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CANADA HEALTH ACT

ANNUAL REPORT
2016–2017

Canada

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

I am honoured to present to Parliament and to Canadians the Canada Health Act Annual Report 2016–2017, my first as Minister of Health.

AS A FORMER SOCIAL WORKER, I dedicated 25 years of my professional life to working in communities. From this experience, I have seen firsthand that access to high-quality health care is one of the key determinants that enable individuals to lead fulfilling and productive lives. Protecting and upholding human rights and social justice are the fundamental objectives of social work and are closely linked to the values that underpin the *Canada Health Act*—equity, fairness and solidarity.

These values are undermined when patients are charged for medically necessary care at the point of service. Canadians should have equitable access to required medical care based on their need and not on their ability, and willingness, to pay. This is why the Prime Minister has charged me with the responsibility to "Promote and defend the Canada Health Act to make absolutely clear that extra-billing and user fees are illegal under Canada's public Medicare system, and develop policies in collaboration with provinces and territories to improve verification and recourse mechanisms when instances of non compliance arise."

There was a time when many Canadians faced debt and hardship when they needed to seek treatment for illness or injury. I am grateful that there were great Canadians—Tommy Douglas, Justice Emmett Hall, Monique Bégin, to name just a few—who fought long and hard to correct this and to ensure we all have equitable access to essential health care services.

In May 2017, the late Justice Emmett Hall was inducted into the Canadian Medical Hall of Fame. Tasked with leading the Royal Commission on Health Services in 1961, which ultimately laid the foundation for the *Canada Health Act*, Justice Hall had a profound and enduring impact on Canada's health care system. Considered a founding father of Medicare, he worked tirelessly throughout his life for Indigenous rights, equal access to health care, and the rights of the disabled. His words, in defense of universal access to care, still hold true:

> *We, as a society, are aware that the pain of illness, the trauma 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. The Canadian people determined that they should band together to pay medical bills when they were well and income earning. Health services were no longer to be bought off the shelf and paid for at the checkout stand. Nor was their price to be bargained for at the time they were sought. They were a fundamental need, like education, which Canadians could meet collectively and pay for through taxes.*

While patient charges were quite rampant across Canada during Justice Hall's tenure, today, most Canadians access needed medical care without having to face charges. That said, there are some instances where this is not the case. This is simply not fair.

During my first meeting with my provincial and territorial counterparts, I indicated that Canadians should not be faced with charges for surgeries, tests, or doctors' visits. I intend to continue this conversation over the coming months, and to work with provinces and territories to address the issue of patient charges in an even-handed manner.

In 1965, when Prime Minister Lester B. Pearson asked Justice Hall whether Tommy Douglas' Saskatchewan health care experiment could work across Canada, he responded, "most definitely." When I am asked if the *Canada Health Act* remains relevant and should be defended, I say "most definitely."

— The Honourable Ginette Petitpas Taylor, Minister of Health

INTRODUCTION

Canada has a predominantly publicly financed and administered health care system. The Canadian health insurance system is achieved through 13 interlocking provincial and territorial health care insurance plans, and is designed to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital and physician services on a prepaid basis, without charges related to the provision of insured health services.

The Canadian health insurance system evolved into its present form over more than six decades. Saskatchewan was the first province to establish universal, public hospital insurance in 1947 and, ten years later, the Government of Canada passed the *Hospital Insurance and Diagnostic Services Act* (1957), to share in the cost of these services with the provinces and territories. By 1961, all the provinces and territories had public insurance plans that provided universal access to hospital services. Saskatchewan again pioneered by providing insurance for physician services, beginning in 1962. The Government of Canada enacted the *Medical Care Act* in 1966 to cost-share the provision of insured physician services with the provinces and territories. By 1972, all provincial and territorial plans had been extended to include physician services.

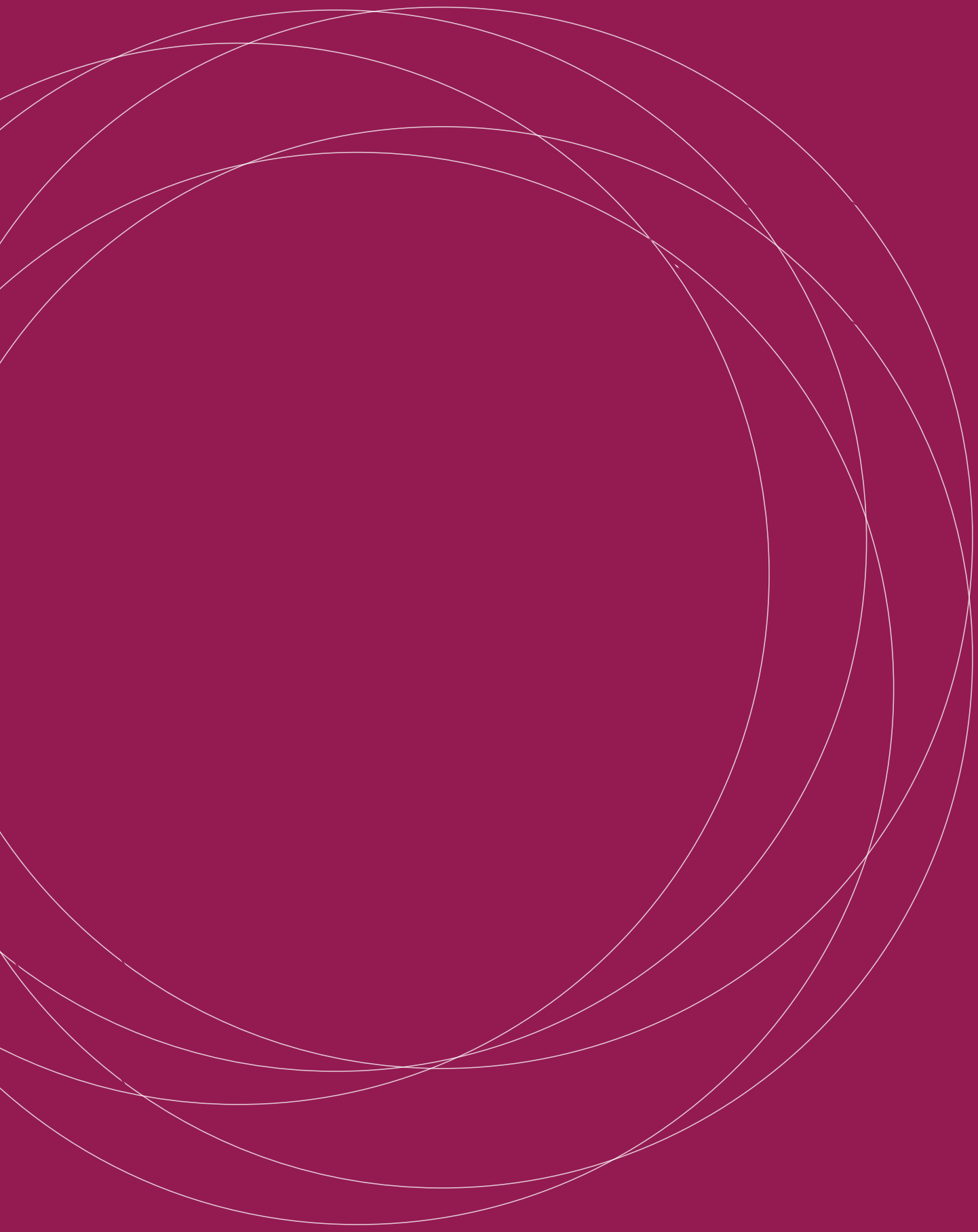
In 1979, at the request of the federal government, Justice Emmett Hall undertook a review of the state of health services in Canada. In his report, he affirmed that health care services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user charges levied by hospitals were creating a two-tiered system that threatened the universal accessibility of care. This report, and the national debate it generated, led to the enactment of the *Canada Health Act* in 1984.

The *Canada Health Act* is Canada's federal health care insurance legislation and defines the national principles that govern the Canadian health care insurance system, namely, public administration, comprehensiveness, universality, portability and accessibility. These principles reflect the underling Canadian values of equity and solidarity.

The roles and responsibilities for Canada's health care system are shared between the federal, provincial and territorial governments. The provincial and territorial governments have primary jurisdiction in the administration and delivery of health care services. This includes setting their own priorities, administering their health care budgets and managing their own resources. The federal government, under the *Canada Health Act*, sets out the criteria and conditions that must be satisfied by the provincial and territorial health care insurance plans for provinces and territories to qualify for their full share of the cash contribution available to them under the federal Canada Health Transfer.

On an annual basis, the Federal Minister of Health is required to report to Parliament on the administration and operation of the *Canada Health Act*, as set out in section 23 of the Act. The vehicle for so doing is the *Canada Health Act Annual Report*. While the principal and intended audience for the annual report is Parliamentarians, it is a public document that offers a comprehensive description of insured health services in each of the provinces and territories. The Annual Report is structured to address the mandated reporting requirements of the Act; as such, its scope does not extend to commenting on the status of the Canadian health care system as a whole.

Provincial and territorial health care insurance plans generally respect the criteria and conditions of the *Canada Health Act* and many exceed the requirements of the Act. However, when instances of possible non-compliance with the Act arise, Health Canada's approach to the administration of the Act emphasizes transparency, consultation and dialogue with provincial and territorial health care ministries. Health Canada's goal is not to levy penalties as a punitive measure but to ensure compliance with the principles of the *Canada Health Act* so that Canadians have access to the health care they need, when they need it.



CHAPTER 1

CANADA HEALTH ACT OVERVIEW

This section describes the *Canada Health Act*, its requirements, key definitions, Regulations and 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, and the letter from former Federal Minister, A. Anne McLellan, to her provincial and territorial counterparts on the Canada Health Act Dispute Avoidance and Resolution process. A history of the evolution of federal health care transfers follows.

WHAT IS THE *CANADA HEALTH ACT?*

The *Canada Health Act* 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 Act is to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital and physician services on a prepaid basis, without charges related to the provision of insured health 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 Act as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the Act include serving members of the Canadian Forces and inmates of federal penitentiaries.

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

Insured hospital services are defined under the Act 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 therefor from the hospital.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by the provincial or territorial health care insurance plan, in conjunction with the medical profession.

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

They are:

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

THE CRITERIA

1. PUBLIC ADMINISTRATION (SECTION 8)

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

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

2. COMPREHENSIVENESS (SECTION 9)

The comprehensiveness criterion of the Act 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).

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 plan to establish entitlement.

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 (up to three months) imposed by the new province or territory of residence. It is the responsibility of residents to inform their province or territory's health care insurance plan that they are leaving and to register with the health care insurance plan of their new province or territory.

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. If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

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

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

5. ACCESSIBILITY (SECTION 12)

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

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" 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.

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.

THE CONDITIONS

1. INFORMATION (SECTION 13(A))

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

2. RECOGNITION (SECTION 13(B))

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

EXTRA-BILLING AND USER CHARGES

The provisions of the *Canada Health Act* pertaining to 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 confirmed that either extra-billing or user charges exist in a province or territory, a mandatory dollar-for-dollar deduction from the federal cash transfer to that province or territory is required under the Act.

EXTRA-BILLING (SECTION 18)

Under the Act, 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 dentist providing insured surgical-dental 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 was to charge a patient any amount for an office visit that is insured by the provincial or territorial health care insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore also contrary to the accessibility criterion.

USER CHARGES (SECTION 19)

The Act defines user charges as any charge for an insured health service, other than extra-billing.For example, if patients were charged a facility fee for the non-physician (i.e., hospital) services provided at a clinic, that fee would be considered a user charge. User charges are not permitted under the Act because, as is the case with extra-billing, they constitute a barrier or impediment to access.

OTHER ELEMENTS OF THE ACT

REGULATIONS (SECTION 22)

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

- defining the services included in the Act's definition of "extended health care services," e.g., nursing home care or home care;
- prescribing which services are excluded from hospital services;
- prescribing the types of information that the Federal Minister of Health may reasonably require, as well as the format and submission deadline for the information; and

- prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

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

PENALTY PROVISIONS OF THE *CANADA HEALTH ACT*

MANDATORY PENALTY PROVISIONS

Under the Act, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT. For example, this means that when it has been determined that a province or territory has allowed any amount in extra-billing by physicians, the federal cash contribution to that province or territory will be reduced by that same amount. The amount of such a deduction for a fiscal year is determined by the Federal Minister of Health. Although it is usually based on information provided by the province or territory in accordance with the *Extra-billing and User Charges Information Regulations* (described below), Section 20 of the Act requires the Minister to make an estimate of the amount of extra-billing and user charges where information is not provided in accordance with the Regulations. This process requires the Minister to consult with the province or territory concerned.

DISCRETIONARY PENALTY PROVISIONS

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

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

EXCLUDED SERVICES AND PERSONS

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

EXCLUDED SERVICES

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

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

In addition to the medically necessary hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of other programs and services. 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 the province or territory.

EXCLUDED PERSONS

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

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

POLICY INTERPRETATION LETTERS

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

EPP LETTER

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, Federal Minister of Health and Welfare Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the Act

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 Act'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 their impact on Canada's universal, publicly funded health care system.

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

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

DISPUTE AVOIDANCE AND RESOLUTION PROCESS

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

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on Act-related 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.

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

EVOLUTION OF FEDERAL HEALTH CARE TRANSFERS

GRANTS TO HELP ESTABLISH PROGRAMS AND COST-SHARING

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 totaled 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 the adoption of the *Hospital Insurance and Diagnostic Services Act* (HIDSA) in 1957. The implementation of the HIDSA 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 July 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 HIDSA, the federal government reimbursed the provinces and territories for approximately 50 per cent of the costs of hospital insurance. In both cases, funding was conditional on certain program criteria being met. Under the *Medical Care Act*, the federal contribution was set at 50 per cent 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

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 and increases to the population.

Under the EPF Act and subsequent funding arrangements, the total amount of the provincial and territorial health care entitlement was 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 Established Programs Financing "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.

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 program delivery criteria were not met. It was not until the enactment of the *Canada Health Act* in 1984 that 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.

CANADA HEALTH AND SOCIAL TRANSFER

In the 1995 Budget, the federal government announced a restructuring of the EPF Act, from then on to be called the *Federal-Provincial Fiscal Arrangements Act*, with provisions for a Canada Health and Social Transfer (CHST), for the purpose of maintaining the national criteria and conditions of the *Canada Health Act*, including the Act's provisions relating to extra-billing and user charges.

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 EPF. The new CHST cash amount provided to provinces and territories was less than the combined values of EPF and CAP, reflecting the need for fiscal restraint at the time the CHST was introduced. The 1995 and 1996 Budget legislation provided for total CHST amounts (cash and tax transfers) for subsequent years, with an annual floor of $11 billion for the cash component to apply until 2002–2003.

The Federal-Provincial Fiscal Arrangements Act also transferred the cash payment authority from Health Canada to the Department of Finance. However, the Federal Minister of Health continued to be responsible for:

- recommending the amounts of any deductions or withholdings pursuant to the conditions and criteria of the Act to the Governor in Council;
- determining the amounts of any deductions pursuant to the extra-billing and user charges provisions of the Act;
- and ensuring that these amounts are communicated to the Department of Finance before the CHST payment dates.

From 1997 to 2000, there were several increases to the cash portion of the CHST, including increases to the cash floor. In 1998, the cash floor was increased to $12.5 billion. With the federal government's return to surpluses, Budget 1999 announced an additional $11.5 billion for health care. Of this amount, $8 billion was provided in CHST cash over the following four years. The remaining $3.5 billion was provided through a trust fund notionally allocated over three years to provide provinces and territories flexibility over when to draw down the funds. Budget 2000 then provided an additional $2.5 billion for health care through another trust fund to provinces and territories, notionally allocated over four years.

2000 AND 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. This included an additional $21.1 billion in 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 health reform (primary care, home care and catastrophic drugs). This was provided through $14 billion in increased CHST transfers and $16 billion for the Health Reform Transfer, as well as $1.5 billion for medical equipment. This was in addition to $5.3 billion in federal direct spending on health information technologies, Aboriginal health initiatives, patient safety and other health-related federal initiatives.

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 the 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 *Canada Health Act*. 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 per cent for the CHT and 38 per cent 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 in funding, over ten years until 2013–2014, to the provinces and territories for health. This included $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.

BUDGET 2007

Budget 2007 put all major transfers on a long-term, principles-based track to 2013–2014. In order to provide comparable treatment for all Canadians regardless of where they live, the budget legislated equal per capita cash support for the CST, starting in 2007–2008, and the CHT, starting after the 10-Year Plan to Strengthen Health Care concluded in 2013–2014. In addition, Budget 2007 invested an additional $1 billion to help provinces and territories introduce wait time guarantees, including initiatives delivered through Canada Health Infoway.

