that Yukoners have a high satisfaction rate with their health care system; and
- Diabetes Collaborative, which helps physicians provide improved care for patients with diabetes.

The 2004-2005 health care expenditures increased over the 2003-2004 expenditures as follows:

- Insured Health Services increased by \$3,834,000;
- Yukon Hospital Services increased by \$1,273,000;
- Continuing Care increased by \$2,303,000;
- Community Nursing and Emergency Medical Services increased by \$1,199,000; and
- Community Health Programs increased by \$189,000.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

- effective linkages and coordination of existing services and service providers;
- recruitment and retention of qualified health care professionals;
- increasing costs related to service delivery;
- increasing costs related to changing demographics; and
- acquiring and maintaining new and advanced high-technology diagnostic and treatment equipment.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, sections 3(2) and 4, establish the public authority to operate the health medical care plan. There were no amendments made to these sections of the legislation in 2004-2005.

The *Hospital Insurance Services Act*, sections 3(1) and 5, establish the public authority to operate the health hospital care plan. There were no amendments made to these sections of the legislation in 2004-2005.

Subject to the *Health Care Insurance Plan Act* (section 5) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in operating the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of Yukon's right of subrogation under this Act to the rights of insured persons;
- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the hospital insurance plan;
- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research programs and obtain statistics for such purposes;

- ❑ appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
- ❑ prescribe the forms and records necessary to carry out the provisions of this Act; and
- ❑ perform such other functions and discharge such other duties as may be assigned by the regulations.

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 Executive Council Member 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 for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report, to be tabled December 2005, covers the fiscal years 1999-2000 to 2004-2005.

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 30 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.

The most recent audit was for the year ended March 31, 2005.

Regarding the Yukon Hospital Corporation, section 11(2) of the *Hospital Act* requires every hospital to submit a report of the operations of the Corporation for that fiscal year, the report to include the financial statements of the Corporation and the auditor's report. The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

1.4 Designated Agency

The Yukon Health Care Insurance Plan has no other designated agencies authorized to receive monies or to issue payments pursuant to the *Health Care Insurance Plan Act* or the *Hospital Insurance Services Act*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 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. There were no amendments made to these sections of the legislation in 2004-2005.

In 2004-2005, insured in-patient and out-patient hospital services were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital¹ and 12 Health Centres.² Additional visiting nursing services are provided from one satellite health station.³

1 This facility provides 24-hour emergency treatment, short-term admissions and respite care

2 Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

3 Community Nurse Practitioners provide itinerant services on a regularly scheduled basis.

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 *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 establishes and maintains a quality assurance program. Currently, the Yukon Hospital Corporation is operated under a three-year accreditation through the Canadian Council on Health Services Accreditation.

The Yukon government assumed responsibility for operating Health Centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/Nursing Station Facility/Health Centre Treatment Facility, and the Community Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the *Hospital Insurance Services Regulations*, sections 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:

- (i) accommodation and meals at the standard or public ward level,
- (ii) necessary nursing service,
- (iii) 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,
- (iv) drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital,

- (v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
- (vi) routine surgical supplies,
- (vii) use of radiotherapy facilities where available,
- (viii) use of physiotherapy facilities where available,
- (ix) services rendered by persons who receive remuneration therefore from the hospital.

Section 2(f) of the same 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, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely:

- (i) necessary nursing service,
- (ii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury,
- (iii) drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital,
- (iv) use of operating room and anaesthetic facilities, including necessary equipment and supplies,
- (v) routine surgical supplies,
- (vi) services rendered by persons who receive remuneration therefore from the hospital,
- (vii) use of radiotherapy facilities where available,
- (viii) use of physiotherapy facilities where available.

Pursuant to the *Hospital Insurance Services Regulations*, all in- 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, Department of 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.

A total of \$600,00 was dedicated for the purchase of new hospital equipment, this included new anesthesia and ventilation equipment. Cardiac stress testing and echocardiography equipment was purchased for \$101,000. PACS digital medical imaging software to allow medical images read by radiologists located off-site was also acquired in the fiscal year ending March 31, 2005.

In 2004-2005 two new ambulances and supplies and training equipment were purchased for Whitehorse to support rural Emergency Medical Services personnel to maintain and upgrade their current skill set.

These measures will help reduce the Territory's reliance on out-of-territory services.

2.2 Insured Physician Services

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. There were no amendments made to these sections of the legislation in 2004-2005.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are to:

- ☐ register for licensure pursuant to the *Medical Professions Act*; and
- ☐ maintain licensure pursuant to the *Medical Professions Act*.

The estimated number of resident physicians participating in the Yukon Health Care Insurance Plan in 2004-2005 was 62.

Section 7(5) of the *Yukon Health Care Insurance Plan Regulations* allows physicians in the Territory to bill patients directly for insured services by giving notice in writing of this election. In 2004-

2005, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations. Services not covered by the Plan include advice by telephone; medicallegal services; preparation of records and reports; services required by a third party; cosmetic services; and services determined to be not medically required.

Insured services added in 2004-2005 include:

- ☐ limited general practitioner consult;
- ☐ pain management, acute or chronic in hospital by certified anaesthetist;
- ☐ visit (in Emergency Department at Whitehorse General Hospital);
- ☐ complete examination (in Emergency Department at Whitehorse General Hospital); and
- ☐ second extensive examination (in emergency department at Whitehorse General Hospital).

The process used to add a new fee to the Relative Value Guide to Fees⁴ 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 costs or fees are normally set in accordance with similar costs or 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 Director, Insured Health and Hearing Services, manages this process and no public consultation is required.

4 Physician's fee guide manual.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the Territory 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. In 2004-2005, six dentists billed the Plan for insured dental services that were provided to Yukon residents. The Plan is also billed directly for services provided outside the territory.

Dentists are able to opt out of the health care plan in the same manner as physicians. In 2004-2005, no dentists provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Regulations and require the unique capabilities of a hospital for their performance (e.g. surgical correction of prognathism or micrognathia).

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 *Regulations Respecting Health Care Insurance Services*. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services, administers this process.

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 physician services include:

- ☐ services that are not medically necessary;
- ☐ charges for long-distance telephone calls;
- ☐ preparing or providing a drug;

- ☐ advice by telephone at the request of the insured person;
- ☐ medicolegal services including examinations and reports;
- ☐ cosmetic services;
- ☐ acupuncture; and
- ☐ experimental procedures.

Section 3 of the *Yukon Health Care Insurance Plan Regulations* contains a nonexhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include:

- ☐ non-resident hospital stays;
- ☐ special/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.)

Uninsured dental services include:

- ☐ procedures considered restorative; and
- ☐ procedures that are not performed in a hospital under general anaesthesia.

Further, the Act states that any service that a person is eligible for, and entitled to, under any other Act is not insured.

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 noninsured services, such as fibreglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

The Territory 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.

Physicians in the Territory may bill patients directly for noninsured 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; thirdparty 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.

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 Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees, 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, 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. The Director, Insured Health and Hearing Services, manages this process. No services were removed from the Relative Value Guide to Fees in fiscal year 2004-2005.
- Hospital services – an amendment by Order-In-Council to section 2 (e) (f) of the *Yukon Hospital Insurance Services Regulations* would be required. As of March 31, 2005, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been deinsured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- Surgical-dental services – an amendment by Order-In-Council to Schedule B of the *Regulations Respecting Health Care Insurance Services* 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.

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 respectively, and the *Hospital Insurance Services Act* and Regulations, sections 2 and 4 respectively. 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 the Yukon, but does not include a tourist, transient or visitor to the Yukon. Where applicable, the eligibility of all persons is administered in accordance with the Inter-Provincial 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".

Changes affecting eligibility made to the legislation in 2004-2005 now require that all persons returning to or establishing residency in Yukon complete the waiting period. The only exception is for children adopted by insured persons.

The following persons are not eligible for coverage in the Yukon:

- persons entitled to coverage from their home province or territory (e.g. students and workers covered under temporary absence provisions);
- visitors to the Territory;

- ☐ refugee claimants;
- ☐ members of the Canadian Forces;
- ☐ members of the Royal Canadian Mounted Police (RCMP);
- ☐ inmates in federal penitentiaries;
- ☐ study permit holders; 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 the Territory;
- ☐ become a permanent resident; and
- ☐ the day following discharge or release if stationed in or resident in the Territory.

3.2 Registration Requirements

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the Regulations from so doing, shall register himself and his dependants with the Director, Insured Health and Hearing Services, at the place and in the manner and form and at the times prescribed by the Regulations". Registration is administered in accordance with the Inter-Provincial Agreement on Eligibility and Portability.

Persons and dependants under the age of 19 who move permanently to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form available from the Insured Health and Hearing Services office or community Territorial Agents. Once coverage becomes effective, a health care card is issued.

Family members receive separate health care cards and numbers. Health care cards expire every year on the resident's birthday and an updated label with the new expiry date is mailed out accordingly.

As of March 31, 2005, there were 31,505 residents registered with the Yukon Health Care

Insurance Plan. There were no residents who notified Insured Health Services of their decision to opt out of the Yukon Health Care Insurance Plan in 2004-2005.

3.3 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals as follows:

Returning Canadians	Waiting period is applied.
Permanent Residents ⁵	Waiting period is applied.
Minister's Permit	Waiting period is applied if authorized.
Convention Refugees	Waiting period is applied if holding Employment
Foreign Workers	Waiting period is applied if holding Employment
Clergy	Waiting period is applied if holding Employment
* Employment Authorization must be in excess of 12 months	

The estimated number of new individuals receiving coverage in 2004-2005 under the following conditions is:

Returning Canadians	43
Permanent Residents	57
Minister's Permit	0
Convention Refugees	0

⁵ Previously referred to as "landed immigrants".

The estimated number of individuals receiving coverage in 2004-2005 under the following conditions is:

Foreign Workers	39
Clergy	0

3.4 Premiums

The payment of premiums by Yukon residents was eliminated on April 1, 1987.

4.0 Portability

4.1 Minimum Waiting Period

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 entitled to coverage are required to complete the minimum waiting period with the exception of children adopted from outside Canada by insured persons. (See section 3.1.)

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 is entitled to insured services during a period of 12 months continuous absence".

Persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in cancellation of the coverage.

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services, may approve other absences in excess of 12 continuous 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, Insured Health and Hearing Services, may approve absences in excess of 12 continuous 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 Inter-Provincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures.

No amendments were made to these sections of the legislation in 2004-2005.

The Yukon participates fully with the Inter-Provincial 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 the 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 the 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. The following amounts were paid to out-of-territory hospitals for the fiscal year 2004-2005:

In-patient services	Out-patient services
\$5,857,725	\$1,306,531

Note: Figures are by date of service and subject to adjustment.

In 2004-2005 payments to out-of-territory and out-of-country physicians totaled \$1,921,260.

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*. No amendments were made to these sections of the legislation in 2004-2005.

Sections 5 and 6 state that "Where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence".

Persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". 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.)