CURRENT TRANSFER LEVELS

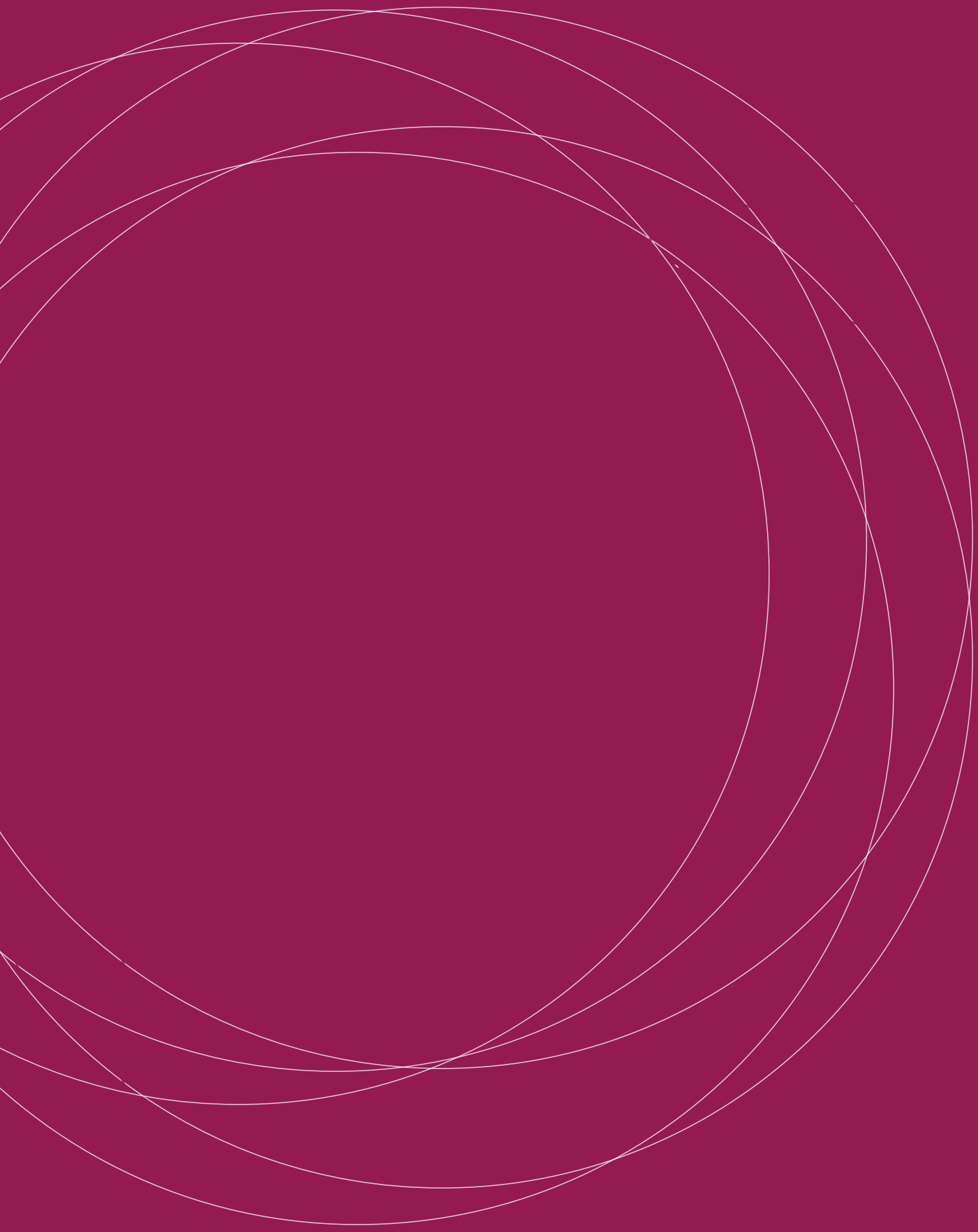
As announced by the Government of Canada in December 2011, and legislated in the *Jobs, Growth and Long-term Prosperity Act*, the CHT grew at an annual rate of six per cent for an additional three years beyond 2013–2014 (i.e., until 2016–2017). Starting in 2017–2018, the CHT will grow in line with a three-year moving average of nominal gross domestic product growth, with funding guaranteed to increase by at least three per cent per year.

Following up on the 2007 legislation for a transition to an equal per capita cash allocation for the CHT in 2014–2015, the *Jobs, Growth and Long-term Prosperity Act* ensured a fiscally responsible transition by providing protection so that no province or territory would receive less than its 2013–2014 CHT cash allocation in subsequent years as a result of the move to equal per capita cash.

In 2016, the Government of Canada focused its health care negotiations with the provinces and territories on priority areas for investment. In Budget 2017, the Government of Canada confirmed $11 billion in funding over ten years for provinces and territories, starting in 2017–18, targeted specifically to improve access to home care and mental health services. Based on an overarching framework outlining common priorities in these areas, funding will flow to provinces and territories through bilateral agreements. The Canadian Institute for Health Information has been tasked with developing common indicators across provinces and territories to measure overall progress in improving access to services in these two areas.

Additional information on federal-provincial-territorial funding arrangements is available upon request from the Department of Finance, or by visiting its website at: Federal Support to Provinces and Territories—Major Federal Transfers at: www.fin.gc.ca/access/fedprov-eng.asp

Information about the home care and mental health bilateral agreements are available at www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities.html



CHAPTER 2
ADMINISTRATION AND COMPLIANCE

ADMINISTRATION

In administering the *Canada Health Act* (CHA), the Federal Minister of Health is assisted by Health Canada staff and by the Department of Justice.

THE CANADA HEALTH ACT DIVISION

The Canada Health Act Division of Health Canada is responsible for administering the CHA. Members of the Division fulfill the following ongoing functions:

- monitoring and analyzing provincial and territorial health care insurance plans for compliance with the criteria, conditions, and extra-billing and user charges provisions of the CHA;
- disseminating information on the CHA;
- responding to enquiries 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;
- developing and maintaining formal and informal relationships with health officials in provincial and territorial governments for information sharing;
- producing the Canada Health Act Annual Report on the administration and operation of the CHA;
- conducting issue analysis and policy research to provide strategic advice;
- collaborating with provincial and territorial health department representatives through the Interprovincial Health Insurance Agreements Coordinating Committee (see below);
- working in partnership with the provinces and territories to encourage compliance with the CHA;
- asking provincial and territorial health ministries to investigate and provide information and clarification when possible compliance issues arise, and, when necessary, recommending corrective action to them, in order to ensure the criteria and conditions of the Act are upheld;
- informing the Federal Minister of Health of possible non-compliance and recommending appropriate action to resolve the issue; and
- working with Health Canada Legal Services and Justice Canada on litigation issues that implicate the CHA.

INTERPROVINCIAL HEALTH INSURANCE AGREEMENTS COORDINATING COMMITTEE

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

All provinces and territories participate in hospital reciprocal billing agreements, and all, with the exception of Quebec, participate in medical reciprocal billing agreements. These agreements generally ensure that a patient's health card will be accepted, in lieu of payment, when the patient receives insured hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province. The intent of these agreements is to ensure that Canadian residents do not have to pay directly for medically necessary hospital and physician services when they travel within Canada.

Of note, these agreements are interprovincial, not federal, and while they facilitate the portability criterion, they are not a requirement of the CHA. During the reporting period, IHIACC added services related to medical assistance in dying to reciprocal billing.

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

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

Newly established in 2016, the Policy Research Working Group examines policy-related issues that impede coverage of insured health services with the aim of increasing the consistency and coordination of inter-provincial billing practices.

COMPLIANCE

Health Canada's approach to resolving possible 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.

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

Staff in the Compliance and Interpretation Unit of the Canada Health Act Division assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate action. Verifying the facts with provincial and territorial health officials 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, such as eligibility for health insurance coverage and portability of health services within and outside Canada, and are resolved quickly with provincial or territorial assistance.

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

COMPLIANCE ISSUES

For the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the *Canada Health Act*. However, on the basis of their health ministry's report to Health Canada, a deduction in the amount of $184,508 was taken from the March 2017 Canada Health Transfer payments to British Columbia in respect of extra-billing and user charges for insured health services at private clinics in fiscal year 2014–2015. At the same time, the governments of British Columbia and Canada agreed to an audit project to determine the extent and nature of extra-billing and user charges in British Columbia. Results from that project were expected in late 2017 and will be reported in next year's Canada Health Act Annual Report.

In Quebec, on the basis of patient charges reported by the Quebec Auditor General with respect to 2014–15, the Minister estimated a deduction amount of $9,907,229, which was levied to Quebec's March 2017 Canada Health Transfer payments.

As reported in last year's Canada Health Act Annual Report, on March 31, 2016, the Government of Canada gave notice that it would appear as a party in the *Cambie Surgeries Corporation et al. v. Medical Services Commission et al*. litigation, before the British Columbia Supreme Court, pursuant to British Columbia's *Constitutional Question Act*. The plaintiffs in the litigation are seeking to invalidate provisions of British Columbia's *Medicare Protection Act* that prohibit user charges, extra-billing and private insurance for health services covered under British Columbia's provincial health care insurance plan, on the basis that these provisions violate sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*. Canada is making arguments in support of the constitutionality of provisions of the *Medicare Protection Act*, which reflect the principles of the CHA. During the reporting period, Canada continued to support British Columbia in its defence in this Charter challenge, and to prepare evidence on behalf of the federal government.

Health Canada continues to monitor provincial and territorial compliance with the CHA. The following key developments occurred since the 2015–2016 Canada Health Act Annual Report was published:

During 2016–2017, Health Canada continued to consult with Alberta Health about private primary health care clinics that charge patients annual enrollment and membership fees. If the receipt of insured services is conditional upon the payment of fees, it would pose concerns under the accessibility criterion of the CHA. Typically, the fees cover a basket of uninsured services but also promise quick access to and unrushed appointments with family physicians. In June 2016, Health Canada was informed that audits were to be conducted of four clinics and the results would be shared with the federal government. Health Canada will continue to monitor this issue.

Under the CHA, the definition of "hospital services" specifies that standard or public ward level accommodation is an insured service. Charges for preferred accommodation are permissible under the CHA only where such accommodation is not medically required, and is provided at the patient's request. If ward level accommodation is not available or cannot be offered, patients must be provided private or semi-private accommodations at no charge. After reviewing provincial and territorial legislation and policies in 2014, Health Canada was concerned inappropriate charges for accommodations might be occurring in Quebec, Ontario, and British Columbia. Quebec and British Columbia addressed these concerns, while Ontario resolved the issue during the 2017–18 period.

Following media reports in March 2017, Health Canada wrote to Ontario to express its concerns that some clinics in Ontario were imposing enrollment fees on insured residents as a condition of receiving insured services. In the absence of details describing specific instances of this practice, the province was unable to comment on the cases mentioned in the media. Nonetheless, the province informed Health Canada that it had taken efforts in the past to educate clinics that enrollment fees could not be a barrier to service for insured residents, and would approach these clinics again to ensure they were aware of their obligations under the Ontario *Commitment to the Future of Medicare Act*. Health Canada was satisfied with this approach and no further compliance action was taken.

MRI and CT services are considered to be insured health services when they are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, whether the scan is provided in a hospital or a clinic. While Saskatchewan is the only province that expressly encourages this practice through legislation, there is evidence of residents paying out of pocket to secure faster access to diagnostic services in other provinces, including British Columbia, Alberta, Quebec, New Brunswick and Nova Scotia.

In July 2015, Health Canada wrote to the Quebec Ministry of Health concerning Bill 20, which proposed to allow patient charges (accessory fees) by physicians, when they provide certain publicly insured health services in their offices or private clinics. The Federal Minister of Health communicated her concerns over accessory fees to the Quebec Health Minister in early September 2016 and on September 28, 2016, the Quebec Health Minister introduced regulations under Quebec's health legislation which limited these charges to the transportation of blood and biological samples as of January 2017.

Abortion services are insured in all provinces and territories; however, access to these insured services varies within and between jurisdictions across the country. Last year's CHA Annual Report indicated that Prince Edward Island planned to begin providing abortion services on the Island to its residents. With the opening of a women's health centre in January 2017, which offers abortions services, Health Canada considers Prince Edward Island to be in compliance with the *Canada Health Act*. In New Brunswick, abortion services are only covered if performed in a hospital; procedures provided in the private clinic in Fredericton or other private clinics are not covered. The lack of coverage for private clinic abortions under the New Brunswick provincial health care insurance plan remains a concern under the accessibility and comprehensiveness criteria of the CHA.

During 2016–2017, Health Canada continued to monitor the following ongoing compliance and interpretation issues:

Health Canada remains concerned about patient payments for drugs administered in hospital out-patient clinics and their appropriateness under the CHA, since drugs and biological products administered in hospitals that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability are insured health services under the CHA.

Physician services received by Quebec residents when out-of-province are not reimbursed at host province rates, which is a requirement of the portability criterion of the CHA. Canadians from provinces other than Quebec also report difficulties having their provincial or territorial health insurance cards honoured while out-of-province, particularly by walk-in clinics, which runs counter to the spirit of the CHA. For all jurisdictions, except Prince Edward Island and the three territories, the per diem rates for reimbursement of out-of-country hospital services appear lower than home province or territory rates, which is contrary to the requirement of the portability criterion of the CHA.

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 in 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 allowed extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244,732,000 in deductions was refunded to New Brunswick ($6,886,000), Quebec ($14,032,000), Ontario ($106,656,000), Manitoba ($1,270,000), Saskatchewan ($2,107,000), Alberta ($29,032,000) and British Columbia ($84,749,000).

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. The table at the end of this section summarizes deductions and refunds that have been made to provincial or territorial transfer payments since 1984–1985.

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

In January 1995, Federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary surgical services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given approximately 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 $3,585,000 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 care insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of $280,430 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 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 Canada Health and Social Transfer (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 a private 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, total deductions of $372,135 were made to Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee. A final deduction of $5,463 was taken from the March 2005 Canada Health Transfer (CHT) payment to Nova Scotia as a reconciliation of deductions that had already been taken for 2002–2003. A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT payment to reconcile amounts actually charged in respect of extra-billing and user charges with the penalties that had already been levied based on provincial estimates reported for fiscal 2003–2004.

In January 2003, British Columbia provided a financial statement in accordance with the *Canada Health Act Extra-billing and User Charges Information Regulations*, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000–2001, totaling $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 *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 the Minister estimated to have been charged during fiscal year 2001–2002.

Since 2005, $1,641,798 in cash transfer deductions have been taken from British Columbia's CHT payments in light of patient charges occurring in the province. This amount is the sum of deductions taken from fiscal year 2004/05 to 2016/17, as shown in the table at the end of this chapter. This methodology was used in subsequent years.

A deduction of $1,100 was taken from the March 2005 CHT payment to Newfoundland and Labrador as a result of patient charges for a magnetic resonance imaging scan in a hospital which occurred during 2002–2003. The March 2007 CHT payment to Nova Scotia was reduced by $9,460 in respect of extra-billing during fiscal year 2004–2005.

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

In March 2017, on the basis of amounts of extra-billing and user charges reported by the Quebec Auditor General with respect to 2014–2015, the Minister estimated a deduction amount of $9,907,229. In light of corrective action the provincial government had already taken to eliminate accessory fees in January 2017, that amount was subsequently returned to Quebec by the Government of Canada.

Since the passage of the CHA, from April 1984 to March 2017, deductions totaling $11,807,000 have been taken from transfer payments in respect of the extra-billing and user charges provisions of the CHA. This amount excludes deductions totaling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated, as well as the $9,907,229 deduction returned to Quebec in March 2017, in light of corrective action the provincial government had already taken to address the issue of accessory fees in January 2017.