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 the 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. The standard ward rate for the Whitehorse General Hospital as of April 1, 2004, was \$1,246. This rate is established through Order-in-Council and are derived as follows:

- Standard Ward Rate = (total operating expenses - non-related in-patient costs-related newborn costs - associated out-patient costs) / (total patient days - patient days for other services; e.g. non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the *Charges for Out-Patient Procedures Regulation*. The out-patient rate is currently \$153 and is established through Order-in-Council and derived by the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC).

The following amounts were paid in 2004-2005 for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
\$30,566	\$9,965

Note: Figures are by service date and subject to adjustment.

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 Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers.

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.

There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Pursuant to the *Hospital Act*, the “Legislature and Government have responsibility to ensure the availability of necessary hospital facilities and programs”. The Minister must approve any significant changes to the level of service delivery. Acute care beds are readily available and no waitlist for admission exists at either of Yukon’s two acute care facilities.

The estimated number of fulltime equivalent (FTEs) nurses and other health care professionals working in facilities providing insured hospital services in the Yukon as of March 31, 2005, is:

Profession	Whitehorse General Hospital	Watson Lake Cottage Hospital
	# of FTEs	# of FTEs
Registered Nurses	74.5	7.5
Licensed Practical	8	2*
Nurse Pract.	0	0
Social Worker	1	0
Pharmacist	2	0
Physiotherapist	4.40	0
Occup. Therapist	1.40	0
Psychologist	0	0
Medical Lab/X-Ray	25.5	0
Dietician	3.75	0
Public Health	0	2
Home Care	0	1

The Whitehorse General Hospital and Community Nursing manage the supply of nurses and health care professionals in the Territory’s two hospitals with the Department of Health and Social Services. Shortfalls in staffing are covered by temporary, casual or auxiliary workers to ensure residents have continued access to insured services.

Recruitment and Retention

Recruitment and retention initiatives include:

Community Nursing

A Yukon Advisory Committee on Nursing was struck to advise the Department of Health and Social Services on nursing issues.

Recommendations will help Yukon recruit and

retain nurses in both the long and short term. Yukon is providing:

- ☐ competitive salaries;
- ☐ recruitment and retention bonuses;
- ☐ participation at job fairs;
 - training and educational opportunities;
 - travel bonus / \$2,000 after one year; and
 - relief positions.

Whitehorse General Hospital

- ☐ competitive salaries;
- ☐ wage scale recognizes experience;
- ☐ cooperative work schedules;
- ☐ on-site fitness centre/24-hour;
- ☐ monthly clinical skill development;
- ☐ continuing education/development; and
- ☐ travel bonus / \$2,000 after one year.

Facilities

Whitehorse General Hospital: As the only major acute care hospital facility in the Territory, this facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide Emergency Department services on rotation.

Emergency surgery patients at the Whitehorse General Hospital are normally seen within 24 hours. Elective surgery patients are normally seen within one to two weeks. The number of Visiting Specialist clinics is routinely adjusted to address wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3).

Surgical services provided include:

- ☐ minor orthopaedics;
- ☐ selected major orthopaedics;
- ☐ gynecology;
- ☐ paediatrics;
- ☐ general abdominal;
- ☐ mastectomy;
- ☐ emergency trauma;
- ☐ ear/nose/throat/otolaryngology; and
- ☐ ophthalmology including cataracts.

Diagnostic services include:

- ☐ radiology (including ultrasound, computed tomography, xray and mammography);
- ☐ laboratory; and
- ☐ electrocardiogram.

Selected rehabilitative services are available through out-patient therapies.

Watson Lake Cottage Hospital: This primary acute care facility is located in Watson Lake. Medical services include emergency trauma, low-risk maternity, medicine, paediatrics, palliative and respite care. Diagnostic services include x-ray, laboratory and electrocardiogram. This is a 12-bed facility and there is no waitlist for admission.

Health Centres: Out-patient and 24-hour emergency services are provided at the remaining 12 community Health Centres by Community Nurse Practitioners and auxiliary nursing staff.

Patients requiring insured hospital services not available locally are transferred to acute care facilities interterritory or out-of-territory through the Travel for Medical Treatment Program.

Measures to Improve Access

A number of measures have been taken to better manage access to insured hospital services. The Department of Health and Social Services continues to work with the Yukon Hospital Corporation and Community Nursing to ensure the current waiting time for insured hospital services in the Territory is reduced or maintained at existing levels. For example:

- ☐ Heart defibrillators were made available in all rural Yukon Health Centres. This provides an important tool for Community Nurse Practitioners and improves local access to cardiac care.
- ☐ Officials from the Department attend nursing recruitment fairs across Canada and provide information on working in the Territory to nurses in attendance.
- ☐ The Technical Review Committee continues to make recommendations to the Department on health programs and services in the Yukon as required. Its mandate is to develop criteria for initiating, eliminating, expanding or reducing programs or services.
- ☐ Telehealth provides real-time video in most Yukon communities and outlying rural communities with access to Whitehorse, and services to Whitehorse with outside centres in

British Columbia or Alberta. Funding was provided through the Canada Health Infrastructure Partnerships Program (CHIPP) to October 31, 2003.

- Telehealth educational sessions have occurred regularly between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia. These sessions have been attended by patients, physicians, nurses, social workers, psychiatrists, mental health counsellors and allied professionals such as Community Health Representatives and First Nation Wellness workers.

5.3 Access to Insured Physician and Surgical-Dental Services

Existing legislation and administration of services provides all eligible Yukon residents with equal access to insured physician and dental services on uniform terms and conditions.

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2005, (see Statistical Annex item #7):

General Practitioners/Family Practitioners	54
Specialists	8
Dentists	6

Beyond the usual distribution of physicians and specialists in the Territory, uniform access to insured physician and dental services is ensured through the Travel for Medical Treatment Program. This program covers the cost of medically necessary transportation, allowing eligible persons to access services that are not available in their home communities. Eligible persons are routinely sent to Whitehorse, Vancouver, Edmonton or Calgary to receive services.

Most physicians in the Yukon are located in Whitehorse. Beyond Whitehorse, only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two

contracted physicians provide resident services in Faro and Mayo.

The Visiting Physician Program provides local access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians providing visiting services through this program are compensated under contract for lost practice time, mileage, meals and accommodation, in addition to a sessional rate or fee-for-service billings.

In addition, the Department of Health and Social Services and the Visiting Specialist Program provide local access at the Whitehorse General Hospital, Mental Health Services or the Yukon Communicable Disease Unit to non-resident visiting specialist services not regularly available in the Territory. Visiting specialists are reimbursed for expenses in addition to a sessional rate or fee-for-service billings.

The number of specialists providing services under the Visiting Specialist Program and the Department of Health and Social Services is:

Ophthalmology	1
Oncology	3
Orthopaedics	4
Internal Medicine	2
Otolaryngology	2
Neurology	2
Rheumatology	1
Dermatology	1
Dental Surgery*	3
Infectious Disease*	1
Psychiatry*	3

* Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Visiting Specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2005, the waitlist for nonemergency specialist services was estimated at:

Ophthalmology	12-18 months
Orthopaedics	2-12 months
Otolaryngology	0 months
Neurology	2-5 months
Rheumatology	3-5 months
Dental Surgery*	2-3 months

* Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Note: There is no waitlist for visiting services not included in the above listing. Patients are seen on the next scheduled visit (i.e., Oncology, Internal Medicine, Dermatology, Infectious Disease and Psychiatry).

The Department of Health and Social Services has taken several measures to reduce waiting times for insured physician services. A variety of recruitment and retention initiatives were begun in 2001-2002 and 2002-2003 such as a Resident Support Program; Locum Support Program; Physician Relocation Program; Education Support; and a Rural Training Fund. The Department of Health and Social Services continues to work with the Yukon Medical Association to find additional cooperative initiatives to be implemented within the terms of the renewed Memorandum of Understanding in April 1, 2004.

Other measures taken in 2004-2005 to ensure access and reduce wait times:

- Yukon has declared a need that will permit internationally trained medical graduates to be granted a special license to practice in Yukon. These physicians will work under the supervision of a resident Yukon physician and provide medical services to the residents of Whitehorse. Since May of this year, the Yukon Medical Council has licensed five of these physicians.

The Yukon Medical Council and the Department of Health and Social Services are promoting a program that provides clinical assessments for international medical graduates to ensure they have the necessary skills and experience to provide a high standard of care to Yukon patients.

Physicians have indicated that they are interested in exploring new models for health care provision. The Government is working with physicians in Yukon to facilitate this.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, before entering 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 most recent four-year Memorandum of Understanding came into effect April 1, 2004, and shall remain in effect to March 31, 2008. This MOU establishes the terms and conditions for payment of physicians and established two new programs: New Patient Program, and Physician Retention Program.

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*. No amendments were made to these sections of the legislation in 2004-2005.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2004-2005, two full-time resident rural physicians and four resident specialists were compensated on a contractual basis. Two physicians providing visiting clinics in outlying communities were paid a sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital) through global 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 and utilization projections from prior years. 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.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The Watson Lake Cottage Hospital and all Health Centres are funded through the Yukon government's budget process.

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. No amendments were made to these sections of the legislation in 2004-2005.

6.0 Recognition Given to Federal Transfers

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2003-2004 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1) (d) (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. These documents are available to Health Canada as part of the Additional Materials section.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care

Continuing Care Health Services are available to eligible Yukon residents. In 2004-2005, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services:

- ☐ personal care;
- ☐ extended care services;
- ☐ intermediate care;
- ☐ special care;
- ☐ respite;
- ☐ day program; and
- ☐ meals on wheels.

A new continuing care facility was opened in summer 2002 with 83 beds staffed and in operation. Twelve additional beds can be made available should future occupancy trends indicate a need.

In total, there were 113 continuing care beds in the Territory in 2004-2005.

There is no legislated requirement for long-term residential care services for adults in Yukon.

No other major changes were made in the administration of these services in 2004-2005.

7.2 Home Care Services

The Yukon Home Care Program provides assessment and treatment, care management, personal support, homemaking services, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. In most rural communities, nursing services are provided through the community nursing program and home support workers assist clients with personal care, homemaking and respite services. Therapy services are provided by a travelling regional team of physiotherapists and occupational therapists. Services are available

Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided. Twenty-four hour care is not available.

There is no legislated requirement for home care services in Yukon.

No other major changes were made in the administration of these services in 2004-2005.

7.3 Ambulatory Health Care Services

The Yukon Home Care Program provides the majority of ambulatory health care services outside institutional settings. Most other services are provided through Community Nursing or public health. All residents have equal access to services.

These services are not provided for in legislation. There were no changes made in the administration of these services in 2004-2005. In addition to the services described above, the following are also available to eligible Yukon residents outside the requirements of the *Canada Health Act*:

- **The Chronic Disease and Disability Benefits Program** provides benefits for eligible Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medicalsurgical supplies and equipment. (*Chronic Disease and Disability Benefits Regulation*)
- **The Pharmacare Program and Extended Benefits programs** are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services and medicalsurgical supplies and equipment. (*Pharmacare Plan Regulation* and *Extended Health Care Plan Regulation*)
- **The Travel for Medical Treatment Program** assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation to receive services not available locally. (*Travel for Medical Treatment Act* and *Travel for Medical Treatment Regulation*)

- **The Children's Drug and Optical Program** is designed to assist eligible low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 and younger. (*Children's Drug and Optical Program Regulation*)
- **Mental Health Services** provide assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. (*Mental Health Act* and *Mental Health Act Regulations*)
- **Public Health** is designed to promote health and well-being throughout the Territory through a variety of preventive and education programs. This is a non-legislated program.
- **Emergency Medical Services** is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non-legislated program.
- **Hearing Services** provides services designed to help people of all ages with a variety of hearing disorders, by providing routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.
- **Dental Services** provides a comprehensive diagnostic, preventive and restorative dental service to children from preschool to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for preschool to grade 12. This is a non-legislated program.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	31,133	31,036	30,534	30,917	31,505

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	13 ¹	13 ¹	13 ¹	13 ¹	13 ¹
e. total	15	15	15	15	15
3. Payments (\$):					
a. acute care	20,350,026	21,920,937	22,515,448	24,877,479	26,255,596
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	5,483,948 ¹	5,997,920 ¹	6,133,453 ¹	6,318,565 ¹	8,503,986
e. total	25,833,974	27,918,907	28,648,901	31,196,044	34,759,582
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments (\$):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004 ²	2004-2005 ²
7. Number of participating physicians (#): ³					
a. general practitioners	43	49	53	55	54
b. specialists	6	5	6	8	8
c. other	0	0	0	0	0
d. total	49	54	59	63	62
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	164,497	160,932	186,479	191,002	207,053
b. specialists	14,789	11,881	11,040	10,460	11,978
c. other	0	0	0	0	0
d. total	179,286	172,813	197,519	200,462	219,031
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	5,803,619	5,692,583	6,740,552	7,336,403	8,168,042
b. specialists	1,263,380	1,143,968	971,283	984,711	1,033,537
c. other	0	0	0	0	0
d. total	7,066,999	6,836,551	7,711,835	8,321,114	9,201,579
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	35.28	35.38	36.15	38.61	39.45
b. specialists	85.43	96.29	87.98	94.14	86.29
c. other	0.00	0.00	0.00	0.00	0.00
d. all services	39.42	39.56	39.04	41.51	42.01
13. Number of services provided through <u>all payment methods</u> (#): ⁴					
a. medical	131,685	131,004	154,591	151,825	171,657
b. surgical	25,670	26,653	26,388	31,894	31,036
c. diagnostic	18,978	15,156	16,540	16,472	16,338
d. other	0	0	0	0	0
e. total	176,333	172,813	197,519	200,461	219,031
14. Total payments to physicians paid through <u>all payment methods</u> (\$): ⁴					
a. medical	5,729,729	5,550,975	6,386,109	6,802,367	7,722,884
b. surgical	1,028,529	1,057,467	1,029,697	1,257,750	1,289,558
c. diagnostic	308,741	228,109	296,029	260,997	189,137
d. other	0	0	0	0	0
e. total	7,066,999	6,836,551	7,711,835	8,321,114	9,201,579
15. Average payment per service, <u>all payment methods</u> (\$): ⁴					
a. medical	43.51	42.38	41.31	44.80	44.99
b. surgical	40.07	39.68	39.02	39.44	41.55
c. diagnostic	16.27	15.05	17.90	15.04	11.58
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	40.08	39.56	39.04	41.51	42.01

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	719	663	666	783	674
17. Total number of claims, out-patient (#).	6,760	6,547	7,241	6,938	7,412
18. Total payments, in-patient (\$).	4,218,846	4,299,055	5,861,530	7,587,906	5,857,725
19. Total payments, out-patient (\$).	861,375	945,804	1,037,692	936,376	1,306,531
20. Average payment, in-patient (\$).	5,867.66	6,484.25	8,801.10	9,690.81	8,690.99
21. Average payment, out-patient (\$).	127.43	144.47	143.31	134.96	176.27
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	36,828	32,461	34,853	34,037	35,401
23. Total payments (\$).	1,642,495	1,601,642	1,799,019	1,833,654	1,921,260
24. Average payment per service (\$).	44.60	49.34	51.62	53.87	54.27

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	9	15	9	8	14
26. Total number of claims, out-patient (#).	54	40	26	46	64
27. Total payments, in-patient (\$).	27,520	50,599	9,339	13,536	30,566
28. Total payments, out-patient (\$).	8,368	4,431	2,451	5,994	9,965
29. Average payment, in-patient (\$).	3,057.78	3,373.27	1,037.67	1,692.00	2,183.29
30. Average payment, out-patient (\$).	154.97	110.78	94.27	130.30	155.70
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	not available	not available	not available	not available	not available
32. Total payments (\$).	not available	not available	not available	not available	not available
33. Average payment per service (\$).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory ⁵					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	11	11	8	6	6
35. Number of services provided (#).	222	214	150	104	30
36. Total payments (\$).	50,876	51,078	37,342	25,093	29,712
37. Average payment per service (\$).	229.17	238.69	248.95	241.28	990.40

Insured Physician Services Within Own Province or Territory visiting Specialists, Locum Doctors and Member Reimbursements ⁶					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
38. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	32,986	18,663	21,896	21,109	5,264
b. specialists	7,009	11,323	12,830	6,165	7,771
c. total	39,995	29,986	34,726	27,274	13,035
39. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	1,156,197	699,718	788,293	819,490	243,203 ⁷
b. specialists	303,424	885,944	1,192,364	1,020,988	1,252,498
c. total	1,459,621	1,585,662	1,980,657	1,840,478	1,495,701
40. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	35.05	37.50	36.00	38.82	46.20
b. specialists	43.29	78.25	92.94	165.61	161.18
c. total	36.50	52.88	57.04	67.48	114.74
41. Number of services provided <u>through-fee-for-service</u> (#): ⁴					
a. medical	31,099	23,431	25,402	23,466	8,999
b. surgical	6,121	4,888	7,510	2,097	2,656
c. diagnostic	2,775	1,667	1,814	1,711	1,380
d. total	39,995	29,986	34,726	27,274	13,035
42. Total payments to physicians paid through <u>fee-for-service</u> (\$): ⁴					
a. medical	1,133,717	1,224,899	1,392,766	1,371,373	1,021,817
b. surgical	260,188	285,503	481,940	374,435	368,891
c. diagnostic	65,716	75,261	105,951	94,671	104,993
d. total	1,459,621	1,585,663	1,980,657	1,840,479	1,495,701
43. Average payment per <u>fee-for-service</u> service (\$): ⁴					
a. medical	36.46	52.28	54.82	58.44	113.55
b. surgical	42.51	58.41	64.17	178.56	138.89
c. diagnostic	23.68	45.15	58.41	55.33	76.08
d. all services	36.50	52.88	57.04	67.48	114.74

Endnotes

1. Includes 12 health centres and one satellite health station.
2. Includes on-call payments to physicians.
3. Includes only resident family physicians and specialists.
4. Excludes services and costs provided by physicians under alternative payment agreements.
5. Includes direct billings for insured surgical-dental services received outside the territory.
6. Excludes services and costs provided by alternative payment agreements. Visiting Specialists, Member Reimbursements, Optometrists, and Locum Doctors, questions 38-43, now include Optometrist fee-for-service testing.
7. Reduction for 2004-2005 from prior years is due to a decline in the number of general practitioner locums provided and the transfer of physician data to the resident physician category.

Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, (henceforth the Department) together with eight Health and Social Services Authorities (HSSAs), plan, manage and deliver a full spectrum of community and facility-based services for health care and social services. Community health programs include drop-in clinics, public health clinics, home care, school health programs and educational programs. Physicians and specialists routinely visit communities without resident physicians. Services also include early intervention and support to families and children, mental health and addictions.

Boards of management for each HSSA provide NWT residents with the opportunity to shape priorities and service delivery for their communities. Nurses are the largest group of health care practitioners in the NWT.

As of April 1, 2005, there were more than 40,000 people living in the Northwest Territories, of which half were Aboriginal.¹ The NWT continues to have a relatively young population and a high birth rate. According to 2004 population estimates, approximately 25 percent of the NWT population is under 15 years of age, compared with 18 percent in the overall Canadian population.²

During the reporting period, the Department introduced two important initiatives: the Integrated Service Delivery Model (ISDM) and Tele-Care NWT.

- The ISDM takes a team-based, client-focused approach to provide health and social services in the NWT and combines three key elements: primary community care; interdisciplinary teams; and strengthened core services.
- Tele-Care NWT is a family health and support line for all residents of the Northwest Territories. The free and confidential telephone service operates 24/7 and forms part of the Primary Community Care improvements. It is staffed by bilingual (French/English) nurses registered in the NWT and also offers three-way interpretation service in all NWT Aboriginal languages. The Telecare Nurses help clients use the NWT self-care handbook, and refer clients to primary care providers in the communities or to emergency units at the hospitals.

The Department released the *2004 Report to Residents of the Northwest Territories on Comparable Health and Health System Indicators*. This publication is the NWT contribution to a set of reports from all provinces and territories. Information collection was conducted in the same way across jurisdictions allowing for comparable data.

The Department maintains a bilingual public website (www.hltss.gov.nt.ca) that provides an exhaustive source of information, including electronic copies of reports published by the Department.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The NWT Health Care Plan includes the Medical Care Plan and the Hospital Insurance Plan. The

1 Statistics Canada, Quarterly Population Estimates and Statistics Canada, 2001 Census.

2 Statistics Canada, CANSIM II, Table 051-0001, June 2003

public authority responsible for administering the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through Boards of Management established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act (HIHSSA)*.

Legislation that enables the Health Care Insurance Plan in the NWT includes the *Medical Care Act* (revised 2004) and *Hospital Insurance and Health and Social Services Act* (revised 2005). The amendments to the *Medical Care Act* provides for more timely updates. Changes to the HIHSSA are consequential amendments due to modernizing the *Benefits and Obligations Act* (such as definition of spouse).

1.2 Reporting Relationship

In the NWT, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for administering the *Medical Care Act* and Regulations. The Director reports to the Minister each fiscal year concerning the operation of the Medical Care Plan.

The Minister also appoints members to a Board of Management for each HSSA in the NWT. The Boards are established with the authority to manage, control and operate health and service facilities. The Boards' chairpersons hold office indefinitely, while other members hold office for a term of three years.

An annual audit of accounts is performed on each Board of Management. The Minister has regular meetings with Board of Management chairpersons. This forum allows the chairperson to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Health and Social Services. The Office of the Auditor General of Canada (OAG) audits the payments made under the Medical Care Plan and the Hospital Insurance Plan.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the authority of the HIHSSA and the Regulations. During 2004-2005, four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The NWT provides coverage for a full range of insured hospital services. Insured in-patient 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 and psychological services provided under an approved program;
- ☐ services rendered by persons who are paid by the hospital; and
- ☐ services rendered by an approved detoxification centre.

The NWT also provides a number of out-patient services. These include:

- ☐ laboratory tests, 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 and speech therapy services in an approved hospital; and
- ☐ psychiatric and psychology services provided under an approved hospital program.