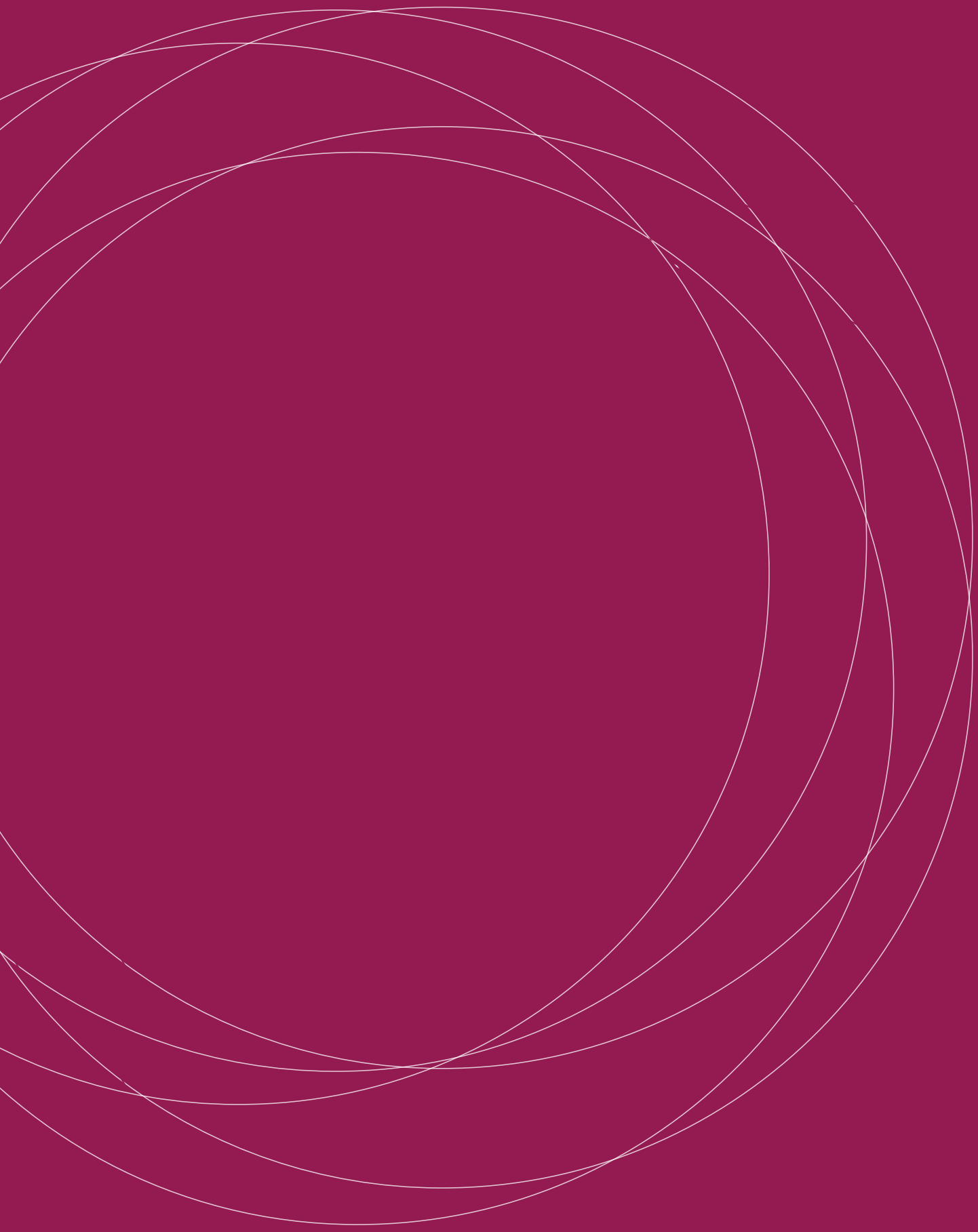
DEDUCTIONS, REFUNDS, AND RECONCILIATIONS TO CHST/CHT CASH CONTRIBUTIONS IN ACCORDANCE WITH THE *CANADA HEALTH ACT* SINCE FY 1984–1985 (IN DOLLARS)

	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YT	NT	NU	TOTAL
1984/85	-	-	-	3,078,000	7,893,000	39,996,000	810,000	1,451,000	9,936,000	2,797,000	-	-	-	**65,961,000**[1]
1985/86	-	-	-	3,306,000	6,139,000	53,328,000	460,000	656,000	11,856,000	30,620,000	-	-	-	**106,365,000**[1]
1986/87	-	-		502,000	-	13,332,000	-	-	7,240,000	31,332,000	-	-	-	**52,406,000**[1]
1987/88–1991/92	-	-	-	-	-	-	-	-	-	-	-	-	-	**0**
1992/93	-	-	-	-	-	-	-	-	-	83,000	-	-	-	**83,000**
1993/94	-	-	-	-	-	-	-	-	-	1,223,000	-	-	-	**1,223,000**
1994/95	-	-	-	-	-	-	-	-	-	1,982,000	-	-	-	**1,982,000**
1995/96	46,000	-	32,000	-	-	-	269,000	-	2,319,000	43,000	-	-	-	**2,709,000**
1996/97	96,000	-	72,000	-	-	-	588,000	-	1,266,000	-	-	-	-	**2,022,000**
1997/98	128,000	-	57,000	-	-	-	586,000	-	-	-	-	-	-	**771,000**
1998/99	53,000	-	38,950	-	-	-	612,000	-	-	-	-	-	-	**703,950**
1999/00	(42,570)	-	61,110	-	-	-	-	-	-	-	-	-	-	**18,540**
2000/01	-	-	57,804	-	-	-	-	-	-	-	-	-	-	**57,804**
2001/02	-	-	35,100	-	-	-	300,201	-	-	-	-	-	-	**335,301**
2002/03	-	-	11,052	-	-	-	-	-	-	4,610	-	-	-	**15,662**
2003/04	-	-	7,119	-	-	-	-	-	-	126,775	-	-	-	**133,894**
2004/05	1,100	-	5,463	-	-	-	-	-	-	72,464	-	-	-	**79,027**
2005/06	-	-	(8,121)	-	-	-	-	-	-	29,019	-	-	-	**20,898**
2006/07	-	-	9,460	-	-	-	-	-	-	114,850	-	-	-	**124,310**
2007/08	-	-	-	-	-	-	-	-	-	42,113	-	-	-	**42,113**
2008/09	-	-	-	-	-	-	-	-	-	66,195	-	-	-	**66,195**
2009/10	-	-	-	-	-	-	-	-	-	73,925	-	-	-	**73,925**
2010/11	3,577	-	-	-	-	-	-	-	-	75,136	-	-	-	**78,713**
2011/12	58,679	-	-	-	-	-	-	-	-	33,219	-	-	-	**91,898**
2012/13	50,758	-	-	-	-	-	-	-	-	280,019	-	-	-	**330,777**
2013/14	(10,765)	-	-	-	-	-	-	-	-	224,568	-	-	-	**213,803**
2014/15	-	-	-	-	-	-	-	-	-	241,637	-	-	-	**241,637**
2015/16	-	-	-	-	-	-	-	-	-	204,145	-	-	-	**204,145**
2016/17	-	-	-	-	9,907,229	-	-	-	-	184,508	-	-	-	**10,091,737**
TOTAL	383,779	0	378,937	6,886,000	23,939,229	106,656,000	3,625,201	2,107,000	32,617,000	69,853,183	0	0	0	**246,446,329**

[1] Deductions subsequently refunded under the statutory refund provision of the *Canada Health Act*, Section 20(5), for extra-billing and user charges deductions made during the fiscal years 1984–1985, 1985–1986, and 1986–1987.

UNDERSTANDING THIS CHART

- To date, most deductions have been based on statements of actual extra-billing and user charges, meaning they are made two years after the extra-billing and user charges occurred.
- If a province or territory fails to file a statement of extra-billing and user charges or the Federal Minister of Health believes a report to be inaccurate, the *Canada Health Act* obligates the Federal Minister of Health to estimate a deduction in consultation with the minister responsible for health in the province or territory in question.
- In instances where provinces and territories estimated anticipated amounts of extra-billing and user charges for the upcoming year, a deduction was taken in respect of those charges in the fiscal year for which they were estimated.
- In addition to forming the basis for most deductions under the Act, the statements of actual extra-billing and user charges provide an opportunity to reconcile any estimated charges with those that actually occurred. These reconciliations form the basis for further modifications to provincial and territorial cash transfers.
- Numbers in parentheses represent reconciliations made to the province or territory.



CHAPTER 3

PROVINCIAL AND TERRITORIAL HEALTH CARE INSURANCE PLANS IN 2016–2017

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* program criteria and conditions in 2016–2017.

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

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

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

To help provinces and territories prepare their submissions to the annual report, Health Canada provided them with the document; Canada Health Act Annual Report 2016-2017: A Guide for Updating Submissions (User's Guide). The User's Guide is designed to help provinces and territories meet Health Canada's reporting requirements. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services. This year's User Guide requested additional information from the provinces and territories on the following topics:

- how jurisdictions handle complaints of extra-billing or user charges, including any mechanisms to refund inappropriate charges;
- whether there are any monitoring or auditing programs related to physician remuneration;
- appeals of decisions rendered by a health care insurance plan related to residency or out-of-jurisdiction coverage;

- additional statistics regarding dentists and their participation status in public health care insurance plans; and,
- the ability of residents to opt-out of provincial or territorial health care insurance plans.

Health Canada will continue to work with provinces and territories to expand and strengthen the scope and content of information made available to Canadians through the Canada Health Act Annual Report.

The process for the Canada Health Act Annual Report 2016–2017 was launched late spring 2017 with bilateral teleconferences. An updated User's Guide was also sent to the provinces and territories at that time.

INSURANCE PLAN DESCRIPTIONS

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

PROVINCIAL AND TERRITORIAL HEALTH CARE INSURANCE PLAN STATISTICS

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

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

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental services by province and territory for five consecutive years ending on March 31, 2017. All information was provided by provincial and territorial officials.

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

ORGANIZATION OF THE INFORMATION

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

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

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

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

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

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

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

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

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

NEWFOUNDLAND AND LABRADOR

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

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

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

With an annual budget of approximately $3 billion, the Department accounts for approximately 40 per cent of Newfoundland and Labrador's total provincial budget. Budget 2016–2017 included funding for new service options for seniors requiring enhanced care; coverage of a number of new drug therapies under the Newfoundland and Labrador Prescription Drug Program, and planning for new health facilities.

In Newfoundland and Labrador, health services are provided to over 530,000 residents by approximately 20,000 health care providers, support staff and administrators.

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 (HIP) and the Medical Care Plan (MCP). Both plans are non-profit and publicly administered.

The *Medical Care and Hospital Insurance Act* came into force on October 1, 2016, replacing both the *Medical Care Insurance Act, 1999* and the *Hospital Insurance Agreement Act*. www.assembly.nl.ca/Legislation/sr/statutes/m05-01.htm.

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

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

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

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

1.2 REPORTING RELATIONSHIP

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

The Government of Newfoundland and Labrador has a provincial planning and reporting requirement for all government departments, including the Department of Health and Community Services. Under the *Transparency and Accountability Act*, the Department of Health and Community Services and the 10 other entities that report to the Minister, including RHAs, produce a strategic plan once every three years and report annually on performance. Plans and reports are tabled in the House of Assembly and posted on the Department's website: www.health.gov.nl.ca/health/publications/index.html

The 2016–2017 Department of Health and Community Services Annual Report was tabled in the House of Assembly on September 28, 2017.

1.3 AUDIT OF ACCOUNTS

Each year, the province's Auditor General independently examines provincial public accounts. MCP expenditures are considered a part of the public accounts. While respecting privacy and personal information, the Auditor General has full and unrestricted access to code-based MCP records.

The four RHAs are subject to financial statement audits, reviews, and compliance audits. Financial statement audits are performed by independent auditing firms that are selected by the RHAs. Review engagements, compliance audits and physician audits are carried out by personnel from the Department under the authority of the *Medical Care and Hospital Insurance Act*. Physician records and professional medical corporation records are reviewed to ensure that the records supported the services billed and that the services are insured under the MCP.

Beneficiary audits are performed by personnel from the Department under the *Medical Care and Hospital Insurance Act*.

The Auditor General regularly conducts independent performance audits of Government programs. In 2016, the Auditor General reviewed acute care bed management, salaried physicians and the road ambulance program. The Department is taking the Auditor General's recommendations into consideration as it implements program improvements.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

As of March 31, 2017, the *Medical Care and Hospital Insurance Act* and the *Hospital Insurance Regulations*, made thereunder, provided for insured hospital services in Newfoundland and Labrador. All the hospital services listed under the *Canada Health Act* are insured services in Newfoundland and Labrador.

Insured hospital services are provided for in-patients and out-patients in 15 hospitals, 23 community health centres and 65 community clinics as well as numerous health and community services clinics throughout the province. As indicated in the statistics table, the change in the numbers of clinics reflects a change in how the Department classifies public health facilities. Insured services include: accommodations and meals at the standard ward level; nursing services; laboratory, radiology and other diagnostic procedures; drugs, biologicals and related preparations; medical and surgical supplies; operating room, case room and anaesthetic facilities; rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology); out-patient and emergency visits; and day surgery.

The coverage policy for insured hospital services is linked to the coverage policy for insured medical services. The Department manages the process of adding or de-listing a hospital service from the list of insured services based on direction from the Lieutenant-Governor in Council. In 2016–2017 Newfoundland and Labrador added, as insured services, trans-catheter aortic valve implantation (TAVI), and the interpretation of retinal photography, and expanded the billing eligibility criteria for overseeing patients on methadone for opioid dependency to also include Suboxone.

2.2 INSURED PHYSICIAN SERVICES

As of March 31, 2017, the enabling legislation for insured physician services was the *Medical Care and Hospital Insurance Act* and the relevant Regulations continued thereunder, which included the:

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

In 2016–2017 (as of March 31, 2017) there were 1,214 physicians (salaried and fee-for-service) active in practice in the province.

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

- all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;

- 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 *Medical Care and Hospital Insurance Act* and Regulations made under the Act.

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

(3) A practitioner may, in writing, notify the minister of his or her election to collect payments in respect of insured services provided by the practitioner to beneficiaries otherwise than from the minister.

(4) An election under subsection (3) shall have effect from the first day of the first month beginning after the expiration of 60 days after the date on which the minister receives the notice of election.

(5) A practitioner who has made an election under subsection (3) may revoke the election by written notice to the minister.

(6) A revocation of election under subsection (5) shall have effect from the first day of the first month beginning after the expiration of 60 days after the date on which the minister receives the notice of revocation.

(7) Notwithstanding subsections (4) and (6), the minister may waive the time periods in those subsections where, in his or her opinion, it is reasonable to do so. As of March 31, 2017 there were no physicians who had opted out of the MCP.

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

2.3 INSURED SURGICAL-DENTAL SERVICES

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

There were 22 dentists providing insured services under the Surgical-Dental Program as of March 31, 2017.

Dentists may opt out of the MCP as per section 8 of the *Medical Care and Hospital Insurance Act* referenced above. These dentists must advise the patient of their opted-out status, state the fees expected, and provide the patient with a written record of services and fees charged. As of March 31, 2017, there were no opted-out dentists. There was no extra-billing in 2016–2017.

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

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

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Hospital services not covered by the MCP 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 the Workplace Health, Safety and Compensation Commission or by other federal or provincial legislation; and services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the College of Physicians and Surgeons of Newfoundland and Labrador.

The use of the hospital setting for any services deemed not insured by the MCP is also uninsured under the HIP. For purposes of the *Medical Care and Hospital Insurance Act*, 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 Department;
- plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- laser treatment of telangiectasia;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma;

- circumcision of newborns;
- hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the province at a facility not approved by the College of Physicians and Surgeons of Newfoundland and Labrador;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- in vitro fertilization and OSST (ovarian stimulation and sperm transfer);
- reversal of previous sterilization procedure;
- surgical, diagnostic or therapeutic procedures provided in facilities as of January 1998 other than those covered under the *Medical Care and Hospital Insurance Act* or approved by the appropriate authority under paragraph 3(d) of the Medical Care Insurance Insured Services Regulations; and
- other services not within the ambit of section 3 of the Medical Care Insurance Insured Services Regulations.

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

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

The *Medical Care and Hospital Insurance Act* provides the Lieutenant-Governor in Council with the authority to make regulations prescribing which services are or are not insured services for the purpose of the Act. This would involve consultation with the Newfoundland and Labrador Medical Association.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

There were 530,144 people registered with the MCP as of March 31, 2017. Residents of Newfoundland and Labrador are eligible for coverage under the *Medical Care and Hospital Insurance Act*. This Act defines a "resident" as a person who is lawfully entitled to be or to remain in Canada, makes his or her home in the province, and is ordinarily present in the province, but does not include a tourist, transient or visitor to the province.

The *Medical Care Insurance Beneficiaries and Inquiries Regulations* identify those residents eligible to receive coverage under the plans. The MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications for coverage. The MCP applies the standard that persons moving to Newfoundland and Labrador from another province become eligible on the

first day of the third month following the month of their arrival. Every resident of the province is required to register for MCP.

Persons not eligible for coverage under the plans include: students and their dependents already covered by another province or territory; dependents of residents if covered by another province or territory; refugee claimants and their dependents; foreign workers with employment authorizations and their dependents who do not meet the established criteria; foreign seasonal workers, tourists, transients, visitors and their dependents; Canadian Forces personnel; inmates of federal prisons; and armed forces personnel from other countries who are stationed in the province. If the status of these individuals changes, they must meet the criteria as noted above in order to become eligible. Applicants wishing to appeal an eligibility issue may request a formal file review from the Minister.

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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, and individuals released from federal penitentiaries. For coverage to be effective, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada authorized to work in the province for one year or more and their eligible dependents, and to international post-secondary students attending a recognized Newfoundland and Labrador educational institution who have a valid study permit entitling them to stay in Canada for more than 365 days and their eligible dependents.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

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

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

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

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

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

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

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in-patient and out-patient services are covered for emergencies, sudden illness, and elective procedures at established rates listed below. Hospital services are considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the 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 haemodialysis is $330 per treatment. The approved rates are paid in Canadian funds.

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

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

4.4 PRIOR APPROVAL REQUIREMENT

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

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

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for insured hospital services and there is no extra-billing by physicians in the province.

Section 7 of the *Medical Care and Hospital Insurance Act* stipulates that a practitioner who provides insured services, whether or not he or she has made an election under section 8 which is in effect, shall not charge or collect from a beneficiary a fee for those insured services in excess of the amount payable under this Act and the regulations. A practitioner or other person who contravenes this is guilty of an offence and liable on summary conviction to a fine of not more than $20,000 for each contravention.

Complaints from residents regarding charges for insured health services are managed by the department. Depending on the circumstance, HCS may investigate or refer the matter to the College of Physicians and Surgeons of Newfoundland and Labrador.