A detailed list of insured in- and out-patient services is contained in the *Hospital Insurance Regulations*. Section 1 of the Regulations states that “out-patient insured services” means the following services and supplies are provided to out-patients:

- ☐ laboratory, radiological and other diagnostic procedures together with the necessary interpretations for helping diagnose and treat any injury, illness or disability, but not including simple procedures such as examinations of blood and urine, which ordinarily form part of a physician’s routine office examination of a patient;
- ☐ necessary nursing service;
- ☐ 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;
- ☐ services rendered by persons who receive remuneration for those services from a hospital;
- ☐ radiotherapy services within insured facilities; and
- ☐ physiotherapy services within insured facilities.

The Minister may add, change or delete insured hospital services. The Minister also determines if any public consultation will occur before making changes to the list of insured services.

Where insured services are not available in the NWT, residents receive them from hospitals in other jurisdictions provided they are medically necessary. The NWT provides medical travel assistance and a supplementary health benefit program (outlined in the Medical Travel Policy), which ensures that NWT residents have no barriers to accessing medically necessary services.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT *Medical Care Regulations* provide for insured physician services. All physicians and nurse practitioners must be licensed to practice in the NWT.

A wide range of medically necessary services is provided in the NWT. No limitation is applied if a service has been deemed an insured service. The Medical Care Plan insures all medically required procedures provided by medical practitioners, including:

- ☐ approved diagnostic and therapeutic services;
- ☐ necessary surgical services;
- ☐ complete obstetrical care;
- ☐ eye examinations; and
- ☐ visits to specialists, even when there is no referral by a family physician.

Following negotiations between the NWT Medical Association and the Director of Medical Insurance, additional medical services may be considered for inclusion in the fee schedule regulation. It is the responsibility of the Director of Medical Insurance to manage the process of adding or deleting a medical service. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations, as follows:

- ☐ establishing a medical care plan that provides insured services to insured persons by medical practitioners that will in all respects qualify and enable the NWT to receive payments of contributions from the Government of Canada under the *Canada Health Act*; and
- ☐ prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the NWT, and the conditions under which the fees and charges are payable.

2.3 Insured Surgical-Dental Services

Insured services and those related to oral surgery, injury to the jaw or disease of the mouth/jaw are eligible. Only oral surgeons may submit claims for billing. The NWT uses the Province of Alberta’s Schedule of Oral and Maxillofacial Surgery Benefits as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided by hospitals, physicians and dentists, but not covered by the NWT Health Care Insurance Plan, include:

- ☐ medical-legal services;
- ☐ third-party examinations;
- ☐ services not medically required;
- ☐ group immunization;
- ☐ in vitro fertilization;
- ☐ services provided by a doctor to his or her own family;
- ☐ advice or prescriptions given over the telephone;
- ☐ surgery for cosmetic purposes except where medically required;
- ☐ dental services other than those specifically defined for oral surgery;
- ☐ dressings, drugs, vaccines, biologicals and related materials administered in a physician's office;
- ☐ eyeglasses and special appliances;
- ☐ plaster and surgical appliances or special bandages;
- ☐ treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act* and Regulations;
- ☐ physiotherapy and psychology services received from other than an insured out-patient facility;
- ☐ services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and
- ☐ routine annual checkups where there is no definable diagnosis.

In the NWT, prior approval applications must be made to the Director of Insured Services for uninsured medical goods or services provided in conjunction with an insured health service. A Medical Advisor provides the Director with recommendations regarding the appropriateness of the request.

The NWT *Medical Care Act* includes *Medical Care Regulations* as well as the Physician Fee Schedule. This Act also provides for the authority to negotiate changes or deletions to the Physician Fee Schedule. The process is described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* defines the eligibility of NWT residents for the NWT Health Care Insurance Plan.

The NWT uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the NWT Health Care Plan Registration Guidelines to define eligibility. There were no changes to eligibility for the reporting period.

Ineligible individuals for NWT health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP), federal inmates and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable; e.g. visas and immigration papers. The applicant must be prepared to provide proof of residency if requested. Registration should occur before the actual eligibility date of the client. As of March 2005, NWT health care cards are valid for a five-year period. Registration and eligibility for coverage are directly linked. Only claims from registered clients are paid.

As of March 2005, there were approximately 44,504 individuals registered with the NWT Health Care Plan. The registered number is taken from the NWT Department of Health and Social Services Health Care Plan registration database.

No formal provisions are in place for clients to opt out of the Health Care Insurance Plan.

3.3 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 health care plan coverage.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the NWT. The waiting periods are consistent with the Interprovincial Agreement on Eligibility and Portability. Generally the waiting periods are the first day of the third month of residency, for those who move permanently to the NWT, or the first day of the thirteenth month for those with temporary employment of less than 12 months, but who can confirm that the employment period has been extended beyond the 12 months.

4.2 Coverage During Temporary Absences in Canada

The Interprovincial Agreement on Eligibility and Portability and the NWT Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the NWT for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the NWT for work, vacation, etc. Once an individual has completed a Temporary Absence form and been approved by the Department as being temporarily absent from the NWT, the full cost of insured services is paid for all services received in other jurisdictions.

The NWT participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The NWT Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada.

As per subsection 11 (1) (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. The NWT does provide personal reimbursement when an NWT resident leaves Canada for a temporary period for personal reasons such as vacations and requires medical attention during that time. Individuals are required to cover their own costs and seek reimbursement upon their return to the NWT. The rates are the same as those contained in the Physician Fee Schedule and the hospital out- or in-patient rate.

Individuals may be granted coverage for up to a year with prior approval, if they are outside the country. In the eligibility rules, NWT residents may continue their coverage for up to one year if they are leaving Canada, but they must provide extensive information confirming that they are maintaining their permanent residence in the NWT. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

4.4 Prior Approval Requirement

The NWT requires prior approval if coverage is to be considered for elective services in other provinces, territories and outside the country. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Program ensures that economic barriers are reduced for all NWT residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Beds were available during the reporting period. If a bed shortage were to arise, the resident would be transported to another facility where appropriate beds exist. NWT hospitals and health centres continued to face some short-term staffing difficulties that had negative effects on their operations. However, through the use of medical travel arrangements, access to services was maintained throughout 2004-2005.

Facilities in the NWT do offer a range of medical, surgical, rehabilitative and diagnostic services. The NWT medical travel program ensures that residents will have access to necessary services not available in NWT facilities.

The number of Telehealth sites remained unchanged during 2004-2005. The Telehealth program has entered into a three-year strategic planning process, which is to provide direction on integration and sustainability for the Telehealth program in relation to the Integrated Service Delivery Model.

With regards to recruiting and retaining professional staff, the NWT faces the same challenges as does the rest of Canada. In addition, the NWT faces unique demands due its remoteness and socio-economic realities.

The Department developed a comprehensive five-year human resource strategy in 2004 to address these issues. This strategy outlined alternatives available to the Department of Health and Social Services and its HSSAs to increase the supply of health professionals required to meet

health care needs of NWT residents. Initiatives directly related to increasing the supply of health professionals include: the promotion of health careers; succession planning; and maximizing northern employment. The Government of the Northwest Territories is working with employees, unions and professional organizations to identify, develop and implement initiatives supporting the retention and recruitment of health and social services professionals.

5.3 Access to Insured Physician and Surgical-Dental Services

All NWT residents have access to all facilities operated by the Government of the Northwest Territories.

The medical travel program provides access to physicians for residents. The Telehealth program expands the specialist services available to residents in isolated communities.

5.4 Physician Compensation

To compensate physicians, the NWT uses two models: Employee contracts and fee-for-service. The majority of family physicians are employed through a contractual arrangement with the NWT. The remainder provides services through a fee-for-service arrangement. The *Medical Care Act* and part of the *Medical Care Regulations* are used in the NWT to govern payments to physicians.

Physician compensation is determined through negotiations between the NWT Medical Association and the Department. In March 2004, the NWT Fee Schedule was renewed along with new four-year General Practitioner and specialist contracts for the Stanton Territorial Health Authority.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department. Amounts allocated in the agreements are based on the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the HIHSSA and the *Financial Administration Act*. No amendments were implemented in 2004-2005 to provisions involving payments to facilities. A comprehensive budget is used to fund hospitals in the NWT.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health Transfer (CHT) has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents.

For fiscal year 2004-2005, these documents included:

- 2004-2005 Budget Address;
- 2004-2005 Main Estimates;
- 2003-2004 Public Accounts; and
- 2003-2006 Business Plan for the Department of Finance.

The Estimates (noted above) represent the government's financial plan, and are presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Continuing Care programs and services offered in NWT communities may include: supported living; adult group homes; long-term care facilities; and extended care facilities. These programs and services operate where applicable according to the Department of Health and Social Services Establishment Policy, the HIHSSA and the *Hospital Standards Regulations*.

Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home

care services. Current services in this area include supported living arrangements in family homes, apartments and group-living homes, where clients live as independently as possible. Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.

In January 2005, the Department introduced *Services Standards and Guidelines for People in Supported Living Homes*. The Guidelines assist potential supported living service providers to prepare for the pre-certification process. The Standards create a framework for quality of care and life, and for the review of organizational evaluation process.

The NWT Home Care Program is a territory-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home Care is based on need and is available to NWT residents without charge. The range of Home Care services include: acute care; post-hospital care; chronic illness care; nutrition services; palliative care; personal care; and respite care. Home care services are delivered through the Regional HSSAs and are based on multi-disciplinary assessments of individual needs. The Home Care Program provides services to the seven regions of Yellowknife, Hay River, Fort Smith, Beaufort Delta, Sahtu, Deh Cho and Tlicho.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	41,673	42,886 ¹	40,399 ¹	43,202 ¹	44,504 ¹

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	4	4	4	4	4
b. chronic care	not applicable ²	not applicable ²	not applicable ²	not applicable ²	not applicable ²
c. rehabilitative care	not applicable ²	not applicable ²	not applicable ²	not applicable ²	not applicable ²
d. other	28 ³	28 ³	28 ³	28 ³	28 ³
e. total	32	32	32	32	32
3. Payments (\$):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not applicable ²	not applicable ²	not applicable ²	not applicable ²	not applicable ²
c. rehabilitative care	not applicable ²	not applicable ²	not applicable ²	not applicable ²	not applicable ²
d. other	not available	not available	not available	not available	not available
e. total	40,282,046	43,309,039	48,384,358	51,523,365	52,237,847
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments (\$):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	29 ⁴	24 ⁴	37 ⁴	44 ⁴	56 ⁴
b. specialists	18 ⁴	13 ⁴	16 ⁴	15 ⁴	21 ⁴
c. other	151 ⁵	175 ⁵	155 ⁵	169 ⁵	129 ⁵
d. total	198 ⁶	212 ⁶	208 ⁶	228 ⁶	206 ⁶
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	81,921	32,339	18,493	20,677	23,084
b. specialists	5,466	5,618	5,524	5,448	4,426
c. other	not available	not available	not available	not available	not available
d. total	87,387	37,957	24,017	26,125	27,510
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	3,357,203	1,226,502	824,503	813,923	903,771
b. specialists	599,167	616,393	617,448	688,979	632,826
c. other	not available	not available	not available	not available	not available
d. total	3,956,370	1,842,895	1,441,951	1,502,902	1,536,597
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	41.0	37.9	44.6	39.4	39.2
b. specialists	109.6	109.7	111.8	126.5	143.0
c. other	not available	not available	not available	not available	not available
d. all services	45.27	48.55	60.04	57.53	55.86
13. Number of services provided through <u>all payment methods</u> (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	200,198	199,748	195,513	198,830	206,752
14. Total payments to physicians paid through <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	16,089,488	19,037,822	19,527,496	28,991,000	29,374,000
15. Average payment per service, <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	80.37	95.31	99.88	145.81	142.07

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	952	992	1,237	1,333	1,204
17. Total number of claims, out-patient (#).	8,090	8,358	9,157	9,481	9,252
18. Total payments, in-patient (\$).	5,235,249	5,688,458	8,630,532	8,934,728	9,160,929
19. Total payments, out-patient (\$).	1,379,154	1,407,152	1,832,221	2,051,688	2,335,051
20. Average payment, in-patient (\$).	5,499.21	5,734.33	6,976.99	6,702.72	7,608.75
21. Average payment, out-patient (\$).	170.48	168.36	200.09	216.40	252.38
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	40,095	42,395	43,862	40,945	41,950
23. Total payments (\$).	2,140,669	2,264,235	2,794,590	2,937,334	3,074,070
24. Average payment per service (\$).	53.39	53.41	63.71	71.74	73.28

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	5	3	1	1	0
26. Total number of claims, out-patient (#).	16	15	51	19	8
27. Total payments, in-patient (\$).	2,908	10,535	1,194	1,283	0
28. Total payments, out-patient (\$).	1,713	2,181	99,009	16,848	1,272
29. Average payment, in-patient (\$).	581.52	3,511.52	1,193.53	1,283.00	0.00
30. Average payment, out-patient (\$).	107.04	145.39	1941.35	886.72	159.03
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	186	101	138	47	40
32. Total payments (\$).	13,989	9,979	9,482	2,424	32,984
33. Average payment per service (\$).	75.21	98.80	68.71	51.57	824.61

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	not available	not available	not available	not available	not available
35. Number of services provided (#).	not available	not available	not available	not available	not available
36. Total payments (\$).	not available	not available	not available	not available	not available
37. Average payment per service (\$).	not available	not available	not available	not available	not available

Endnotes

1. The 2001-2002 figure is as of September 18, 2002; the 2002-2003 figure is as of September 2, 2003; the 2003-2004 figure is as of August 25, 2004; and the 2004-2005 figure is as of September 1, 2005.
2. Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the four hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.
3. Includes Health Centres and Public Health Units.
4. 1999-2000 to 2001-2002 numbers from *Counts from Canadian Institute for Health Information*, Southam Medical Database; and 2002-2003 and 2003-2004 numbers are estimates from NWT Department of Health and Social Services. 2004-2005 figures are for funded positions.
5. This is an estimate of the number of locum physicians. For measures 10 through 15, locum physicians are captured within the general practitioners and specialists categories.
6. Estimate based on total active physicians for each fiscal year.

Nunavut

Introduction

On April 1, 1999, Nunavut became Canada's third and newest territory. The Territory spans two million square kilometers and covers one-fifth of Canada's total landmass. There are 25 communities located across three time zones in Nunavut. The Territory is divided into three regions: the Qikiqtaaluk, which consists of 12 communities; the Kivalliq, which consists of eight communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population in Nunavut is 29,644.

Approximately 53 percent of the population is under the age of 25 years. Inuit make up about 85 percent of Nunavut's population. There is a small French-speaking population of about 4 to 6 percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, which largely includes skilled laborers and seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories as Nunavut statutes pursuant to the *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness with the Government of Nunavut's objectives as outlined in *Pinasuaqtavut 2004-2009*. *Pinasuaqtavut 2004-2009* describes the Government's commitment to building Nunavut's future by achieving healthy communities, simplicity and unity, self-reliance and continuous learning. The incorporation of

traditional Inuit values, known as Inuit Qaujimajatuqangit, in program and policy development, service design and delivery, is an expectation placed on all government departments.

The delivery of health services in Nunavut is based on a primary health care model. There is a local health centre in 24 communities across Nunavut and one regional hospital in Iqaluit. The primary health care providers are nurses with expanded scopes, with the exception of 17 full-time family physicians: 11 in the Qikiqtaaluk region; four in the Kivalliq region; and two in the Kitikmeot region. Nunavut recruits and hires its own family physicians and obtains specialist services from Ottawa, Toronto, Winnipeg, Yellowknife and Edmonton.

The management and delivery of health services in Nunavut was integrated into the overall operations of the Department on March 31, 2000, when the former boards (Qikiqtaaluk, Kitikmeot and Kivalliq) were dissolved. Former board staff became employees of the Department at that time. The Department has a regional office in each of the three regions that manages the delivery of health services at a regional level. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The Territorial budget for health care and social services in 2004-2005 was \$257,385,000, which includes approximately \$59,270,000 allocated for capital.

In May 2004, Nunavut's new *Tobacco Control Act* came into effect. This Act represents a highly progressive piece of legislation, which was created to reduce the number of Nunavummiut exposed to secondhand smoke, to decrease the number of smokers in the Territory and to reduce access and supply of tobacco to minors.

In 2004-2005, Telehealth was implemented in all communities in Nunavut. The network was expanded to enable the simultaneous connection of 14 communities. This represents significant progress from the previous year in which 15 communities were connected to the Telehealth network with a six-site simultaneous capacity.

Nunavut's Telehealth network provides communities with a broad range of health-related services, which include the following: clinical program delivery such as specialist consultation services; health education; continuing medical education; family visitation; and administrative functions. Over the last year, the use of Nunavut's Telehealth network increased by 40 percent.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Nunavut continues to be challenged by the acute shortage of nurses, despite aggressive national and international recruitment and retention activities. Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists is also a challenge.

Approximately one-fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent out of the Territory. In fall 2005, two new regional health facilities, one in Rankin Inlet and one in Cambridge Bay are scheduled to open. In addition, a new regional hospital in Iqaluit is scheduled to open in spring 2007. These facilities will enable Nunavut to build internal capacity and enhance the range of services that can be provided within the Territory. The Department's new strategic vision, *Closer to Home*, which was approved by Cabinet in January 2005, will also serve to strengthen territorial health care capacity by working to ensure that care, learning and jobs are provided within the Territory.

In 2004-2005, Nunavut received approximately \$2,149,247 as part of a three-year allotment of \$4.4 million from the Primary Health Care Transition Fund Provincial/Territorial Envelope. These funds are designated to support the transitional costs of implementing sustainable, large-scale primary health care renewal initiatives. The Government of Nunavut has hired a Primary Health Care Renewal Implementation Coordinator and has plans to improve information technology, mental health training, health promotion, service

provider training, Inuit staff capacity building and population health programming.

Health promotion and prevention activities are high on the Department's list of service priorities. This includes strategies to reduce tobacco use, public education for healthy lifestyle choices, fetal alcohol spectrum disorder (FASD) awareness and the importance of traditional foods, pre-natal nutrition and the Northern Contaminants Program.

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 and Social Services 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.

Through the *Dissolution Act* (Nunavut, 1999), the three former Health and Social Services Boards of Baffin, Kitikmeot and Kivalliq were dissolved and their operations were integrated into the Department of Health and Social Services effective April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

There have been no legislative amendments for fiscal year 2004-2005.

1.2 Reporting Relationship

A Director of Medical Care is appointed under the *Medical Care Act* and is responsible for the administration of the Territory's medical care

insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. Our annual submissions to the *Canada Health Act Annual Report* serve as the basis for these reports under the *Medical Care Act*.

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 has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The *2004 Report to the Second Legislative Assembly of Nunavut* was tabled in May 2004, and can be accessed at:

www.oag-bvg.gc.ca/domino/reports.nsf/html/200405nla_e.html

There was no reference to the operation of the health care insurance plan and no reference to the principles of the *Canada Health Act*.

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 legislation or Regulations in 2004-2005.

In 2004-2005, insured hospital services were delivered in 25 facilities across Nunavut, including a general hospital located in Iqaluit and 24 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut providing a range of in-patient and out-patient hospital services as defined by the *Canada Health Act*. Community health centres

provide public health, out-patient services, emergency room services and some overnight services (observations). There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre. Public health services are provided at a Public Health Clinic in Rankin Inlet and Iqaluit.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services 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 and psychological services provided under an approved program;
- ☐ services rendered by persons who are paid by the hospital; and
- ☐ services rendered by an approved detoxification centre.

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, audiology and speech therapy services in an out-patient facility or in an approved hospital; and
- ☐ psychiatric and psychology services provided under an approved hospital program.

The Department of Health and Social Services makes the determination to add insured services in its facilities 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 Nunavut Financial Management Board.

No new services were added in 2004-2005 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 legislation or Regulations in 2004-2005.

Although the *Nursing Act* (2004) allows for licensure of nurse practitioners in Nunavut, only medical doctors are permitted to deliver insured physician services in Nunavut at this time. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 17 full-time family physicians in Nunavut (11 in the Qikiqtaaluk region; four in the Kivalliq region; and two in the Kitikmeot region), as well as one surgeon at the Baffin Regional Hospital, providing services to Nunavummiut. Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. As of March 31, 2005, Nunavut had 168 physicians participating in the health insurance plan.

Physicians can make an election 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 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 2004-2005, no physicians provided written notice of this election.

Insured physician services refers to all services rendered by medical practitioners that are

medically required. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction to obtain the insured service.

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 additions or deletions were added in 2004-2005.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the Territory 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. In 2004-2005, four oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for 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, of 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 to more sophisticated centres.

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 2004-2005.

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, unless with prior approval.

The Baffin Regional Hospital charges \$1,396 per diem for services provided for non-Canadian resident stays.

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 under Portability). 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 Health 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 and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services for Inuit and First Nations peoples.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the legislation or regulations in 2004-2005.

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 or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor to the Territory. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins the first day of the third month after arrival in the Territory, but first-day coverage is provided under a number of circumstances; e.g. newborns whose mothers or fathers are eligible for coverage. As well, permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents and a non-Canadian who has 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, the Royal Canadian Mounted Police (RCMP) 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 Inter-Provincial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province/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.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut will be going to a staggered renewal process in 2006. 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/territory is required.

As of March 31, 2005, 31,525 residents were registered with the Nunavut Health Care Plan. Nunavut's population statistics are published by Statistics Canada and include a number of temporary residents who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

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 one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which were adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Inter-Provincial/Territorial 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 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 2004-2005 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrollment to ensure coverage continues. Requests for extensions must be renewed yearly and are subject to approval by 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 person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-

Provincial/Territorial Agreement on Eligibility and Portability, as of January 1, 2001.

Nunavut participates in Physician and Hospital Reciprocal Billing. Agreements are in place with other provinces and territories (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 Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory, which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

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.

Out-of-territory hospitals were paid \$18,373,000 in the fiscal year 2004-2005.