The Department works closely with post-secondary educational institutions within the province to maintain an appropriate supply of health professionals. The province also works with external organizations for health professionals not trained in this province. Targeted recruitment incentives are in place to attract health professionals. Several programs have been established to provide targeted sign-on bonuses, bursaries, opportunities for upgrading, and other incentives for a wide variety of health occupations.

With respect to wait times to access insured health services, the province is leading a number of initiatives, including the Strategy to Reduce Hip and Knee Joint Replacement Surgery Wait Times, the Provincial Emergency Department Wait Time Strategy and Provincial Endoscopy Wait Time Strategy and the Provincial Endoscopy Wait Time Strategy.

Strategy to Reduce Hip and Knee Joint Replacement Surgery Wait Times

Government released a five-year strategy aimed at reducing wait times for hip and knee joint replacement surgeries in 2012. In the ensuing years, Newfoundland and Labrador (NL) became a national leader with the shortest wait times in the country for hip and knee replacement surgery. However this past year, in keeping with national trends, wait times for hip and knee replacement started to increase again, most notably in Eastern Health, where demand is the highest and continues to increase. Despite this, during the first two quarters of 2016–2017 (April 1 to September 30), wait time reports demonstrate that, on average, 89 per cent of residents of NL received timely access to benchmark procedures within the recommended targets, which is slightly below the national target of 90 per cent. As the work of this strategy concludes, more than 1,600 hip and knee replacement surgeries are performed here each year, which represents a 59 per cent increase since the year before the strategy was released in 2010–11. More specifically, the number of hip and knee replacement surgeries performed in NL has increased by 76 per cent and 52 per cent respectively.

Provincial Emergency Department Wait Time Strategy

This year rapid improvement events were carried out in the remaining two of the 13 Category A emergency departments in the province. During these events, Labrador-Grenfell Health became the first region in the province to implement a "Take a Number" numbering and time stamp system to track the exact sequence and time each patient presents to the emergency department. This system facilitates collecting the exact patient arrival time so that staff can monitor how long patients wait from when they arrive in the emergency department to when they are initially assessed in the newly implemented Nurse First Triage/Registration area. Many emergency departments in the country have struggled with this issue to find a way to measure this first time segment in the emergency patient journey, as patients

should be triaged very shortly after arriving in emergency and not left to wait in a long line up with other patients. Some of the notable emergency departments wait time improvements in the past three years include:

- The highest volume tertiary care emergency department team reduced the average Initial Physician Assessment (IPA) time by 16 per cent overall, and during the hours that the Fast Track and Rapid Assessment Zone teams are working, the time to IPA has decreased by 37 per cent or a decrease of 40 minutes from 107 minutes to 77 minutes.
- One of the rural emergency department teams reduced the average IPA by 59 per cent overall—down from 94 minutes in 2013–2014, to 39 minutes for 2016–2017. As well, due to this reduction in wait times, the number of patients who left without being seen was reduced to 5.5 per cent from 11.5 per cent, which resulted in 1,450 more patients staying and seeing the Physician or Nurse Practitioner in this emergency department. More significantly, this team has been able to sustain these improvements even with a 23 per cent increase in visits to this emergency department.
- Another rural emergency team reduced the average IPA by 11 per cent, and the number of patients who left without being seen was reduced to 4.1 per cent, which resulted in 570 more patients staying and seeing the Physician or Nurse Practitioner in this emergency department.

This work demonstrates progress toward the strategy's goal to improve the collection, reporting, and use of emergency department wait time data.

Provincial Endoscopy Wait Time Strategy

Through the actions of the Provincial Endoscopy Wait Time Strategy, an automated appointment reminder system was implemented for endoscopy services across the province. In the initial phase, telephone appointment reminders were implemented with plans underway to introduce text and e-mail appointment reminders early in 2017–18. Additionally, the Department continued its work with Eastern Health in partnership with the Canadian Association of Gastroenterology (CAG), to continue offering the Skills Enhancement in Endoscopy (SEE) program in the province. As a result of this work, Eastern Health has become that designated training site for the SEE program in Newfoundland and Labrador as the physician faculty members have achieved SEE Master Trainer Designation from CAG. Since 2014, approximately 40 physicians have participated in one of the 14 SEE course offerings. Eastern Health's pilot implementation of the Pyxis Inventory System for endoscopy materials and supplies proved to be a success as the Pyxis System was cost neutral by realizing at least $90,000 in cost savings within the first 12 months of installation. Benefits of this system are: that minimum and maximum inventory quantities were implemented for all endoscopy supplies, thereby eliminating hoarding, wastage, over ordering, and expiration of supplies; automatic electronic re-ordering of supplies was implemented, thereby reducing ordering and restocking workload, and freeing up nursing staff time for direct patient care and other nursing tasks; and, storage and security solution was implemented as the Pyxis supply cabinets are compact and secure requiring biometrics to access. The Pyxis System also generates reports for purchasing to provide the exact information on usage volumes for budgeting and pricing analysis.

5.2 PHYSICIAN COMPENSATION

As of March 31, 2017, the legislation governing payments to physicians and dentists for insured services was the *Medical Care and Hospital Insurance Act*. Compensation agreements are negotiated between the Provincial Government and the Newfoundland and Labrador Medical Association (NLMA), on behalf of all physicians and the Newfoundland and Labrador Dental Association on behalf of dentists. Representatives from the RHAs play a role in this process. A Memorandum of Agreement was reached with the NLMA in December 2010, which increased overall physician compensation by approximately 26 per cent. The Agreement expired on September 30, 2013 but remains in effect until such time as a new agreement is negotiated. The Current MOA for the Surgical Dental Program expires March 31, 2018. Physicians are paid via fee-for-service, salary, or alternate payment plan (APP) with an increasing interest in APPs as a method of remuneration by physicians.

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

5.3 PAYMENTS TO HOSPITALS

The Department is responsible for funding RHAs for ongoing operations and capital acquisitions. Funding for insured services is provided to the RHAs as an annual global budget. Payments were made in accordance with the *Medical Care and Hospital Insurance Act* and the *Regional Health Authorities Act*. As part of their accountability to government, the RHAs 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 RHAs 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 the 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.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer and the Canada Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador in the annual provincial budget, through press releases, government websites and various other documents. For fiscal year 2016–2017, these documents include the 2016–2017 Public Accounts and Estimates 2016–2017. The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available and are shared with Health Canada for information purposes.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	530,521	532,177	533,156	532,415	530,144

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	51	51	51	51	103[1]
3. Payments for insured health services ($)	1,097,535,388	1,100,291,277	1,131,546,830	1,164,174,814	1,187,786,538

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services ($)	845,280	916,696	914,135	899,538	899,418

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	1,844	1,574	1,773	1,607	1,549
7. Total payments, in-patient ($)	19,988,002	20,969,617	22,423,411	21,928,705	25,223,361
8. Total number of claims, out-patient (#)	27,681	22,429	26,671	23,105	21,915
9. Total payments, out-patient ($)	8,827,387	8,109,628	9,147,633	8,428,054	8,279,887

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	108	127	141	150	113
11. Total payments, in-patient ($)	139,270	451,834	207,198	620,866	138,546
12. Total number of claims, out-patient (#)	410	445	570	561	401
13. Total payments, out-patient ($)	96,116	105,448	71,574	62,285	72,135

[1] Classification of public facilities changed in 2016–2017.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)[2]	1,155	1,183	1,199	1,212	1,214
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($)	236,529,000	251,281,302	294,572,803	299,597,724	309,039,732

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY[3]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	114,000	114,000	106,000	114,000	123,000
20. Total payments ($)	6,762,000	6,954,000	6,836,000	6,910,000	9,124,000

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	3,400	3,300	3,600	3,200	2,800
22. Total payments ($)	231,000	266,000	223,000	236,000	299,000

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	25	26	19	19	22
24. Number of opted-out dentists (#)[a]					not available
25. Number of non-participating dentists (#)[a]					not available
26. Number of services provided (#)	2,880	1,585	1,709	3,397	4,843
27. Total payments ($)	455,780	203,610	279,350	592,660	885,610

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

[2] Excludes inactive physicians. Total salaried and fee-for-service.

[3] Numbers are rounded to the nearest thousand.

PRINCE EDWARD ISLAND

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

The *Health Services Act* provides the regulatory and administrative frameworks for improvements to the health care system in PEI by:

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

Within this governance structure Health PEI has the responsibility to:

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

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

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

1.2 REPORTING RELATIONSHIP

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

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

1.3 AUDIT OF ACCOUNTS

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

The provincial Auditor General, through the *Audit Act,* has the discretion to conduct further audit reviews on a comprehensive or program specific basis.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations define the insured in-patient and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include, but are not limited to: necessary nursing services; laboratory, radiological and other diagnostic procedures; accommodations and meals at a standard ward rate; formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital; operating room, case room and anaesthetic facilities; routine surgical supplies; and radiotherapy and physiotherapy services performed in hospital.

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

2.2 INSURED PHYSICIAN SERVICES

The enabling legislation that provides for insured physician services is the *Health Services Payment Act.*

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The total number of practicing practitioners who billed the Medical Services Insurance Plan as of March 31, 2017 was 367. This includes all physicians (complement, locums, visiting specialists, and other non-complement physicians). Under section 10 of the *Health Services Payment Act,* a physician or practitioner who is not a participant in the Medical Services Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are non-participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health and Wellness. 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, 2017, no physicians had opted out of the Medical Services Insurance Plan.

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

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

2.3 INSURED SURGICAL-DENTAL SERVICES

Dental services are not insured under the Medical Services 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.

Any new surgical-dental services added to the list of insured services covered by the health care insurance plan of PEI is done through negotiations of the Dental Agreement between the Dental Association of PEI, Health PEI and the Government of PEI. In 2016–2017, no new services were added to the dental agreement.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Services not covered by the Hospital Services Insurance Plan include:

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by Health PEI;
- telephone consultation except by internists, palliative care physicians, paediatricians, out-of-province specialists, and orthopedic surgeons, provided the patient was not seen by that physician within three days of the telephone consult;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from Health PEI;
- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- testimony in court;
- travel clinic and expenses;
- surgery for cosmetic purposes unless medically required;

- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- chiropractic, podiatry, optometry, chiropody, osteopathy, naturopathy, and similar treatments;
- physiotherapy, psychology, and acupuncture except when provided in hospital;
- reversal of sterilization procedures;
- in vitro fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from Health PEI; and
- any other services that the Department may, upon the recommendation of the negotiation process between the Department, Health PEI and the Medical Society, declare non-insured.

Hospital services not covered by the Hospital Services Insurance Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of Health PEI.

The process to de-insure services covered by the Medical Services Insurance Plan is done in collaboration with the Medical Society, Health PEI and the Department. No services were de-insured during the 2016–2017 fiscal year.

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

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

3.0 UNIVERSALITY

3.1 ELIGIBILITY

The *Health Services Payment Act* and Regulations, section 3, define eligibility for the Medical Services Insurance Plan. This Plan is designed to provide coverage for eligible Prince Edward Island (PEI) residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day, in PEI. While there is no formal appeal process, an individual can seek clarification regarding their eligibility determination.

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

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

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

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

The number of residents registered with the Medical Services Insurance Plan in PEI as of March 31, 2017, was 150,194.

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

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

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

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

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

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

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

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

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

4.4 PRIOR APPROVAL REQUIREMENT

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

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Both of Prince Edward Island's (PEI) hospital 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. While there is no formal complaints process for inappropriate charges, an individual can seek clarification on the appropriateness of any charges through the Ministry of Health and Wellness.

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

PEI recognizes that the health system must constantly adapt and expand to meet the needs of our citizens.

Several examples of initiatives from the 2016–2017 fiscal year include:

- PEI has begun the significant expansion of the Ambulatory Care Centre at the Prince County Hospital (PCH). Ambulatory care at PCH includes four main services: Nursing Care Suite, Oncology, Surgical Clinic, and Endoscopy. As part of the expansion, a new Women's Wellness Centre will be constructed and a new suite of services will be phased-in.
- PEI continued investing in health services in rural communities, opening a new digital radiography suite at the Souris Hospital in Eastern Kings County.
- A new Health Patient Navigator Program was initiated across the province. This service is intended to help Islanders access health services, as well as how to contact them.
- PEI established two Community Health Engagement Committees - one from the west and one from the east - that will collect input from Islanders on the direction of the health care system. They will provide ongoing feedback to the Minister of Health and Wellness and Health PEI on provincial strategies for health-care delivery and identify issues from a regional perspective.
- PEI implemented the Remote Patient Monitoring Program to support Islanders living with congestive heart failure.
- PEI implemented the Strongest Families mental health program for families with children between the ages of 3 to 17.
- PEI opened a mental health walk-in clinic in West Prince to offer immediate mental health support to help with anxiety, depression and other more complex mental health issues.

5.2 PHYSICIAN COMPENSATION

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and the government to represent their interests in the process. The current five-year Physician Master Agreement between the PEI Medical Society, on behalf of Island physicians, the Department of Health and Wellness, and Health PEI was effective April 1. 2010 to March 31, 2015. Negotiations for the new Master Agreement are ongoing, and the current Master Agreement remains in effect until a new agreement has been ratified.

Many physicians continue to work on a fee-for-service basis; however, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are expanding and seem to be the preference for new graduates. Currently, 65 per cent of PEI's physicians (excluding locums and visiting specialists) are compensated under an alternate payment method (non-fee-for-service) as their primary means of remuneration.

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

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

The audits include specific steps for:

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

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

5.3 PAYMENTS TO HOSPITALS

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

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

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Prince Edward Island strives to recognize the federal contributions provided through the Canada Health Transfer whenever appropriate. Over the past year, this has included reference in public documents such as the Province of PEI 2016–2017 Annual Budget and in the 2016–2017 Public Accounts, which both were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

It is also the intent of the Department of Health and Wellness to recognize this important contribution in its 2016–2017 Annual Report.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	148,278	146,751	146,170	146,930	150,194

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	7	7	7	7	7
3. Payments for insured health services ($)	192,480,600	197,008,800	206,026,400	210,797,200	218,043,400

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	2,553	2,708	2,412	2,616	2,612
7. Total payments, in-patient ($)	25,941,946	25,515,954	26,099,415	28,867,047	28,644,094
8. Total number of claims, out-patient (#)	19,351	19,692	19,881	20,397	19,166
9. Total payments, out-patient ($)	6,566,417	7,616,353	7,385,351	7,930,682	8,234,123

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	24	40	20	30	26
11. Total payments, in-patient ($)	76,120	157,594	55,418	72,411	97,054
12. Total number of claims, out-patient (#)	125	137	93	133	93
13. Total payments, out-patient ($)	43,482	45,756	53,285	49,591	34,493

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	348	320	335	357	367
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)	88,742,895	91,965,934	95,037,546	98,070,004	102,691,590
18. Total payments for services provided by physicians paid through fee-for-service ($)	55,935,726	57,810,957	59,425,077	64,477,376	65,226,925

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	91,130	89,178	98,980	107,666	113,338
20. Total payments ($)	7,025,721	9,567,703	9,868,637	11,973,879	11,782,835

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	1,109	659	390	585	465
22. Total payments ($)	38,036	38,005	37,500	78,147	36,241

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	2	2	2	2	2
24. Number of opted-out dentists (#)[a]					0
25. Number of non-participating dentists (#)[a]					0
26. Number of services provided (#)	383	361	446	373	365
27. Total payments ($)	125,290	130,393	169,386	129,361	127,385

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

NOVA SCOTIA

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

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

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

The Department is responsible for:

- providing leadership for the health system by setting the strategic policy direction, priorities and standards for the health system; and
- ensuring accountability for funding and for the measuring and monitoring of health-system performance.

NSHA & IWK are responsible for:

- governing, managing and providing health services[1] in the Province and implementing the strategic direction set by the department; and
- Engaging with the communities they serve, through the community health boards.

Insured services[2] in Nova Scotia cover hospital services and physician services as well as home care, long-term care, and pharmaceuticals.

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

Additional information related to health care in Nova Scotia may be obtained from the Department website at http://novascotia.ca/DHW.

[1] **Health Services** are defined in the Act as "services related to the prevention of illness or injury, the promotion or maintenance of health or the care and treatment of sick, infirm or injured persons, and includes services provided in the Province through hospitals and other health-care institutions, public-health services, addiction services, emergency services, mental-health services, home-care services, long-term care services, primary-care services and such other services as may be prescribed by the regulations".

[2] Nova Scotia passed the *Insured Health Services Act* in 2012. This Act has not been repealed but it is not yet proclaimed either and will undergo a review to make sure changes are not necessary prior to its proclamation.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

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

The Department administers the Hospital Insurance Plan and the MSI Plan is administered and operated by Medavie Blue Cross Incorporated (MBC).

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

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

1.2 REPORTING RELATIONSHIP

A. Hospital Insurance

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

B. Medical Insurance

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

1.3 AUDIT OF ACCOUNTS

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

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

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

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

1.4 DESIGNATED AGENCY

MBC administers and has the authority to receive monies to pay physician accounts under the service level agreement with the Department. The rates of pay and specific amounts are based on the physician contract (Master Agreement) negotiated between Doctors Nova Scotia and the Department.

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

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

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

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

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES[1]

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

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

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

[1] Please see discussion on the *Insured Health Services Act* (2012) in footnote 2.