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 non-emergency services, the payment for hospital services is \$1,396 per diem and \$158 for out-patient care. No changes were made to these rates in 2004-2005.

In 2004-2005, Nunavut paid a total of \$6,778 for insured emergency in-patient and out-patient health services to eligible residents temporarily outside Canada.

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 person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

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 are also provided to patients in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital, located in Iqaluit, is the one acute care hospital facility in Nunavut. The hospital has 25 beds available for acute, rehabilitative, palliative and chronic care services and three stretchers in the emergency room. The

hospital has a staff of 87, including 34 nurses and 10 physicians. The facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, palliative care, gastrointestinal bleeds and hypertension treatment. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill, Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency services are provided by all 24 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, all basic services were provided in 2004-2005. Nunavut is seeking to increase resources in all areas.

The use of Telehealth services has been a significant step in improving access to hospital, medical and other health and social services in Nunavut. In 2004-2005, Telehealth facilities were expanded from 15 communities to all 25 communities. 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.

5.3 Access to Insured Physician and Surgical-Dental Services

In addition to the medical travel assistance and Telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other

visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. The Telehealth network, linking all 25 communities, allows for the delivery of a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education. In 2004-2005, Nunavut had 168 physicians registered.

The following specialist services were provided under the visiting specialists program: ophthalmology; orthopaedics; internal medicine; otolaryngology; neurology; rheumatology; dermatology; paediatrics; obstetrics; physiotherapy; occupational therapy; psychiatry; and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

All full-time physicians in Nunavut work under contract with the Department of Health and Social Services. The terms of the contracts are set by the Department. Visiting consultants are either paid on a per-diem basis or fee-for-service.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 24 community health centres are part of the Department's budget as represented in the budgets for regional operations. No payments are made directly to hospitals or community health centres.

6.0 Recognition Given to Federal Transfers

Recognition of Canada Health and Social Transfer to the Government of Nunavut for 2002-2003 and 2003-2004 will be given when the *Medical Care Act Annual Report* is tabled in the Nunavut Legislative Assembly in 2005-2006.

7.0 Extended Health Care Services

The Home Care Program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency and supports family members and community involvement to enable individuals to remain safely in their own homes. Services include basic housekeeping support, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are available between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat Elders Homes. These facilities provide the highest level of long-term care in Nunavut; that is, extensive chronic care services up to the point of acute care (levels 4 and 5) services. Acute care cases are transferred to the closest hospital.

Registered Persons					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
1. Number as of March 31st (#).	26,829	28,630	29,478	31,660	31,525

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
2. Number (#):					
a. acute care	1	1	1	1	1
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	25 ¹	25 ¹	25 ¹	25 ¹	25 ¹
e. total	not available	not available	not available	not available	not available
3. Payments (\$):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
4. Number (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided (#):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments (\$):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
7. Number of participating physicians (#):					
a. general practitioners	59	81	106	75	86
b. specialists	55	67	80	64	82
c. other	0	0	0	0	0
d. total	114	148	186	139	168
8. Number of opted-out physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0 ¹
9. Number of not participating physicians (#):					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
10. Number of services provided through <u>fee-for-service</u> (#):					
a. general practitioners	61,074	39,035	44,876	43,142	42,909 ²
b. specialists	29,485	19,733	20,656	17,419	16,633 ²
c. other	0	0	0	0	0
d. total	90,559	58,768	65,532	60,561	59,542 ²
11. Total payments to physicians paid through <u>fee-for-service</u> (\$):					
a. general practitioners	2,494,221	1,943,399	2,137,218	2,023,584	2,037,408 ²
b. specialists	1,229,811	1,042,366	1,199,648	1,524,873	1,075,253 ²
c. other	0	0	0	0	0
d. total	3,724,032	2,985,765	3,336,866	3,548,457	3,112,661 ²
12. Average payment per <u>fee-for-service</u> service (\$):					
a. general practitioners	40.83	49.79	47.62	48.16	47.48 ²
b. specialists	41.00	52.82	58.08	62.13	64.65 ²
c. other	0.00	0.00	0.00	0	0
d. all services	40.92	50.81	50.92	53.31	52.24 ²
13. Number of services provided through <u>all payment methods</u> (#):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
14. Total payments to physicians paid through <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
15. Average payment per service, <u>all payment methods</u> (\$):					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
16. Total number of claims, in-patient (#).	1,549	1,782	2,524	2,526	2,544
17. Total number of claims, out-patient (#).	8,682	9,155	10,677	12,112	14,492
18. Total payments, in-patient (\$).	7,612,791	7,681,154	18,640,982	17,202,646	15,851,159
19. Total payments, out-patient (\$).	1,352,594	1,525,710	1,740,038	1,552,418	2,521,841
20. Average payment, in-patient (\$).	4,915.00	4,310.41	7,385.49	6,981.59	6,438.33
21. Average payment, out-patient (\$).	156.00	166.65	162.00	138.47	181.95
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
22. Number of services (#).	55,389	39,438	43,064	51,050	45,334
23. Total payments (\$).	3,232,940	2,335,998	2,674,445	2,955,996	2,816,282
24. Average payment per service (\$).	58.00	59.23	62.10	58.61	62.40

Insured Services Provided Outside Canada					
Hospitals	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
25. Total number of claims, in-patient (#).	0	0	0	2	1
26. Total number of claims, out-patient (#).	1	53	3	2	1
27. Total payments, in-patient (\$).	0	0	0	6,300	6,345
28. Total payments, out-patient (\$).	110	128,398	982	400	433
29. Average payment, in-patient (\$).	0.00	0.00	0.00	3,150.00	6,345.00
30. Average payment, out-patient (\$).	110.00	2,422.60	327.28	200.00	433.41
Physicians	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
31. Number of services (#).	0	12	1	19	0
32. Total payments (\$).	0	14,835	8	1,519	0
33. Average payment per service (\$).	0.00	1,236.25	7.61	151.91	0.00

Insured Surgical-Dental Services Within Own Province or Territory					
	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
34. Number of participating dentists (#).	21	not available	not available	not available	not available
35. Number of services provided (#).	not available	not available	not available	not available	not available
36. Total payments (\$).	not available	not available	not available	not available	not available
37. Average payment per service (\$).	not available	not available	not available	not available	not available

Endnotes

1. Health Centres.
2. Figures include shadow billed claims.

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, which 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 the actual deductions can be made. These regulations are also presented in an office consolidation format.

This unofficial consolidation is current to June 2001.



CANADA

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6

L.R. (1985), ch. C-6

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.



CHAPTER 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

CHAPITRE 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

Considérant que le Parlement du Canada reconnaît :

Préambule

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;

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Canada Health Act

services 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:

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 :

SHORT TITLE

Short title **1.** This Act may be cited as the *Canada Health Act*.
1984, c. 6, s. 1.

TITRE ABRÉGÉ

1. *Loi canadienne sur la santé.* Titre abrégé
1984, ch. 6, art. 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 and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;
“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;
“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;
“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;
“health care insurance plan” means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;
“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;
“hospital” includes any facility or portion

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) des membres de la Gendarmerie royale du Canada nommés à un grade;
 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.
« contribution » [Abrogée, 1995, ch. 17, art. 34]
« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces.
« dentiste » Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.
« frais modérateurs » Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

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;

“hospital services”
« services hospitaliers »

“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;

“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 other Act of Parliament or under any Act of the legislature of a province that relates to workers’ or workmen’s compensation;

“insured health services”
« services de santé assurés »

« 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.

« habitant »
“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 :

« hôpital »
“hospital”

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.

« 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.

« médecin »
“medical practitioner”

« ministre » Le ministre de la Santé.

« ministre »
“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.

« professionnel de la santé »
“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.

« régime d’assurance-santé »
“health care insurance plan”

« services complémentaires de santé » Les services définis dans les règlements et offerts aux habitants d’une province, à savoir :

« services complémentaires de santé »
“extended health care services”

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

« 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.

« services de chirurgie dentaire »
“surgical-dental services”

“insured person”
« assuré »

“insured person” means, in relation to a province, a resident of the province other than

- (a) a member of the Canadian Forces,
- (b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,
- (c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary 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;

“medical practitioner”
« médecin »

“medical practitioner” means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

“Minister”
« ministre »

“Minister” means the Minister of Health;

“physician services”
« services médicaux »

“physician services” means any medically required services rendered by medical practitioners;

“resident”
« habitant »

“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;

“surgical-dental services”
« services de chirurgie dentaire »

“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;

“user charge”
« frais modérateurs »

“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.

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.

« 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.

« services de santé assurés »
“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 :

« services hospitaliers »
“hospital services”

- 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.

« services médicaux » Services médicalement nécessaires fournis par un médecin.

« services médicaux »
“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 payer pour la prestation de ce service au titre du régime provincial d’assurance-santé.

« surfacturation »
“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.

Loi canadienne sur la santé

Chap. C-6

CANADIAN HEALTH CARE POLICY

POLITIQUE CANADIENNE DE LA SANTÉ

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.

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.

Objectif premier

PURPOSE

RAISON D'ÊTRE

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.

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.

Raison d'être de
la présente loi

CASH CONTRIBUTION

CONTRIBUTION PÉCUNIAIRE

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social 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.

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 et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

Contribution
pécuniaire

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

CONDITIONS D'OCTROI

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
- (e) accessibility.

1984, c. 6, s. 7.

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) l'accessibilité.

1984, ch. 6, art. 7.

Règle générale

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;

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;

Gestion publique

Designation of agency permitted	<p>(b) the public authority must be responsible to the provincial government for that administration and operation; and</p> <p>(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.</p> <p>(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</p> <p>(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or</p> <p>(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.</p> <p>1984, c. 6, s. 8.</p>	<p>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.</p> <p>(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 :</p> <p>a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;</p> <p>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.</p> <p>1984, ch. 6, art. 8.</p>	Désignation d'un mandataire
Comprehensiveness	<p>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.</p> <p>1984, c. 6, s. 9.</p>	<p>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.</p> <p>1984, ch. 6, art. 9.</p>	Intégralité
Universality	<p>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 province to the insured health services provided for by the plan on uniform terms and conditions.</p> <p>1984, c. 6, s. 10.</p>	<p>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 assurés prévus par celui-ci, selon des modalités uniformes.</p> <p>1984, ch. 6, art. 10.</p>	Universalité
Portability	<p>11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province</p> <p>(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;</p>	<p>11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :</p> <p>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;</p>	Transférabilité

(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.

(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.

(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.

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

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.

(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.

(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.

12. (1) La condition d’accessibilité suppose que le régime provincial d’assurance-santé :

Requirement for consent for elective insured health services permitted

Definition of “elective insured health services”

Accessibility

Consentement préalable à la prestation des services de santé assurés facultatifs

Définition de «services de santé assurés facultatifs»

Accessibilité

(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.

CONDITIONS FOR CASH CONTRIBUTION

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

Conditions

(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

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.

(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 :

Rémunération
raisonnable

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.

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujéti à l'obligation pour le gouvernement de la province :

Obligations de la
province

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre

(b) shall give recognition to the Canada Health and Social 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.