Out-patient services include:

- laboratory and radiological examinations;
- diagnostic procedures involving the use of radiopharmaceuticals;
- electroencephalographic examinations;
- use of occupational and physiotherapy facilities, where available;
- necessary nursing services;
- drugs, biologicals and related preparations;
- blood or therapeutic blood fractions;
- hospital services in connection with most minor medical and surgical procedures;
- day-patient diabetic care;
- services provided by the Nova Scotia Hearing and Speech Clinics, where available;
- ultrasonic diagnostic procedures;
- home parenteral nutrition, where available; and
- haemodialysis and peritoneal dialysis, where available.

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

2.2 INSURED PHYSICIAN SERVICES

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

As of March 31, 2016, 2,562 physicians were paid through the Medical Services Insurance (MSI) Plan.

Physicians retain the ability to opt in or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. MSI reimburses patients who pay the physician directly due to opting out. As of March 31, 2017, no physicians had opted out.

Insured services include those that are medically necessary. Additional services were added to the list of insured physician services in 2016–2017. A complete list can be obtained from the Department. On an as needed basis, new fee codes are approved that represent enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes, or adjustment to existing fee codes, to the list of insured physician services is accomplished through a collaborative Department, Nova Scotia Health Authority and Doctors Nova Scotia committee structure. Public consultations are not generally undertaken when listing or delisting insured medical services. Physicians wishing to have a new fee code added to the MSI Physician Manual submit a formal application to the Fee Committee (FC) for review. Each request is thoroughly researched.

FC (under the terms and conditions of the Master Agreement) has the decision-making authority to approve adjustments based on consensus and available budget. If the fee is approved, MBC is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 INSURED SURGICAL-DENTAL SERVICES

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association, must be certified competent in the practice of dental surgery, and must also have privileges from the Nova Scotia Health Authority/ IWK to deliver services at specific hospitals. The *Health Services and Insurance Act* is written so that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. In 2016–2017, 26 dentists submitted claims through the MSI Plan for providing insured surgical-dental services.

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

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

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

At this time, there are no 'opted-out' nor 'non-participating' dentists providing insured surgical-dental services.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL DENTAL SERVICES

Uninsured hospital services include:

- preferred accommodation at the patient's request;
- telephones;
- televisions;
- drugs and biologicals ordered after discharge from hospital;
- cosmetic surgery;

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

Uninsured Physician Services include:

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

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

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

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

If a service or procedure is deemed by the Department not to be medically 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 also applies to dental services and hospital services. Public consultations are not undertaken during the determination of medical necessity and de-listing of insured services. The last time there was any significant de-insurance of services was in 1997.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

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

In 2016–2017, a person was considered to be "ordinarily present" in Nova Scotia if the person:

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

Persons moving to Nova Scotia from another Canadian province will normally be eligible for Medical Services Insurance (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 IRCC.

Individuals insured under the *Workers' Compensation Act* or any other Act in the Legislature or of the Parliament of Canada or under any statute or law of any other jurisdiction either within or outside of Canada are not eligible for MSI Coverage (such as members of the Canadian Forces, federal inmates and some classes of refugees). Once individuals are no longer covered under any of the Acts, statutes or laws noted above, they are then eligible to apply for and receive Nova Scotia health insurance coverage,

provided that they are either a Canadian Citizen, a permanent resident as defined by IRCC or meet the NS residency requirements. An administrative review may be requested for individuals who are deemed ineligible.

In 2016–2017, the total number of residents registered with the health insurance plan was 1,012,642.

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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

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

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

In 2016–2017, there were 44,014 permanent residents registered with the health care insurance plan.

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

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

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

In 2016–2017, there were 3,999 individuals with Employment Authorizations covered under the health care insurance plan.

Study Permits: Persons moving to Nova Scotia from another country and who possess a Study Permit will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, unless required in the course of their studies. MSI coverage is extended for a maximum of 12 months at a time and only for

services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependents of such persons, who are legally entitled to remain in Canada, will be granted coverage on the same basis once the student has gained entitlement.

In 2016–2017, there were 1,486 individuals with Student Authorizations covered under the health care insurance plan.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

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

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

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

The total amount paid by the plan in 2016–2017 for in-patient and out-patient hospital services received in other provinces and territories was $34,229,741.

As of August 1, 2014, Nova Scotia residents receive out-of-province coverage for vacation for one additional month. This allows Nova Scotia residents to have a vacation outside of the province for seven months in each calendar year and continue to be eligible for MSI. Nova Scotia residents who are vacationing outside of Nova Scotia for not more than seven months in a calendar year will be deemed a resident if the following conditions are met:

(a) The resident communicates to MSI of their absence from Nova Scotia;

(b) The resident does not establish residency outside Nova Scotia; and

(c) New or returning residents must be physically present in Nova Scotia for at least 183 days prior to the absence.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

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

As of August 1, 2014, Nova Scotia residents receive out-of-country coverage for vacation for one additional month. This allows Nova Scotia residents to have a vacation outside of the country for seven months in each calendar year and continue to be eligible for MSI. Nova Scotia residents who are vacationing outside of Nova Scotia for not more than seven months in a calendar year will be deemed a resident if the following conditions are met:

(a) The resident communicates to MSI of their absence from Nova Scotia;

(b) The resident does not establish residency outside Nova Scotia; and

(c) New or returning residents must be physically present in Nova Scotia for at least 183 days prior to the absence.

Students and their dependents 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 or research) outside Canada which does not exceed 24 months are still covered by MSI, providing the person has already met the residency requirements.

The total amount spent in 2016–2017 for insured in-patient services provided outside of Canada was $964,123. Nova Scotia does not cover out-patient services out-of-country.

4.4 PRIOR APPROVAL REQUIREMENT

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

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the Regulations, all residents of the province are entitled to receive insured hospital services from hospitals on uniform terms and conditions. As well, all residents of the province are insured on uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. There are no user charges or extra charges allowed under the plan. Complaints generally come directly to the Department of Health and Wellness via telephone or e-mail, or are directed to the College of Physicians and Surgeons of Nova Scotia (CPSNS). Complaints are investigated and addressed.

Nova Scotia continually reviews access situations across Canada to ensure equity of access.

Alternative Payment Plans for physicians continued to be implemented and/or expanded to improve recruitment in rural and hard-to-fill areas, improving access to primary health care in those communities.

5.2 PHYSICIAN COMPENSATION

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

In the 1997–1998 fiscal year, about nine per cent of doctors were paid solely through alternative funding. In 2016–2017, approximately 23 per cent of physicians were remunerated exclusively through alternative funding. Approximately 68 per cent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms such as academic funding agreements with clinical departments for the provision of clinical, academic, administrative and research services; alternative payment plans for individual physicians and groups are utilized mostly in rural areas. Other funding programs such as emergency agreements and sessional funding are also utilized across the province.

To audit payments, an annual audit plan is followed based on a risk assessment. Audits occur in response to concerns brought to the attention of the MSI administrator and may occur in response to concerns identified through service verification letters.

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

5.3 PAYMENTS TO HOSPITALS

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

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

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

In 2016–2017, there were 2,975 hospital beds in Nova Scotia (3.1 beds per 1,000 population). Department direct expenditures for insured hospital services operating costs were $1,790,425,313.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

In Nova Scotia, the *Health Services and Insurance Act* acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware of ongoing federal contributions to Nova Scotia health care through the Canada Health Transfer (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:

- Public Accounts 2015–2016 released August 09, 2016; and
- Budget Estimates and Supplementary Detail 2015–2016 released April 19, 2016.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	998,763	1,000,124	1,001,708	1,008,726	1,012,642

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	35	35	35	35	35
3. Payments for insured health services ($)[1]	1,619,915,286	1,679,289,646	1,735,234,990	1,720,856,746	1,790,425,313

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)[2]	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)	not applicable	not applicable	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	2,259	2,034	2,020	2,019	1,882
7. Total payments, in-patient ($)	19,854,352	18,363,912	17,984,193	19,022,461	19,801,011
8. Total number of claims, out-patient (#)	39,611	39,551	41,207	40,344	37,910
9. Total payments, out-patient ($)	12,272,547	12,888,192	13,352,105	14,174,680	14,428,730

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	not available	not available	not available	not available	not available
11. Total payments, in-patient ($)	1,104,701	1,242,889	777,019	1,409,302	964,123
12. Total number of claims, out-patient (#)	not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments, out-patient ($)	not applicable	not applicable	not applicable	not appicable	not applicable

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

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

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	2,507	2,581	2,580	2,602	2,562
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	not applicable	not applicable	not applicable	not applicable	not applicable
17. Total payments for services provided by physicians paid through all payment methods ($)	694,184,053	712,629,560	730,417,814	740,465,887	735,418,537
18. Total payments for services provided by physicians paid through fee-for-service ($)	310,301,903	310,882,780	317,048,025	378,290,569	377,118,049

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	208,505	204,888	210,771	222,026	220,932
20. Total payments ($)	8,512,631	8,607,696	8,884,002	9,304,321	9,167,527

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	2,096	3,141	2,789	1,413	1,426
22. Total payments ($)	110,695	173,452	157,344	72,025	74,209

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	21	26	25	28	26
24. Number of opted-out dentists (#)[a]	-	-	-	-	0
25. Number of non-participating dentists (#)[a]	-	-	-	-	0
26. Number of services provided (#)[3]	7,007	7,391	8,492	8,591	7,713
27. Total payments ($)[4]	1,397,223	1,356,416	1,442,994	1,401,379	1,342,014

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

[3] Total services includes block funded dentists.

[4] Total payments does not include block funded dentists.

NEW BRUNSWICK

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

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

1.2 REPORTING RELATIONSHIP

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

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

1.3 AUDIT OF ACCOUNTS

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

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

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

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

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

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

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

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

2.2 INSURED PHYSICIAN SERVICES

The *Medical Services Payment Act* and corresponding Regulations provide for insured physician services. As of March 31, 2017 there were 1,666 participating physicians in New Brunswick. No physicians rendering health care services elected to opt out of the Medical Services Plan. When a physician opts out of Medicare, they must complete the specified Medicare claim form and indicate the amount charged to the patient. The beneficiary then seeks reimbursement by certifying on the claim form that the services have been received and forwarding the claim form to Medicare. The charges must not exceed the Medicare tariff. If the charges are in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:

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

The services which residents are entitled to under Medicare include:

(a) the medical portion of all medically required services rendered by medical practitioners; and

(b) certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital.

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 based on conformity to the definition of "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and/or Canada. Considerations under the term "medically necessary" include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

In 2016–2017 the following services were added to the list of insured services:

Code	Service Description
8161	MAID (Medical Assistance in Dying)
8162	MAID (Medical Assistance in Dying) — mileage per km outside a 5km Radius
8163	Mastectomy with chest masculinization

2.3 INSURED SURGICAL-DENTAL SERVICES

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

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

As of March 31, 2017, there were 172 dental practitioners registered including 158 dentists, 10 of which provided services insured under the Medical Services Plan.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Uninsured hospital services include: take-home drugs; third-party requests for diagnostic services; visits to administer drugs; vaccines; sera or biological products; televisions and telephones; preferred accommodation at the patient's request; and hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*. Services are not insured if provided to those entitled under other statutes.

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

- elective plastic surgery or other services for cosmetic purposes;
- correction of inverted nipple;
- breast augmentation;
- otoplasty for persons over the age of eighteen;

- removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
- abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located;
- surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than risk inherent in the removal of the cataract itself, due to existence of an illness or other complication;
- medicines, drugs, materials, surgical supplies or prosthetic devices.
- 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;
- examination of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
- dental services provided by a medical practitioner or an oral and maxillofacial surgeon;
- services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
- services that are provided in conjunction with, or in relation to, the services referred to above;
- testimony in a court or before any other tribunal;
- immunization, examinations or certificates for purpose of travel, employment, emigration, insurance or at the request of any third party;
- services provided by medical practitioners or oral and maxillofacial surgeons to members of their immediate family;
- psychoanalysis;
- electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;
- laboratory procedures not included as part of an examination or consultation fee;
- refractions;
- services provided within the province by medical practitioners, oral and maxillofacial surgeons or dental practitioners for which the fee exceeds the amount payable under Regulation;
- the fitting and supplying of eye glasses or contact lenses;
- trans-sexual surgery;
- radiology services provided in the province by a private radiology clinic;
- acupuncture;
- complete medical examinations when performed for the purposes of periodic check-up and not for medically necessary purposes;
- circumcision of a newborn;

- reversal of vasectomies;
- second and subsequent injections for impotence;
- reversal of tubal ligations;
- intrauterine insemination;
- bariatric surgery unless the person has a body mass index of 40 or greater or of 35 or greater but less than 40, as well as obesity-related comorbid conditions; and
- venipuncture for purposes of taking blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services. There are no specific policies or guidelines, other than the Act and Regulations, to ensure that charges for uninsured medical goods and services (e.g., fibreglass casts), provided in conjunction with an insured health service, do not compromise reasonable access to insured services. The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical service plans across the country, and the previous use of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any changes to the Regulation until the advice and recommendations of the New Brunswick Medical Society are received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

In 2016–2017, no services were removed from the insured services list.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

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

As of March 31, 2017, there were 761,157 persons registered in New Brunswick.

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

Exceptions are as follows:

- Dependants of Canadian Armed Forces personnel or their spouses moving from within Canada to New Brunswick are entitled to first day coverage under the program, provided they are deemed to have established permanent residency in New Brunswick.
- Immigrants or Canadian residents moving or returning to New Brunswick from outside of Canada are entitled to first day coverage, provided they are deemed to have established permanent residency in the province. Proper documentation is required from Immigration, Refugees, and Citizenship Canada. Decisions on coverage and residency are reviewed on a case-by-case basis.

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

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

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

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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

Foreign students are considered visitors to the Province and are not eligible for coverage.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

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

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

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

Students

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

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

Residents

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

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

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

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

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

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

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

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

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

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

Mobile Workers

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

applications must be in writing;

- documentation is required as proof of Mobile Worker status (e.g., letter from employer or contract confirming that frequent travel is necessary outside the province; a letter from the resident detailing their permanent residence as New Brunswick and the frequency of their return to the province; a copy of their New Brunswick driver's licence; if working outside Canada, a copy of resident's immigration documents that allow them to work outside the country); and
- the worker must return to New Brunswick during their off-time.
- Mobile Worker status is assigned for a maximum of two years, after which the resident must reapply and submit documentation to confirm a continuation of Mobile Worker status.

Contract Workers

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

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

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

Students

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

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

4.4 PRIOR APPROVAL REQUIREMENT

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

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

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

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

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

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

Heamodialysis is exempt from the out-of-country coverage policy. Patients are required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the inter-provincial rate of $472 per session.

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.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

New Brunswick's health care system delivers equitable, quality care to the public it serves. New Brunswick does not permit user fees for insured health services as defined by the *Canada Health Act*.

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

Improving access to primary care and acute care is a pillar of the New Brunswick Family Plan. The plan aims to improve the lives of all residents by addressing the factors that have the greatest impact upon health and well-being. It focuses government action in seven priority areas: improving access to primary and acute care; promoting wellness; supporting people with mental health challenges; fostering healthy aging and support for seniors; advancing women's equality; reducing poverty; and supporting people with disabilities. As part of the Plan, Government announced a number of investments in 2016–17 that will further improve access to health services. They include:

- Modernization of the lagoon treating wastewater from the Stella-Maris-de-Kent Hospital;
- Investment to restore, preserve and protect critical infrastructure at the Hotel-Dieu of St. Joseph Hospital in Perth-Andover;
- Expansion and renovation of the Paquetville Health Centre;
- Investment in the Dr. Georges –L.-Dumont University Hospital Centre in Moncton to continue the work on the addition of a new surgical unit;
- The Horizon Health Network and the University of New Brunswick formed a partnership to establish the Fredericton Downtown Community Health Centre which will provide integrated health service delivery, education and research in a primary care setting. In addition to providing interdisciplinary primary health care, the Centre will advance exploration and innovation in community-based health service delivery and applied health research. The clinic officially opened March 17, 2017;
- Investment in the Moncton Hospital to help build separate units for neonatal intensive care, maternity and newborns, as well as restore and improve the hospital's cardiac care areas;

- Investment in the expansion of the Dr. Everett Chalmers Regional Hospital in Fredericton to go towards a new surgical suite and recovery room, as well as separate units for day surgery, intensive care, ambulatory procedures, central sterile reprocessing, specimen collection and clinical records. A gynecology, maternal and newborn unit will also be part of the new addition; and
- Investment in the Saint John Regional Hospital to cover the redesign and redevelopment of the Intensive Care Unit (ICU), surgical and oncology units.

5.2 PHYSICIAN COMPENSATION

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

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

5.3 PAYMENTS TO HOSPITALS

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

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

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

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

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

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

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	748,570	749,613	750,691	754,522	761,157

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	59	60	61	62	62
3. Payments for insured health services ($)	1,736,939,230	1,771,731,561	1,876,686,329	1,666,482,214	1,704,602,299

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)[1]	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)[1]	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	4,820	5,175	4,476	4,882	5,013
7. Total payments, in-patient ($)	48,373,187	56,033,200	44,805,445	51,746,542	54,943,694
8. Total number of claims, out-patient (#)	60,927	52,858	55,412	49,180	53,322
9. Total payments, out-patient ($)	21,213,988	19,086,912	20,236,157	18,099,035	21,439,060

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	274	209	150	212	212
11. Total payments, in-patient ($)	202,669	254,241	239,512	227,190	501,255
12. Total number of claims, out-patient (#)	1,080	1,004	882	1,119	1,059
13. Total payments, out-patient ($)	286,912	286,584	354,378	690,382	328,293

[1] There are no private for-profit facilities operating in New Brunswick.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)[2]	1,640	1,635	1,631	1,652	1,666
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)[3]	581,432,080	554,684,438	577,131,145	582,756,568	596,481,038
18. Total payments for services provided by physicians paid through fee-for-service ($)	307,211,084	306,411,123	325,012,469	359,837,199	371,926,128

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	210,727	254,378	194,660	240,172	239,484
20. Total payments ($)	15,089,061	22,127,528	18,284,577	21,436,423	24,954,879

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	6,425	4,714	2,621	2,028	2,173
22. Total payments ($)	397,912	315,078	246,305	278,398	232,495

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)[4]	20	21	18	19	10
24. Number of opted-out dentists (#)[a]					NA
25. Number of non-participating dentists (#)[a]					NA
26. Number of services provided (#)	4,949	2,083	2,311	1,830	2,466
27. Total payments ($)	663,654	718,088	618,627	498,480	699,799

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

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

[3] The total payment for all payment methods is a preliminary figure and includes budgeted amounts for alternate funding plans. Fee-for-service is for automated fee-for-service only.

[4] These are the number of dentists and oral maxillofacial surgeons (OMS) participating in New Brunswick's Medical Services Plan during each fiscal year. Out of the 100+ dentists and OMSs registered, these billed the Medical Services Plan.

QUEBEC

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH INSURANCE PLAN AND PUBLIC AUTHORITY

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

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

1.2 REPORTING RELATIONSHIPS

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

1.3 AUDIT OF ACCOUNTS

The plans (the Quebec Hospital Insurance Plan and the Quebec health and drug insurance plans) are administered by the public authorities on a non-profit basis. All books and accounts are audited by the auditor general of the province.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

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

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

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

The MSSS administers an ambulance transportation program that is free of charge to persons aged 65 and older depending on the parameters described in the provincial policy on user transportation.

In addition to basic insured health services, the Régie also covers optometric services for people who are under age 18 or 65 and over and for last-resort financial assistance recipients; dental care for children age 10 and under and last-resort financial assistance recipients; and acrylic dental prostheses for last-resort financial assistance recipients.

It also covers, for Quebec residents within the meaning of the *Health Insurance Act* (R.S.Q. c. A-29) who meet the eligibility criteria for each program, prostheses, orthotics, orthopedic appliances, walking and posture aids, hearing aids, assistive listening devices and visual aids. This coverage applies only to aids and appliances covered in the regulations. Financial aid is granted for external breast prostheses, ocular prostheses, permanent ostomy appliances, and compression clothing for people with lymphedema.

With regard to drug insurance, since January 1, 1997, the Régie has covered, in addition to recipients of last-resort financial assistance and persons aged 65 and over, Quebec residents who otherwise would not have access to a private drug insurance plan. In 2016–2017, the public drug insurance plan covered 3.6 million insured persons.

2.2 INSURED PHYSICIAN SERVICES

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

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

2.3 INSURED SURGICAL-DENTAL SERVICES

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

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Uninsured hospital services include: plastic surgery for purely cosmetic purposes, accommodation in a private or semi-private room at the patient's request, television, telephone, drugs and biological products ordered after discharge from hospital, and services to which the patient is entitled under the *Act respecting industrial accidents and occupational diseases* or other federal or provincial legislation.

The following services are not insured: any examination or service not related to a process of curing or preventing illness; psychoanalysis of any kind, unless such service is delivered in a facility maintained by an institution authorized for such purpose by the Minister of Health and Social Services; any service provided solely for aesthetic purposes; any refractive surgery, except where there is documented failure in respect of corrective lenses and contact lenses for astigmatism of more than 3.00 diopters or anisometropia of more than 5.00 diopters measured from the cornea; any consultation by telecommunication or by correspondence, with the exception of telehealth services within the meaning of the *Act respecting health services and social services*; any service delivered by a professional to his or her spouse or children; any

examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than one who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examination, vaccination, immunization or injection where the service is provided to a group or for certain purposes; any service delivered by a professional on the basis of an agreement or contract with an employer, association or body; any adjustment of eyeglasses or contact lenses; any surgical extraction of a tooth or dental fragment performed by a physician, unless such service is provided in a hospital centre in certain cases; all acupuncture procedures; injection of sclerosing substances and the examination performed at that time; mammography used for detection purposes, unless this service is required by medical prescription in a place designated by the Minister to a recipient 35 years of age or older, provided that the person has not been so examined for one year; thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in humans, unless these services are delivered in a hospital centre; ultrasonography, unless this service is delivered in a hospital centre or by a radiologist or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose; optical tomography of the eyeball and confocal scanning laser ophthalmoscopy of the optic nerve, unless these services are delivered in a facility maintained by an institution that operates a hospital or are delivered in association with the delivery, by intravitreal injection, of an antiangiogenic drug for the treatment of certain pathologies; any radiological or anaesthetic service provided by a physician if required for providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of radiology, if required by a person other than a physician or dentist; any sex-reassignment surgery, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; any services that are not related to pathology and that are delivered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim booklet, for colour blindness or a refractive error, in order to provide or renew a prescription for eyeglasses or contact lenses; any assisted reproduction services, with the exception of artificial insemination, including ovarian stimulation services within the meaning of the *Act*.

3.0 UNIVERSALITY

3.1. ELIGIBILITY

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

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

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

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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

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

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

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

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

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

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

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

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

Insured persons who leave Quebec to settle in another province or territory of Canada remain eligible for health insurance for up to three months after leaving the province, but are no longer eligible for Quebec drug insurance starting from the day of their departure.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

To retain eligibility for health insurance, a person must not be absent from Quebec for 183 days or more within a calendar year. However, students and full-time unpaid trainees may retain their status as residents of Quebec, provided they so notify the Régie—in the first case for a maximum of four consecutive calendar years, and in the second for a maximum of two consecutive calendar years.

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

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

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

For residents who are not in one of the above situations and receive insured services in a hospital outside Canada, the Régie reimburses the cost of such services, when they become necessary due to an emergency or sudden illness, to a maximum of C$100 per day if the patient was hospitalized, including for day surgery, or to a maximum of C$50 per day for outpatient services. However, hemodialysis treatments are covered to a maximum of C$220 per treatment. In these cases, the Régie covers the associated professional services at either the amount actually paid or the amount that would have been paid by the Régie for the same services in Quebec, whichever is lower. The services must be rendered in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments, or for any services that are experimental in nature.

Costs for insured services provided by physicians, dentists, maxillofacial surgeons and optometrists are reimbursed at the rate that would have been paid by the Régie to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. When they are delivered abroad, all professional services insured by the Quebec Health Insurance Plan are reimbursed at the Quebec rate, usually in Canadian funds.

An insured person who moves permanently from Quebec to another country ceases to be insured on the day of departure.

4.4 PRIOR APPROVAL REQUIREMENT

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

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

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

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Everyone has the right to receive adequate health care services without any kind of discrimination. In Quebec, the *Health Insurance Act* does not allow user fees to be imposed. It also prohibits any person from demanding or receiving any payment from a person for incidental fees related to an insured service,

except in cases prescribed by regulation and the conditions mentioned therein. If anyone thinks that the person has been incorrectly billed fees, the person may request reimbursement from the Régie, which will determine whether any amounts have been unjustifiably paid. If appropriate, the RAMQ will reimburse the insured person and will recover the amount reimbursed from the health-care professional or the clinic involved. It is also possible to reimburse insured persons who have not made reimbursement requests if the Régie finds that fees have been charged to them illegally.

A situation that appears to be illegal with respect to fees charged to an insured person may also be reported to the Régie which, after verification, will follow up appropriately. These follow-ups may include an inspection or an investigation of the clinics or the professionals involved.

Improving access to health and social services for the population is a government priority. In order to achieve this objective in a more difficult economic and budgetary environment, Quebec has undertaken a transformation of the health and social services network (the network) and its governance. On April 1, 2015, Quebec adopted the *Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies* (chapter O-7.2) (LMRSSS). The purpose of the LMRSSS is to:

- simplify access to health and social services and the continuum of care for the population;
- foster greater fluidity within establishments through the efficient integration of patient services;
- ensure better clinical patient information flow between care providers; and
- increase the network's efficiency and effectiveness by meeting the challenge of population-based responsibility.

For most health and social services regions, the LMRSSS has established an integrated health and social services centre or an integrated university health and social services centre which generally encompasses all of the health missions (CH, CHSLD, CLSC, CR and CPEJ).

On March 31, 2017, the health and social services network had 141 institutions: 51 public and 90 private. These institutions administer 1,649 facilities or physical spaces providing health and social services to the Quebec population.

The 51 public institutions are administered by 33 president-CEOs or CEOs. They include integrated health and social services centres (CISSS) and integrated university health and social services centres (CIUSSS), hereafter referred to as integrated centres, as well as grouped institutions and other institutions that have been neither grouped nor merged.

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

The 29 remaining public institutions are distributed as follows:

- 5 university hospital centres (CHU), 1 university institute (IU) and 1 institution which are not attached to an integrated centre but to the MSSS, and which offer specialized or ultra-specialized services beyond the boundaries of their health and social service region, namely:
- CHU de Québec—Université Laval;
- Quebec Heart and Lung Institute—Université Laval;
- Centre hospitalier de l'Université de Montréal;
- McGill University Health Centre;
- Centre hospitalier universitaire Ste-Justine;
- Montréal Heart Institute;
- Institut Philippe-Pinel de Montréal;
- 5 public institutions not targeted or affected by the *Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies* (chapter O-7.2) (LMRSSS) that serve a Northern or Aboriginal population; and
- 17 public institutions attached to an integrated centre. These institutions were not merged with other institutions under the LMRSSS but are administered by the board of the integrated centre to which they are attached.

In addition, as of March 31, 2017, Quebec had 39 public and private institutions under agreement with a centre hospitalier (CH) [hospital centre] mission providing diagnostic services and general and specialized medical care in the secteurs de la santé physique (CHSGS) [physical health] or mental health (psychiatric care: CHPSY) sectors. As of that date, there were 21,128 beds with a CH mission: 19,999 beds for soins généraux et spécialisés (CHSGS) [general and specialized care] and 1,129 beds for psychiatric care (CHPSY). According to the most recent available data, from April 1, 2015, to March 31, 2016, Quebec hospital institutions had 798,375 admissions for short-term care and 368,083 admissions for day surgery. These admissions accounted for 6,973,728 patient days.

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

Since 2002, family medicine groups (GMF) have served as flagships for the organization of front-line health care and services in Quebec. GMFs promote teamwork, collaboration among professions, institutional responsibility to the population, and the development of trust and close collaboration between patients and clinicians. Review of the GMF management framework led to the creation of the Programme ministériel de financement et de soutien professionnel [departmental funding and professional support program], hereafter referred to as "the Program." The Program came into force

on November 16, 2015. It offers financial and professional support tailored to the realities of clinicians and the needs of patients. It has introduced equitable, patient-centred funding, additional professional support (in addition to nursing personnel, social workers, pharmacists and other health professionals), a more balanced service offer, less burdensome administrative procedures, and mandatory use of electronic health records. These features have the voluntary support of physicians and the benefit of a team funding structure. The core of the model continues to be the registration of patients with a group physician and a service offering that allows registered patients to take advantage of accessible services. The elementary structure of the GMFs ensures that registered patients have reasonable and timely access, as is demonstrated by the addition of a measurement of patients' attendance at the GMF in which they are registered. The new Program updates terms of funding and resource allocation, and is designed to be more flexible to implement. It relies on the professional commitment of clinical communities to provide accessible, continuous and quality services. As of March 31, 2017, Quebec had 302 accredited GMFs in the province, and 6 of the 52 network clinics had obtained their GMF-network designation, while the others were in the process of obtaining it.

5.2 PHYSICIAN COMPENSATION

Physicians are remunerated in accordance with the negotiated fee schedule. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient.

While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and non-participating professionals who practise outside the plan, with no reimbursement from the Régie going to either them or their patients.

According to the most recent data available, in 2016–2017 the Régie paid an estimated $7.7 billion for professional services provided to Quebec residents. Professional services (including reimbursements to insured persons and payments to professionals) received outside Quebec were estimated at $48.6 million.

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

Awareness-raising mechanisms

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

Systematic controls

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

Specific controls (inspections, investigations, service audits performed)

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

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

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

5.3 PAYMENTS TO HOSPITALS

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

The payments made in 2016–2017 to institutions operating as hospital centres for insured health services provided to residents of Quebec totalled over $12.29 billion. Payments to hospital centres in other provinces or outside Canada for hospital services totalled approximately $234.88 million.

ONTARIO

Ontario has one of the largest and most complex publicly-funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care (MOHLTC), Ontario's health care system was supported by over $56 billion (including capital) in spending during 2016–2017.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

Ontario Health Care and Health Care Planning

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

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

Local Health Integration Networks (LHINs) were established under the *Local Health System Integration Act,* 2006 (LHSIA) to help improve Ontarians' health through better access to high-quality health services, coordinated health care, and effective and efficient management of the health system at the local level. Since April 1, 2007, the LHINs have had responsibility for funding, planning and integrating health care services at the local level. This included services delivered by hospitals, community care access centres, long-term care homes, community health centres, community support service agencies, and mental health and addictions agencies.

On December 7, 2016, the *Patients First Act*, 2016 was passed by the Ontario legislature. The legislation is improving access to health care services by putting patients at the centre of a truly integrated health system. The legislation also gives Ontario's 14 LHINs an expanded role, including responsibilities for primary care planning, home and community care service delivery, and the strengthening of public health linkages through the Medical Officers of Health.

To support their expanded mandate, the roles and responsibilities of the former 14 community care access centres were transferred to the LHINs. Each LHIN also established sub-regions across their geography to help them better understand and address patient needs at the local level. Sub-regions will serve as a focal point for local planning and performance monitoring and management, to support the establishment of a truly integrated health system.

1.2 REPORTING RELATIONSHIP

The *Health Insurance Act* stipulates that the Minister of Health and Long-Term Care is responsible for the administration and operation of OHIP, and is Ontario's public authority for the purposes of the *Canada Health Act*.

The LHSIA, 2006 requires each LHIN to prepare an annual report on its affairs and operations for the previous fiscal year. The LHSIA requires the Minister to table the reports in the Legislative Assembly of Ontario. The Government of Ontario's Agency and Appointments Directive also requires that every Ontario board-governed agency (including LHINs) prepare an annual report.

MOHLTC has an accountability agreement with each LHIN that includes obligations, measures and targets. The agreements also include funding allocations by sector, for example, long-term care homes and hospitals. The LHSIA provides the LHINs with the authority to fund defined health service providers and to enter into service accountability agreements with health service providers.

1.3 AUDIT OF ACCOUNTS

Every year the Auditor General of Ontario reports on the results of their examination of government resources and administration. The Auditor General's report is tabled by the Speaker of the Legislative Assembly, usually in the fall, at which time it becomes available to the public. Audit reports on select areas of the MOHLTC chosen for review by the Auditor General are included within this annual report, the last of which was released on November 30, 2016.

MOHLTC's accounts are published annually in the Public Accounts of Ontario. The 2016–2017 Public Accounts of Ontario were tabled and released on September 7, 2017.

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 the Act.

Insured in-patient hospital services include medically required: use of operating rooms, obstetrical delivery rooms and anesthetic facilities; necessary nursing services; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability; drugs, biologicals and related preparations; and accommodation and meals at the standard ward level.

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

Hospital services are not specifically listed in *Regulation 552* in the *Health Insurance Act*, rather, the Regulation lists broad categories of services. This permits the Regulation to cover new medical and technological advances as they become accepted standards of practice.

Adding a new broad category of hospital services to the list of insured services covered by the OHIP requires a regulatory change. Regulatory changes are approved by Cabinet and generally there is a public consultation process by way of Ontario's Regulatory Registry.

No regulation changes to add hospital services were completed in fiscal year 2016–2017.

2.2 INSURED PHYSICIAN SERVICES

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

Under *Regulation 552* of the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary; referred to in the Schedule of Benefits — Physician Services; and rendered in such circumstances or under such conditions as specified in the Schedule of Benefits—Physician Services. Physicians provide medical, surgical and diagnostic services, including primary health care services. Services are provided in a variety of settings, including: physician offices, community health centres, hospitals, mental health facilities, licensed independent health facilities, and long-term care homes.

In general terms, insured physician services include: consultations and visits, for diagnosis and treatment of medical conditions, maternity care, anesthesia, immunizations and surgical procedures. Physicians must be registered to practise medicine in Ontario by the College of Physicians and Surgeons of Ontario, and be located in Ontario when rendering the service.