DEFAULTS

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.

(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

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

(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.

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

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.

MANQUEMENTS

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.

(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) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

(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.

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

Renvoi au gouverneur en conseil

Étapes de la consultation

Impossibilité de consultation

Décret de réduction ou de retenue

Referral to Governor in Council

Consultation process

Where no consultation can be achieved

Order reducing or withholding contribution

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.

(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.

(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.

(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.

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.

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

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.

(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.

(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.

(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.

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.

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.

Modification des décrets

Avis

Entrée en vigueur du décret

Nouvelle application des réductions ou retenues

Application aux exercices ultérieurs

Extra-billing	<p>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.</p> <p>1984, c. 6, s. 18.</p>	SURFACTURATION ET FRAIS MODÉRATEURS	<p>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.</p> <p>1984, ch. 6, art. 18.</p>	Surfacturation
User charges	<p>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.</p>		<p>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.</p>	Frais modérateurs
Limitation	<p>(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.</p> <p>1984, c. 6, s. 19.</p>		<p>(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.</p> <p>1984, ch. 6, art. 19.</p>	Réserve
Deduction for extra-billing	<p>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 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.</p>		<p>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 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.</p>	Déduction en cas de surfacturation
Deduction for user charges	<p>(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.</p>		<p>(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.</p>	Déduction en cas de frais modérateurs
Consultation with province	<p>(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.</p>		<p>(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.</p>	Consultation de la province

Chap. C-6

Canada Health Act

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.

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 and Social 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.

(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.

(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.

(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.

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.

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).

(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.

Comptabilisation

Remboursement à
la province

Réserve

Application aux
exercices
ultérieurs

Règlements

Consentement des
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.

(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 1er avril 1984.

(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.

Exception

Consultation des provinces

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 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.

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 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.

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

**Extra-billing and User
Charges Information
Regulations**

**Règlement concernant
les renseignements sur la
surfacturation et les frais
modérateurs**

SOR/86-259

DORS/86-259

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

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

SHORT TITLE

1. These Regulations may be cited as the Extra-billing and User Charges Information Regulations.

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*)

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 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.

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

TITRE ABRÉGÉ

1. Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.

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*)

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 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.

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.

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 two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/ 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 its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 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 *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health 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.

[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 bona-fide 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 bona-fide 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, bona-fide 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 inter-provincial 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 co-ordinated 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

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 CHA 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.

Minister of Health



Ministre de la Santé

Ottawa, Canada K1A 0K9

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 – Documents Related to the Canadian Health Care System

The following is a listing of provincial and territorial documents and materials that relate to the five criteria of the *Canada Health Act* and to the recognition condition. These documents include annual reports of health care departments, financial documents relating to provincial and territorial health care, audit and evaluation reports and references to provincial and territorial legislation. Also included is some material that is national in scope.

Provincial/Territorial References to the Health Care System

Government of Newfoundland and Labrador

- ☐ Department of Health and Community Services. *Annual Report, 2004-2005*
www.health.gov.nl.ca/health/publications/default.htm
- ☐ Department of Health and Community Services. *HealthScope 2004. Reporting to Newfoundlanders and Labradorians on Comparable Health and Health System Indicators*
www.health.gov.nl.ca/health/publications/pdfiles/healthscope_report_2004.pdf
- ☐ Office of the Auditor General. *Report of the Auditor General to the House of Assembly on Reviews of Departments and Crown Agencies for the year ended March 31, 2004*
www.ag.gov.nl.ca/ag/2004AnnualReport/AR2004.htm
- ☐ Legislation
www.health.gov.nl.ca/health/legislation/default.asp

Government of Prince Edward Island

- ☐ PEI Department of Health. *Annual Report 2003-2004*.
www.gov.pe.ca/photos/original/hss_ar_03_04.pdf
- ☐ PEI Department of Health. *Prince Edward Island's Second Report on Common Health Indicators*.
www.gov.pe.ca/photos/original/HSS_CHI_04.pdf
- ☐ PEI Department of Health. *A System that Meets the Priority Needs of the Citizens*.
www.gov.pe.ca/photos/original/DH_WaitTimes.pdf
- ☐ PEI Department of Health. *Hospital and Medical Services Insurance on Prince Edward Island*.
www.gov.pe.ca/photos/original/hss_hms_ins_pei.pdf
- ☐ Office of the Auditor General. *2005 Report of the Auditor General to the Legislative Assembly*.
www.gov.pe.ca/photos/original/ag_2004_report.pdf
- ☐ Legislation
www.gov.pe.ca/law/statutes/index.php3

Government of Nova Scotia

- Department of Health. *Annual Accountability Report for the Fiscal Year 2004-2005*
www.gov.ns.ca/health/downloads/2004-2005_Annual_Accountability_Report.pdf
- Department of Health. *2005 2006 Business Plan*
www.gov.ns.ca/health/downloads/2005_2006%20DoH%20Business%20Plan.pdf
- Nova Scotia Wait Times: *Getting Healthcare Services*
www.gov.ns.ca/health/waittimes/
- Auditor General of Nova Scotia: *Chapters from the Annual Reports of 1996 2004 relating to Health*
www.gov.ns.ca/audg/health.html
- Legislation: *Consolidated Public Statutes*
www.gov.ns.ca/legislature/legc/

Government of New Brunswick

- Department of Health and Wellness. *2003-2004 Annual Report*.
www.gnb.ca/0051/pub/pdf/2003_04_AnnualReport.pdf
- Department of Health and Wellness. *Budget 2004-2005 Backgrounder*.
www.gnb.ca/0051/budgets/pdf/Backgrounders2004_05_e.pdf
- Department of Health and Wellness. *Reporting to New Brunswickers - The New Brunswick Health Care Report Card 2004*
www.gnb.ca/0051/pub/pdf/2947e_final.pdf
- Department of Health and Wellness. *Healthy Futures: Securing New Brunswick's Health Care System. The Provincial Health Plan 2004-2008*
www.gnb.ca/0051/pdf/healthplan_2004_2008_e.pdf
- Legislation: Department of Health and Wellness. *Statutes Under the Jurisdiction of the Minister of Health and Wellness and Administered by the Department of Health and Wellness*.
www.gnb.ca/0062/deplinks/ENG/Haw.htm

Government of Quebec

- Ministère de la Santé et des Services sociaux. [Department of Health and Social Services] *Rapport annuel de gestion 2004-2005*.
http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05_102_01.pdf
- Ministère de la Santé et des Services sociaux. [Department of Health and Social Services] *Report on the progress made regarding the bilateral agreement entered into during the federal provincial territorial meeting of the first ministers on health, (September 2004)*
http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05_720_01A
- Vérificateur générale du Québec. [Auditor General of Quebec] *Report to the National Assembly for 2004-2005*
www.vgq.gouv.qc.ca/publications/Rapp_2005_1/Highlights/Highlights.pdf
- Legislation.
www.justice.gouv.qc.ca/english/sites/lois_a.htm

Government of Ontario

- Ministry of Health and Long-term Care. *Ontario's Health System Performance Report 2004*
www.health.gov.on.ca/english/public/pub/ministry_reports/pirc_04/pirc_04.html
- Ministry of Health and Long-term Care. *2003–2004 Report Card for Ontario Drug Benefit Program*
www.health.gov.on.ca/english/public/pub/ministry_reports/odb_report03/drug_rep.html
- Ministry of Health and Long-Term Care. *Wait Times in Ontario*
www.health.gov.on.ca/transformation/wait_times/wait_mn.html
- Office of the Auditor General of Ontario. *Reports by Topic: Health*
www.auditor.on.ca/en/reports_health_en.htm
- Legislation: *Commitment to the Future of Medicare Act, 2004*
www.health.gov.on.ca/english/public/legislation/bill_8/hu_medicare.html

Government of Manitoba

- Manitoba Health. *Departmental Annual Report 2004-2005*
www.gov.mb.ca/health/ann/index.html
- Manitoba Health. *Manitoba Infohealth Guide*.
www.gov.mb.ca/health/guide/index.htm
- Manitoba Health. *Wait Time Information*
www.gov.mb.ca/health/waitlist/index.html
- Office of the Auditor General of Manitoba.
www.oag.mb.ca/reports/reports_fr.htm
- Legislation: *Consolidated Statutes*
<http://web2.gov.mb.ca/laws/statutes/index.php>

Government of Saskatchewan

- Saskatchewan Health. *Its for Your Benefit - A Guide to Health Coverage in Saskatchewan*.
http://www.health.gov.sk.ca/mc_dp_skhealthbooklet.pdf
- Saskatchewan Health. *2004-2005 Annual Report*.
www.health.gov.sk.ca/mc_dp_skhlt_h_2004_05_ar.pdf
- Drug Plan and Extended Benefits Branch. *Annual Statistical Report 2004-2005*
http://formulary.drugplan.health.gov.sk.ca/publications/2004-2005_Annual_Report.pdf
- Medical Services Branch. *Annual Statistical Report 2004-2005*
www.health.gov.sk.ca/mc_dp_msb_asr04_05.pdf
- Saskatchewan Health Information Network. *Annual Report 2004-2005*
www.health.gov.sk.ca/mc_dp_shin_ar_2004_05.pdf
- Office of the Provincial Auditor of Saskatchewan.
www.auditor.sk.ca
- Saskatchewan Health Legislation.
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Government of Alberta

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Annex E – Glossary of Terms Used in the Annual Report

The terms described in this glossary are defined within the context of the *Canada Health Act*. In other situations, these terms may have different definition or interpretation.

Term	Description
Accessibility	<p>The accessibility criterion of the <i>Canada Health Act</i> (section 12) requires that health care insurance plans of provinces and territories provide:</p> <ul style="list-style-type: none"> ❑ insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; ❑ payment for insured health services according to a system of payment authorized by the law of the province or territory; ❑ reasonable compensation for all insured health care services rendered by physicians and dentists; and ❑ payment to hospitals to cover the cost of insured health care services.
Acute Care	<p>Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.</p>
Acute Care Facility	<p>An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.</p>
Admission	<p>The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.</p>
Block Fee	<p>This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.</p>
Canada Health Act (CHA)	<p>The <i>Canada Health Act</i> received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which replaced the <i>Hospital Insurance and Diagnostic Services Act</i> (1957) and the <i>Medical Care Act</i> (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The health portion of the CHST was replaced by the Canada Health Transfer effective April 1, 2004.</p>

Term	Description
Canada Health and Social Transfer (CHST)	<p>Coming into effect April 1, 1996, the Canada Health and Social Transfer (CHST) to provinces and territories provided support of health care, post-secondary education, social assistance and social services. The CHST replaced the Canada Assistance Plan, which cost-shared provincial and territorial social assistance programs. It also replaced the Established Programs Financing (EPF), which provided funding to support health care and post-secondary education.</p> <p>The CHST was composed of a tax transfer and a cash transfer. The tax transfer component went back to 1977 when, under EPF, the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates in all provinces while they increased their tax bases by an equivalent amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments.</p> <p>The CHST gave provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the CHA and the condition that there be no period of minimum residency with respect to social assistance.</p>
Canada Health Transfer (CHT)	<p>Effective April 1, 2004, the CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the <i>Canada Health Act</i>. The CST is a block fund in support of post-secondary education, social assistance and social services. It provides provinces and territories with the flexibility to allocate funds among social programs according to their respective priorities.</p>
Chronic Care	<p>Chronic care is care required by a person who is chronically ill or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable and who requires a range of services and medical management that can only be provided by a hospital.</p>
Chronic Care Facility	<p>A chronic care facility is a health care facility that provides ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.</p>
Comprehensiveness	<p>A criterion of the <i>Canada Health Act</i> (section 9), which states that the health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where provided by law in a province or territory, services rendered by other health care practitioners.</p>
Consultation Process	<p>Under Section 14(2) of the <i>Canada Health Act</i>, the Minister of Health must consult with a province or territory with respect to a potential breach of the five criteria and two conditions of the Act, before discretionary penalties can be levied for that province or territory.</p>
Convention Refugee	<p>A Convention refugee is a person who meets the definition of refugee in the <i>1951 United Nations Convention Relating to the Status of Refugees</i>. In general, it is someone who has left his or her home country and has a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group and is unable or, by reason of his or her fear, unwilling to seek the protection of the home country. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.</p>

Term	Description
Coordinating Committee for Reciprocal Billing (CCRB)	Please see "Interprovincial Health Insurance Agreements Coordinating Committee."
Diagnostic Imaging	A procedure that detects or determines the presence of various diseases and/or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
Diagnostic Physician Service	For purposes of reporting on the <i>Canada Health Act</i> , a diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the <i>Canada Health Act</i> . Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach of any of the five criteria or two conditions of the <i>Canada Health Act</i> have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Dispute Avoidance and Resolution (DAR)	In April 2002, provincial and territorial governments accepted a <i>Canada Health Act</i> dispute avoidance and resolution (DAR) process that would apply to the interpretation of the principles of the <i>Canada Health Act</i> as outlined by the Honourable A. Anne McLellan, federal Minister of Health, in a letter to the Honourable Gary Mar, Alberta Minister of Health and Wellness. The <i>Canada Health Act</i> dispute avoidance and resolution process commits governments to continue to actively participate in ad-hoc federal, provincial and territorial committees on <i>Canada Health Act</i> issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise. Health Canada will also continue to provide advance assessments on provincial and territorial measures and direction, when requested. Please see Annex C of this report for a more detailed description of the DAR process.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.

Term	Description
Epp Letter	<p>In June 1985, approximately one year following the passage of the <i>Canada Health Act</i> in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the <i>Canada Health Act</i>.</p> <p>Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the <i>Canada Health Act</i>. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act.</p> <p>The Epp letter remains an important reference for interpretation of the <i>Canada Health Act</i>. The letter has been reproduced for reference purposes in Annex B of this report.</p>
Established Programs Financing (EPF)	<p>Introduced in 1977, the <i>Federal-Provincial Fiscal Arrangements and Established Programs Financing Act</i>, also known as the <i>EPF Act</i>, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories.</p> <p>The EPF transfer was a block fund which increased annually on the basis of economic and population growth. Under the EPF, cash and tax transfers were provided to provinces and territories in support of health and post-secondary education. Tax transfers consisted of income tax points transferred by the federal government to provincial and territorial governments in 1977.</p> <p>In 1995-1996, the last year of EPF, provinces and territories received \$22.0 billion in EPF entitlement (cash plus tax), 71.2 percent of which was intended for health care and the rest for post-secondary education.</p> <p>The EPF transfer was replaced in 1996 by the Canada Health and Social Transfer.</p>
Extended Health Care Services	<p>Section 2 of the <i>Canada Health Act</i> defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.</p>
Extra-billing	<p>Section 2 of the <i>Canada Health Act</i> defines extra-billing as 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 insurance plan of a province or territory.</p>
Extra-billing and User Charges Information Regulations	<p>The only regulations in force under the <i>Canada Health Act</i> are the Extra-billing and User Charges Information Regulations, which require provincial and territorial governments to provide to the federal Minister of Health, prior to the beginning of a fiscal year, estimates of extra-billing and user charges that are permitted to exist under their health care insurance plans so that appropriate deductions to federal transfers can be levied. Provincial and territorial governments are also required under these Regulations to provide financial statements showing the amounts of extra-billing and user charges actually charged in a fiscal year so that reconciliations with previously estimated deductions can be applied. A copy of these regulations is provided in Annex A of this report.</p>

Term	Description
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Diane Marleau wrote to each of her provincial and territorial counterparts, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the <i>Canada Health Act</i> includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the <i>Canada Health Act</i> calculated from October 15, 1995. These penalties take the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer. The Marleau Letter is included in Annex B of this report.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	The <i>Canada Health Act</i> (section 2) defines a health care insurance plan as a plan or plans established by the law of a province or territory to provide for insured health services as defined under this same Act. (Please refer to definition of insured health services in this glossary.)
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the <i>Canada Health Act</i> . The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the <i>Canada Health Act</i> in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently \$28,387 in the fund. There have been 5 applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.

Term	Description
Hospital	Section 2 of the <i>Canada Health Act</i> defines a hospital as any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include a hospital or institution primarily for the mentally disordered, or a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows for the reciprocal processing of out-of-province or out-of-territory claims for hospital in- and out-patient services from either jurisdiction. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Services	Under Section 2 of the <i>Canada Health Act</i> , 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 other Act of Parliament or under any act of the legislature of a province that relates to workers' or workmen's compensation.
Insured Hospital Services	<p>Under Section 2 of the <i>Canada Health Act</i> and the Federal Policy on Private Clinics, insured hospital services include any of the following services provided to in-patients or out-patients at a hospital or clinic if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely:</p> <ul style="list-style-type: none"> <input type="checkbox"/> accommodation and meals at the standard or public ward level and preferred accommodation if medically required; <input type="checkbox"/> nursing service; <input type="checkbox"/> laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; <input type="checkbox"/> drugs, biologicals and related preparations when administered in the hospital or clinic; <input type="checkbox"/> use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; <input type="checkbox"/> medical and surgical equipment and supplies; <input type="checkbox"/> use of radiotherapy facilities; <input type="checkbox"/> use of physiotherapy facilities; and <input type="checkbox"/> services provided by persons who receive remuneration from the hospital or clinic.

Term	Description
Insured Person	<p>An insured person is interpreted under the <i>Canada Health Act</i> as a resident of a province or territory other than</p> <ul style="list-style-type: none"> ❑ a member of the Canadian Forces, ❑ a member of the Royal Canadian Mounted Police who is appointed to rank therein, ❑ a person serving a term of imprisonment in a penitentiary as defined in the <i>Penitentiary Act</i>, or ❑ a resident of the province or territory who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province or territory for eligibility for or entitlement to insured health services.
Insured Physician Service	Please see "Physician Services."
Insured Surgical-Dental Service	Please see "Surgical-Dental Services."
Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)	<p>The Interprovincial Health Insurance Agreements Coordinating Committee, comprised of federal, provincial and territorial health department officials, was established in 1991 as the Coordinating Committee for Reciprocal Billing (CCRB), with the mandate to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of the provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory, when travelling or during educational leave or temporary employment. In 2002, the Committee changed its name to the Interprovincial Health Insurance Agreements Coordinating Committee to better reflect that the Committee's scope also extends to eligibility for health insurance coverage as well as interprovincial/territorial billing issues.</p>
Mandatory Penalties	<p>Provinces that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from federal transfer payments. Mandatory penalties are outlined in sections 20 to 21 of the <i>Canada Health Act</i>. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach any of the extra-billing and user charges provisions of the <i>Canada Health Act</i> has been identified and could not otherwise be resolved through consultations between the respective levels of government.</p>
Medical Necessity	<p>Under the <i>Canada Health Act</i>, the provincial and territorial governments are required to provide medically necessary hospital and physician services to their residents on a prepaid basis, and on uniform terms and conditions. The Act does not define medical necessity. The provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, are primarily responsible for determining which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by public health insurance to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.</p>

Term	Description
Medical Practitioner	Section 2 of the <i>Canada Health Act</i> defines a medical practitioner as a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licenced physician to residents of the other jurisdiction. Where a reciprocal billing agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physician	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at provincial or territorial fee schedule rates. The provincial or territorial plans reimburse patients of opted-out physicians for charges up to, but not more than the amount paid by the plan under fee schedule agreement.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Care	Out-patient diagnostic care includes health care services in a health care facility for procedures that do not require an overnight stay and that detect and/or determine various diseases or health conditions.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician/Dentist	These are licensed physicians or dentists who are enrolled in provincial or territorial health insurance plans.
Physician Services	Section 2 of the <i>Canada Health Act</i> defines physician services as any medically required services rendered by medical practitioners.
Portability	This criterion of the <i>Canada Health Act</i> (section 11) requires that provincial and territorial health insurance plans not impose any minimum period of residence, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period imposed by the health care insurance plan of another province or territory.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends or profits to its owners, shareholders, operators or members.

Term	Description
Private (not-for-profit) Health Care Facility	This is a privately owned health care facility that is recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Provision of Information Condition	The <i>Canada Health Act</i> (section 13 (a)) requires that provincial and territorial governments provide information to the federal minister of health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of administering the Act.
Public Administration Criterion	The public administration criterion set out in section 8 of the <i>Canada Health Act</i> requires that each provincial and territorial health care insurance plan be administered and operated on a non-profit basis by a public authority that is responsible to the provincial or territorial government, and whose accounts and financial transactions are publicly audited.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides insured health care services under a provincial or territorial health care insurance plan on an in- or out-patient basis.
Recognition Condition	The <i>Canada Health Act</i> (section 13(b)) requires that provincial and territorial governments give recognition to the Canada Health and Social Transfer (CHST) in any public documents, advertisements or promotional material relating to insured health care services and extended health services in the province or territory.
Refugee Claimant	A refugee claimant is a person of non-Canadian nationality who has arrived in Canada and has applied for refugee protection status in Canada under the <i>Immigration and Refugee Protection Act</i> . If a refugee claimant receives a final determination from the Immigration and Refugee Board that he or she meets the definition of refugee in the 1951 <i>United Nations Convention Relating to the Status of Refugees</i> , then he or she may apply for permanent residence status in Canada.
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required by a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	Section 2 of the <i>Canada Health Act</i> defines a resident as a person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.

Term	Description
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology, and urology.
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Surgical-Dental Services	Section 2 of the <i>Canada Health Act</i> defines surgical-dental services as 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.
Surgical Physician Service	For purposes of reporting on the <i>Canada Health Act</i> , a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	Under the portability criterion of the <i>Canada Health Act</i> (section 11(1)(b)), the term "temporarily absent" is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.
Universality	This criterion of the <i>Canada Health Act</i> (section 10) requires that each provincial or territorial health care insurance plan entitle one hundred per cent of the insured persons of the province or territory to the insured health services provided for by the plan on uniform terms and conditions.
User Charge	Section 2 of the <i>Canada Health Act</i> defines a user charge as any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charge imposed by extra-billing. Please refer as well to the definition for extra-billing.