During 2016–2017, most physicians submitted claims for all insured services rendered to insured persons directly to OHIP, and a small number of physicians billed the insured person. Physicians who do not bill OHIP directly are commonly referred to as having opted out of the Plan. When a physician has opted out of the Plan the physician bills the patient an amount not exceeding the amount payable for the service under the Schedule of Benefits—Physician Services (this was permitted on a grandparented basis following proclamation of the *Commitment to the Future of Medicare Act* in 2004). The patient then recoups that amount from the Plan.

There were approximately 30,900 physicians who submitted claims to OHIP in 2016–2017. This figure includes physicians submitting both fee-for-service claims and physicians included in an alternative payment plan who submitted tracking or shadow-billed claims. In 2016–2017, there were 20 opted-out physicians in Ontario.

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

In 2016–2017, there was one change made to the Schedule. The change was made on April 1, 2016 and was related to echocardiography services.

2.3 INSURED SURGICAL-DENTAL SERVICES

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

Generally, insured dental services include: oral and maxillo-facial surgery that would normally be required to be performed in a hospital; root resection and apical curettage procedures when performed in association with other insured dental procedures; and dental extractions when performed in a hospital for the safety of high risk patients and if prior approval is obtained from the MOHLTC.

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

In Ontario in the fiscal year 2016–2017, 839 dentists had active billing numbers and 283 dentists billed OHIP. There were 556 dentists who had active billing numbers but did not bill OHIP. Following proclamation of the Commitment to the Future of Medicare Act in 2004, dentists are required to submit claims for all insured surgical-dental services to OHIP, i.e. are prohibited from charging the patient for insured services. No dentists are "opted-out' or exempt under 'grandparenting' provisions.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Uninsured hospital services include but are not limited to: private or semi-private accommodation unless no ward room is available or if prescribed by a physician, oral-maxillofacial surgeon or midwife due to a patient's condition; telephones and televisions; charges for certain private-duty nursing; and provision of medications for patients to take home from hospital, with prescribed exceptions.

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

Uninsured physician services include: services that are not medically necessary; services not listed in the Schedule of Benefits—Physician Services; and services that are excluded from insured services under Section 24 of *Regulation 552*.

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

Complaints regarding charges for insured services are investigated under the *Commitment to the Future of Medicare Act* (CFMA) Program. Investigations are opened to determine whether any patient was charged for an insured service; this would include whether a block fee included charges for an insured service, or if a charge for a service was, in fact, for all or part of an insured service. If it is found that a patient was charged for an insured service, the MOHLTC ensures that patients are reimbursed in accordance with provisions of the CFMA.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

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

- hold Canadian citizenship or an immigration status as prescribed in *Regulation 552*;
- make his or her primary place of residence in Ontario;
- subject to some limited exceptions, be physically present in Ontario for at least 153 days in any 12-month period; and
- for most new and returning residents, be physically present in Ontario for 153 of the first 183 days following the date residence is established in Ontario. For example, a person cannot be away from the province for more than 30 days in the first six months of residency.

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

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

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

Persons who were previously ineligible for OHIP coverage but whose status and/or residency situation has changed may be eligible upon application, subject to the requirements of *Regulation 552*.

3.2 OTHER CATEGORIES OF INDIVIDUALS

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

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

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

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

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

Holders of Temporary Resident Permits: A Temporary Resident Permit is issued to an individual by IRCC when there are compelling reasons to admit an individual into Canada who would otherwise be inadmissible under the federal *Immigration and Refugee Protection Act*. Each Temporary Resident Permit has a case type or numerical designation on the permit that indicates the circumstances allowing the individual entry into Canada. Individuals who hold a permit with a case type of 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 or 80 (if for adoption) are eligible for OHIP coverage. Individuals who hold a permit with a case type of 80 (except for adoption), 81, 84, 85 and 96 are not eligible for OHIP coverage.

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

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

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

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

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

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

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

3.3 PREMIUMS

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

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

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

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

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

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

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

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

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

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

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

Ontario participates in Reciprocal Hospital Billing Agreements with all other provinces and territories for payment of insured in-patient and out-patient hospital services. Rates are set and approved annually by the Interprovincial Health Insurance Agreements Coordinating Committee. Payment for in-patient services is at the hospital's approved in-patient per diem rate. Payment for out-patient services is at the standard approved out-patient rate.

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

Out-of-province (within Canada)

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

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

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

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

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

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

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

Reasons and lengths of time a person can receive continuous Ontario health insurance coverage during an extended absence

Reason	OHIP Coverage
Study	Duration of full-time academic studies (unlimited)
Work	Five-year terms (specific residency requirements must be met for 2 years between absences)
Charitable Worker	Five-year terms (specific residency requirements must be met for 2 years between absences)
Vacation/Other	Two-year terms (specific residency requirements must be met for 5 years between absences)

Certain family members may also qualify for continuous OHIP coverage while accompanying the primary applicant on an extended absence outside Canada.

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

Payment of out-of-country services for Ontarians who are temporarily absent from Canada, such as for travelling, are captured under *Regulation 552* of the *Health Insurance Act*.

Out-of-country costs for prescribed hospital and health facility services required to treat a condition that is acute and unexpected, arose outside of Canada, and requires immediate treatment are reimbursed at rates set out in *Regulation 552* under the *Health Insurance Act*:

- a maximum $400 (CAD) for in-patient services for a higher level of care as described in the Regulations and $200 (CAD) for any other level of care;
- a maximum $50 (CAD) for out-patient services (except dialysis); and
- a maximum of $210 (CAD) for renal dialysis.

During 2015–2016, out-of-country emergency, medically necessary, out-of-country physician services were reimbursed at the Ontario rates set out in *Regulation 552* under the *Health Insurance Act* or the amount billed, whichever was less.

4.4 PRIOR APPROVAL REQUIREMENT

As set out in *Regulation 552* under the *Health Insurance Act*, payment for non-emergency health services provided outside of Canada requires written prior approval from MOHLTC before the services are rendered.

The prior approval application must include written confirmation from the referring Ontario physician that the services—are:

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

Requests for prior approval of funding require the written endorsement of a physician who is a specialist in the type of services for which prior approval has been requested. This requirement does not apply to emergency services and services that are within a general practitioner's scope of practice.

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

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

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

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Funding for all insured hospital, physician, and designated practitioner services provided to insured Ontario residents is in accordance with the *Health Insurance Act* and Regulations. Access to insured services without charges is protected under Part II of the *Commitment to the Future of Medicare Act* (CFMA), "Health Services Accessibility." The CFMA prohibits extra-billing by including a prohibition that prohibits a person or entity from charging or accepting payment or other benefit for an insured service rendered to an insured person except as permitted in the CFMA. The CFMA further prohibits any person or entity from paying, conferring, charging or accepting a payment or other benefit in exchange for preferred access (queue jumping) to an insured service. In addition, the CFMA prohibits physicians, practitioners and hospitals from refusing to provide an insured service if an insured person chooses not to pay a "block fee" for an uninsured service.

The MOHLTC investigates all possible contraventions of the CFMA that come to its attention. For situations in which it is determined that extra-billing has occurred, the MOHLTC takes steps to ensure that the amount is repaid to the payee.

Health Card Validation (HCV) assists health care providers with access to information requested for claims payment. HCV allows the provider to determine the point-in-time status of a patient's Ontario health number (and version code) indicating eligibility or ineligibility for provincially funded health care services, thereby reducing claim rejects. A health care provider may subscribe for validation services if they have a valid and active billing number as assigned by the MOHLTC. If patients require access to insured services and do not have a valid health card in their possession, upon obtaining patient consent, the provider may obtain the necessary information by utilizing the accelerated health number release service provided by ServiceOntario's Health Number Look Up service which is offered 24 hours a day, 365 days per year to physicians or hospitals registered for this service.

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

- Acute care priority services include:
- selected cardiovascular services;
- selected cancer services;
- chronic kidney disease services;
- critical care services; and
- organ and tissue donation and transplantation.

Primary Health Care: During 2015–2016, consistent with the government direction outlined in Patients First: Action Plan for Healthcare 2015, Ontario continued to align its new and existing primary health care delivery models to help improve and expand access to primary health care physician services for all Ontarians. The various primary health care physician compensation models encourage access to comprehensive primary health care services for Ontario as a whole, as well as for targeted population groups and remote underserviced communities. On December 7, 2016, Ontario passed Bill 41—*Patients First Act, 2016*. This legislation will improve access to health care services by giving patients and their families faster and better access to care and putting them at the center of a truly integrated health system. It would improve and integrate local planning and delivery of front-line primary care and in-home community services to support easier access to care, better coordination and continuity of care.

Health Care Connect (HCC): HCC refers Ontarians who need a primary health care provider (family doctor or nurse practitioner) to a provider who is accepting new patients in their community. Insured persons without a primary health care provider who register with HCC may be referred to a family doctor or a nurse practitioner if there is an available provider who is accepting new patients in their community.

During 2016–2017, MOHLTC continued to administer various initiatives in order to improve access to health care services across the province. Ontario's physician supply has stabilized due to past medical school expansion and ongoing evidence-informed planning, and the province is working to enhance the retention and distribution of physicians through measures, such as:

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

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

- **Northern and Rural Recruitment and Retention Initiative (NRRRI):** The NRRRI supports the recruitment and retention of physicians in rural and northern communities. The NRRRI provides financial recruitment incentives to physicians who establish a fulltime practice in an eligible community. Community eligibility for the NRRRI is based on a Rurality Index for Ontario score of 40 or more. Also eligible are the five Northern Ontario Census Urban Referral Centre census metropolitan areas (Thunder Bay, Sudbury, North Bay, Sault Ste. Marie and Timmins).
- **Northern Physician Retention Initiative (NPRI):** The NPRI provides physicians who have completed a minimum of four years of continuous full-time practice in Northern Ontario with a $7,000 retention incentive paid at the end of each fiscal year in which they continue to practise full-time in Northern Ontario. NPRI supports retention of physicians in Northern Ontario and encourages them to maintain active hospital privileges. Northern Ontario is defined as the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Muskoka, Rainy River, Sudbury, Thunder Bay and Timiskaming.
- **Northern Health Travel Grant (NHTG) Program:** The NHTG Program helps defray travel-related costs for residents of Northern Ontario who must travel long distances to access insured medical specialist services, or designated health care facility-based procedures that are not locally available, within a radius of 100km. The NHTG Program also promotes using specialist services located in Northern Ontario, which encourages more specialists to practise and remain in the north.

5.2 PHYSICIAN COMPENSATION

Physicians are paid for the services they provide through a number of mechanisms. Many physician payments are provided through fee-for-service arrangements. Fee-for-service remuneration is based on the Schedule of Benefits - Physician Services under the *Health Insurance Act*. Other physician payment models include Primary Health Care Models (such as blended capitation models), Alternate Payment Plans, and funding arrangements for physicians in Academic Health Science Centres. Physicians that

belong to these other payment models may also bill fee-for-service when providing services that are outside of the scope of these models.

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

Post-payment activities include payment reviews, education and audit. If payments for inappropriate claims are identified, the ministry works with the physician to resolve the issue. The MOHLTC may also use remedies in contract provisions or the *Health Insurance Act*. Audits include a formal review process to seek recovery of payment. Post-payment reviews are identified through monitoring such as data analytics, as a result of concerns reported to the MOHLTC, such as through the fraud hotline or other mechanisms.

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

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

MOHLTC negotiates many elements of physician compensation with the Ontario Medical Association (OMA). The last Physician Services Agreement (PSA) expired on March 31, 2014 and the MOHLTC and the OMA commenced negotiations for a new PSA in January 2014.The MOHLTC and the OMA negotiated from January 2014 to January 2015, but they were unsuccessful in reaching a PSA. In the absence of a new PSA, the MOHLTC implemented a set of initiatives (Ten-Point Plan for Saving and Improving Service) to change the funding for certain physician services and programs.

The MOHLTC subsequently engaged the OMA in confidential discussions from October 2015 to July 2016, focused on working towards the next PSA. These discussions led to a tentative agreement on July 7, 2016. On August 14, 2016, the OMA held a ratification vote and the PSA was rejected by the OMA membership.

The MOHLTC continues to work with the OMA in hopes of agreeing upon a new PSA.

5.3 PAYMENTS TO HOSPITALS

Ontario hospitals are funded through a mix of base funding, which is ongoing funding, and one-time funding. The majority of funding provided to hospitals is through base funding, which is comprised of:

- Health System Funding Reform (HSFR) including Health Based Allocation Model (HBAM) and Quality Based Procedures (QBPs);

- Non-HSFR base funding, such as Post-Construction Operating Plan (PCOP); and,
- Wait Times, Priority Programs and other non-HSFR base funding.

On April 1, 2012, Ontario began the implementation of the Health System Funding Reform (HSFR) Strategy for funding hospitals. HSFR shifts health care funding from a predominantly global budget system towards an activity-based funding model which ensures that patients get the right care, at the right place, at the right time, and at the right price, consistent with our *Patients First Action Plan*. HSFR offers an integrated approach to health system funding and puts the patient at the core through adopting a 'funding follows the patient' principle. HSFR is a significant shift from the way Ontario hospitals were traditionally funded, which was largely based on historically-derived global budgets, which were established in 1969.

HSFR is comprised of two key components: HBAM and QBP funding, which together comprised approximately 47 per cent of hospital's total funding in 2016–2017 (32 per cent HBAM; 15 per cent QBP).

Health-Based Allocation Model (HBAM): HBAM is an evidence-based, population health-based funding formula that uses demographic and clinical information to inform funding allocation. HBAM takes into account both the expected number of procedures and treatments the hospital is projected to perform and the complexity or acuity of these cases. Demographic information includes basic information such as age, sex as well as socio-economic status and rural geography. Clinical information includes measures of disease and status such as diagnostic and procedural information related to the different types of care provided to the population. HBAM enables the government to equitably allocate available funding at the organizational level to health service providers. Funding is allocated amongst providers based on the share of their expected expense calculation and available funding.

Quality-Based Procedures: QBPs are an integral part of HSFR as they align funding with quality improvement. They target clusters of patients with clinically related diagnoses or treatments that have been identified by an evidence-based framework as providing opportunity for process improvements, clinical redesign to improve patient outcomes, enhanced patient experience and potential cost savings. QBPs allow the health system to achieve better quality and system efficiencies. The price for most QBPs is currently based on the average price of providing care, adjusted for patient acuity.

Non-HSFR Base will continue to be used for activities that cannot be modeled, including those that are unique (such as forensic mental health), or where HSFR would introduce significant funding instability (such as small hospitals).

The Post-Construction Operating Plan (PCOP) Program provides operational funding to support the service and facility expansions associated with approved capital projects. Ontario's Wait Time Strategy provides targeted funding to improve access to key health services by reducing wait times.

Provincial Programs Funding

Provincial Program funding supports low-volume, high-cost, specialized programs such as selected cardiovascular, transplant and neuroservices that are managed at a provincial rather than regional level.

Hospital Service Accountability Agreements (H-SAA): When the LHINs assumed responsibility for their local health care systems they negotiated two year H-SAAs with their respective hospitals and became the lead for the Hospital Annual Planning Submissions, which inform the H-SAAs. The LHINs have amended the 2008/09– 2009/10 H-SAA each year from 2010/11 to 2017/18 versus negotiating a new two year agreement. These are referred to as Amending Agreements.

Public hospitals submit planning submissions to the LHINs that are the result of broad consultations within the organizations (all levels of staff, unions, physicians and board), the community and region. Some of the data submitted in the planning submissions are used to populate schedules for service volumes and performance targets that form the contractual basis for the H-SAA.

The H-SAA outlines the terms and conditions of the services provided by the hospital, the funding it will receive, along with the performance levels expected. There are various performance indicators that are monitored, managed and evaluated in the agreement.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health Transfer in its Public Accounts of Ontario 2016–2017.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)[1]	13,349,791	13,452,921	13,545,565	13,723,465	13,829,743

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)[2]	146	145	145	143	143
3. Payments for insured health services ($)[3]	16,418,200,000	16,361,203,000	16,377,339,000	16,387,182,900	16,784,015,574

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)[4]	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services ($)[4]	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	7,019	6,924	7,087	7,160	6,337
7. Total payments, in-patient ($)	58,107,802	60,733,276	65,048,142	66,194,339	61,781,960
8. Total number of claims, out-patient (#)	130,058	133,429	136,778	129,182	120,710
9. Total payments, out-patient ($)	37,866,652	41,057,654	42,332,365	42,834,485	43,097,597

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA[5]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	29,616	26,354	33,296	57,412	29,782
11. Total payments, in-patient ($)	43,824,878	45,624,997	54,634,942	58,362,023	71,235,200
12. Total number of claims, out-patient (#)	not available	not available	not available	not available	not available
13. Total payments, out-patient ($)	not available	not available	not available	not available	not available

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

[2] Number represents all publicly funded hospitals excluding specialty psychiatric hospitals. Specialty psychiatric hospitals are excluded in order to conform to Canada Health Act Annual Report requirements.

[3] Amount represents funding for all public and private hospitals excluding specialty psychiatric hospitals. Fiscal Year 2012/13–2016/17 is based on Public Accounts.

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

[5] Indicators 10 and 11 include both in-patient and out-patient.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	27,242	28,488	29,380	30,177	30,893
15. Number of opted-out physicians (#)	29	28	24	21	20
16. Number of non-participating physicians (#)[6]	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)[7]	11,228,719,988	11,379,311,227	11,823,825,604	11,918,882,881	12,113,803,206
18. Total payments for services provided by physicians paid through fee-for-service ($)[8]	7,402,377,170	7,600,334,259	7,784,933,027	7,803,728,926	8,028,037,940

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	553,823	672,661	623,076	589,688	585,353
20. Total payments ($)	26,017,930	30,248,528	31,360,835	29,524,980	30,851,717

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	214,080	192,773	170,362	142,485	124,678
22. Total payments ($)	6,537,845	5,844,999	6,473,814	6,518,994	7,749,118

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	273	275	275	278	281
24. Number of opted-out dentists (#)[a]	not applicable	not applicable	not applicable	not applicable	not applicable
25. Number of non-participating dentists (#)[a]	not applicable	not applicable	not applicable	not applicable	not applicable
26. Number of services provided (#)	93,672	95,810	96,258	99,570	98,823
27. Total payments ($)[9]	12,525,404	12,713,974	12,040,331	12,442,618	13,124,123

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

[6] Ontario has no non-participating physicians, only opted-out physicians who are reported under item #15.

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

[8] Effective from FY 2016/17 Total Payments for services provided by physicians paid through fee-for-service is based on Public Accounts.

[9] Effective from FY 2016/17 Total payments for Insured Surgical-Dental Services within Own Province or Territory is based on Public Accounts.

MANITOBA

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

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

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

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

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

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

There were no legislative amendments to the Act or the Regulations in the 2016–2017 fiscal year that affected the public administration of the MHSIP.

1.2 REPORTING RELATIONSHIP

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

1.3 AUDIT OF ACCOUNTS

Section 7 of the *Health Services Insurance Act* requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the MHSIP annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2016–2017 fiscal year and is contained in the Manitoba Health Annual Report, 2016–2017. It is available at www.gov.mb.ca/health/ann/index.html.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

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

As of March 31, 2017, there were 96 facilities providing insured hospital services to both in-and out-patients. Hospitals are designated by the *Hospitals Designation Regulation* (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in-patient and out-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologics and related preparations; routine medical and surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy, physiotherapy, occupational and speech therapy facilities where available.

The Regulation states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The regional health authorities and MHSAL monitor compliance.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations.

2.2 INSURED PHYSICIAN SERVICES

The enabling legislation that provides for insured physician services is the *Medical Services Insurance Regulation* (M.R. 49/93) made under the *Health Services Insurance Act.*

Physicians providing insured services in Manitoba must be lawfully entitled to practice medicine in Manitoba, and be registered and licensed under the *Medical Act.* As of April 30, 2016, there were 2768 physicians registered in Manitoba, with 2660 participating in the MHSIP.

A physician, by giving notice to the Minister in writing, may elect to collect the fees other than from the Minister for medical services rendered to insured persons, in accordance with section 91 of the Act and section 5 of the *Medical Services Insurance Regulation*. The election to opt out of the health care insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or Regulations. No physicians opted out of the medical plan in 2016–2017.

The range of physician services insured by MHSAL is listed in the *Payment for Insured Medical Services Regulation* (M.R. 95/96). Coverage is provided for all medically required personal health care services that are not excluded under *the Excluded Services Regulation* (M.R. 46/93) of the Act, rendered to an insured person by a physician.

During fiscal year 2016–2017, a number of new insured services were added to a revised fee schedule. The Physician's Manual can be viewed on-line at: www.gov.mb.ca/health/manual/index.html.

The process for a medical service to be added to the list of those covered by MHSAL is that physicians must put forward a proposal to their specific section of Doctors Manitoba. Doctors Manitoba will negotiate the item, including the fee, with MHSAL. MHSAL may also initiate this process.

2.3 INSURED SURGICAL-DENTAL SERVICES

Insured surgical and dental services are listed in the *Hospital Services Insurance and Administration Regulation* (M.R. 48/93) under the *Health Services Insurance Act*. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to, or collect from, an insured person a fee in excess of the benefits payable under the Act or Regulations. No providers of dental services had opted out in 2016–2017.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA negotiates the item and fee with MHSAL.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

The *Excluded Services Regulation* (M.R. 46/93) made under the *Health Services Insurance Act* sets out those services that are not insured. These include: examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties; group immunization or other group services except where authorized by MHSAL; services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependents; preparation of records, reports, certificates, communications and testimony in court; mileage or travelling time; services provided by psychologists, chiropodists and other practitioners not provided for in the legislation; 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 MHSAL monitor compliance.

All Manitoba residents have equitable access to services. Third parties such as private insurers or the Workers Compensation Board do not receive priority access to services through additional payment. Manitoba has no formalized process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows regional health authorities and MHSAL to monitor usage and service concerns.

To de-insure services covered by MHSAL, the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2016–2017.

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 and to individuals who hold study permits of six months or more under the *Immigration and Refugee Protection Act* (Canada). Additionally, section 8.1.1 of the *Residency and Registration Regulation* extends deemed residency to temporary foreign workers (and their dependents) in the province to provide agricultural services on the basis of a work permit, regardless of the duration of their work permit.

The *Residency and Registration Regulation*, section 6, defines Manitoba's waiting period as follows:

"A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

Section 6 of the Residency and Registration Regulation stipulates that there is no waiting period for dependents of members of the Canadian Armed Forces.

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan (MHSIP) excludes residents covered under any federal plan, including the following federal statutes: *Aeronautics Act; Civilian War-related Benefits Act; Government Employees Compensation Act; Merchant Seaman Compensation Act; National Defence Act; Pension Act;*

Veteran's Rehabilitation Act; federal inmates or those covered under legislation of any other jurisdiction (*Excluded Services Regulations* subsection 2(2)). These residents become eligible for health services insurance coverage upon discharge from the Canadian Forces, or in the case of an inmate of a penitentiary, upon discharge if the inmate has no resident dependents. Upon change of status, these persons have one month to register with MHSAL (*Residency and Registration Regulation* (M.R. 54/93, subsection 2(3)).

RCMP members are insured persons in Manitoba and are eligible for benefits under the MHSIP.

The process of issuing health insurance cards requires that individuals inform and provide documentation to MHSAL that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months in a calendar year. They must also provide a primary residence address in Manitoba. Upon receiving this information, MHSAL will provide a registration card for the individual and all qualifying dependents.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependent. The six-digit number may be shared by all members of a family including a spouse and dependents. A nine-digit Personal Health Identification Number (PHIN) is used for payment of all medical service claims and hospital services.

As of March 31, 2017, there were 1,353,720 residents registered with the Manitoba Health Services Insurance Plan.

There is no provision for a resident to opt out of the MHSIP.

3.2 OTHER CATEGORIES OF INDIVIDUALS

The *Residency and Registration Regulation* (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit issued by Immigration, Refugees and Citizenship Canada for at least 12 consecutive months, be physically present in Manitoba for six months in a calendar year, and be legally entitled to be in Canada before receiving MHSIP coverage.

Section 8.1(a.1) of the *Residency and Registration Regulation* extends deemed residency to foreign students (and their dependents) holding a valid study permit with a duration of 12 months or more.

Section 8.1.1 of the *Residency and Registration Regulation* extends deemed residency to temporary foreign workers (and their dependents) in the province to provide agricultural services on the basis of a work permit, regardless of the duration of their work permit.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

The *Residency and Registration Regulation* (M.R. 54/93, section 6) identifies the waiting period for insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arriving in Manitoba is entitled to benefits on the first day of the third month following the month of arrival.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

The *Residency and Registration Regulation* (M.R. 54/93 section 7(1)) defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their fulltime enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient, high-cost procedures and out-patient services are based on national rates agreed to by provincial and territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical physician services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for physician medical services received in Quebec are submitted by the patient or physician to MHSAL for payment at host province rates.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The *Residency and Registration Regulation* (M.R. 54/93, sub-section 7(1)) defines the rules for portability of health insurance during temporary absences from Canada.

Section 7(1)(g) of the *Residency and Registration Regulation* extends the period during which a person may be temporarily absent from Manitoba for the purpose of residing outside of Canada from six months to a maximum of seven months in a 12-month period.

Residents on full-time employment contracts outside Canada will receive health services insurance coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Clergy serving as humanitarian aid workers or missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by MHSAL for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by MHSAL for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Manitoba residents receiving coverage under the provincial health insurance plan who receive medical and hospital services outside of Canada are eligible to be reimbursed at the rates set out in the *Medical Services Insurance Regulation* and *the Hospital Services Insurance and Administration Regulation*. Emergency doctors' services outside of Canada are reimbursed at a rate equal to what a Manitoba doctor would receive for a similar service. Emergency hospital care is paid on an average daily rate established by Manitoba Health, Seniors and Active Living.

4.4 PRIOR APPROVAL REQUIREMENT

Prior approval is not required for procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval by MHSAL is required for high cost items or procedures that are not included in the reciprocal agreements.

In order to be eligible for reimbursement, all non-emergency hospital and medical care provided outside Canada requires prior approval from MHSAL. Manitobans requiring medically necessary medical and/or hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for reimbursement of costs incurred outside of Canada, pursuant to the *Medical Services Insurance Regulation*, by providing MHSAL with a recommendation from a specialist stating that the patient requires a specific, medically necessary service.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

MHSAL ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the *Surgical Facilities Regulation* (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

The Health Services Insurance Act and *The Private Hospitals Act* include definitions and other provisions to ensure:

- that no charges can be made to individuals who receive insured surgical services, or to anyone else on that person's behalf; and
- that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

The Accessibility for Manitobans Act includes definitions and principles to ensure accessibility by preventing and removing barriers that disable people with respect to receiving health care services including:

- accommodation;
- the built environment, including facilities, building, structures and premises
- the delivery and receipt of goods, services and information; and
- a prescribed activity or undertaking.

MHSAL remains committed to the principles of Medicare and improving the health status of all Manitobans. In 2016–2017 Manitoba continued to support these commitments through such activities as:

- Partnered with regional health authorities and primary care physicians to match 95 per cent of all registrants without a primary care provider (over 70,000 people) since the Family Doctor Finder program began in July 2013. Overall satisfaction with program registration experience was 91.5 per cent.

- In collaboration with regional health authorities, CancerCare Manitoba, and Diagnostic Services of Manitoba, worked towards reducing the cancer patient journey from suspicion to treatment to two months or less for key selected cancer types.
- Improved access and quality of primary health care, including implementation of eight Quick Care clinics, three primary care mobile clinics in Prairie-Mountain Health Authority, Southern Health-Santé Sud RHA and Interlake-Eastern RHA and eleven Primary Care Networks across Manitoba.
- Providing funding to increase the number of medical and nursing professionals registered to practice in Manitoba as follows:
  - Specialist physicians increased by 13 (from 1394 to 1407)
  - General practitioners increased by 7 (from 1354 to 1361)
  - Registered Nurses increased by 135 (from 13,547 to 13,682).
  - Nurse Practitioners increased by 15 (from 172 to 187).
  - Registered Psychiatric Nurses increased by 35 (from 1,017 to 1,035).
  - Licensed Practical Nurses increased by 46 (from 3,355 to 3,401).
- Oversaw the provincial implementation of digital mammography, which has resulted in more rapid screening and diagnosis of breast cancer.
- Worked with regional health authorities in Manitoba and Nunavut to implement a new Provincial Bed Utilization Committee to address patient flow issues and prioritize admissions to Selkirk Mental Health Centre.
- Expanded, streamlined and increased efficiencies of the Electronic Medical Record (EMR) Repository, with over 190 (and growing) primary care clinics regularly submitting EMR data.
- Worked with regional health authorities across the province to implement the Universal Newborn Hearing Screening program to provide hearing screening to all infants born in Manitoba, and ensure consistency, equity, quality and safety in provincially standardized service delivery by partner organizations.

MHSAL continues to not only invest in improving clients' access to primary care services across the province, but is also addressing continuity of care and ensuring a more comprehensive basket of services are provided. For example, to achieve Manitoba's direction of building an integrated primary care system, investments continue to be made in initiatives such as Primary Care Networks and inter-professional teams. A new primary care capacity planning process has been initiated to better match supply of providers and demand for services in order to better address the long standing needs of certain rural and remote communities.

Investment also continued in existing initiatives that enhance capacity, quality and efficiency in primary care, such as the primary care quality indicators, and establishing home clinics for primary care providers to serve as a patient's home base within the health-care system. Other efforts to support efficiency include Advanced Access training and standards to enable primary care clinics and regional community programs to measure access and work towards patient access to a primary care provider within 24-48 hours.

The implementation and increasing use of electronic medical records in 80 per cent of primary care settings also supports primary care continuous quality improvement reporting for primary care services across Manitoba.

MHSAL continues to explore means to improve and sustain access to acute care and emergency department services throughout Manitoba within its fiscal means. Efforts have been focused on improving the efficiency of services provided, enabling more services to be provided to Manitobans within existing funding. MHSAL initiated a Wait Times Reduction Task Force to identify opportunities for improving access to emergency departments and priority procedures (hip and knee replacement surgery, cataract surgery, and magnetic resonance imaging), and inform recommendations.

In collaboration with Winnipeg Regional Health Authority (WRHA), Prairie Mountain health and Diagnostic Services Manitoba (DSM) MHSAL has advanced on recommendations to address the Office of the Auditor General audit of the Management of MRI Services in Manitoba.

Supported the implementation of investments in cancer prevention, screening and care.

Manitoba continues to experience growth in the number of active practicing nurses. There were 18, 305 active practicing nurses in Manitoba in 2016. This represents a net gain of 214 nurses over 2016 (18,091).

A renewed Collective Agreement was reached with the Manitoba Nurses' Union (MNU) on April 9, 2014 and is in effect for four years, from April 1, 2013 to March 31, 2017. The Agreement provides for wage increases of 10.1 per cent over four years, which breaks down as follows: 2 per cent retroactively for 2013; 2 per cent in 2014 plus 1.1 per cent market adjustment; 2 per cent in 2015; and 2 per cent in 2016 plus a 1 per cent market adjustment. As part of the new Agreement, the parties made a number of post-bargaining commitments, including the commitment to identify, develop and implement system delivery changes intended to improve the effectiveness and efficiency of health care service delivery in Manitoba.

The Nurses Recruitment and Retention Fund, established in 1999, to assist regional health authorities to meet nursing supply demands in terms of both recruitment and retention in Manitoba has continued to provide financial assistance in order to assist eligible nurses of all categories to offset the cost of re-entering the profession and relocate to work in Manitoba, and has provided funding to encourage nurses to work in rural and northern regions and other areas of need in order to enhance the delivery of health care across the province.

In addition to ensuring a sufficient nursing workforce supply, continued targeted efforts will be undertaken in order to ensure that nursing resources are optimized and all nurses are provided opportunities to practice to their full scope.

Ongoing implementation of the overall healthcare transformation, whereby more services may be provided in the community, in primary care settings continues at pace with additional targeted efforts intended to be undertaken over the next few years to address both the increasing age of this workforce, in terms of retirements, as well as the advancing age of the population in terms of the need for long term care services.

The Province has been supporting the expansion of the Physician Assistant (PA) role in Manitoba. PAs are highly skilled health care professionals who practice medicine under the supervision of licensed physicians. PAs are regulated by the College of Physicians & Surgeons of Manitoba (CPSM) and must be registered with the CPSM in order to practice in Manitoba. The CPSM determines a PA's specific scope of practice by approving their practice description, which is signed by their supervising physician.

Since Manitoba established its PA Regulation in 1999 the role of the PA has grown from positions within acute surgical units (general, orthopedic and cardiac) to having PAs providing clinical support in areas of mental health, internal medicine, oncology and primary care. PAs working in primary care in Manitoba have ranged from 'solo' practices in rural Manitoba, supervised and supported by physicians in a nearby community, to working in both regional health authority run primary care clinics and community-based fee-for-service clinics. The demand for PAs continues to grow as the profession has shown great adaptability to address access and service challenges throughout Manitoba's health system. As of November 13, 2017, there were 100PAs registered with the CPSM.

5.2 PHYSICIAN COMPENSATION

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, contract, blended and sessional. The *Health Services Insurance Act* governs remuneration to physicians for insured services. There were no amendments to The *Health Services Insurance Act* related to physician compensation during the 2016–2017 fiscal year.

Fee-for-service remains the primary method of payment for physician services. Alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive non fee-for-service compensation, including through a salary (employment relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods where appropriate. As well, physicians may receive sessional payments for providing medical services on a time based arrangement, as well as stipends for on-call and other responsibilities.

MHSAL represents Manitoba in negotiations with physicians. The physicians are typically represented by Doctors Manitoba with some exceptions, such as oncologists engaged by CancerCare Manitoba.

Doctors Manitoba and Manitoba reached a 4-year agreement on February 12, 2015 to renew the physician Master Agreement. The new physician Master Agreement took effect on April 1, 2015 and will expire on March 31, 2019.

The Manitoba Physician's Manual lists all of the fee tariff descriptions, rates, rules of application and the dispute resolution process in relation to fee-for-service payments to physicians. This document is the Schedule of Benefits payable to physicians on behalf of insured persons in Manitoba pursuant to the *Medical Services Insurance Regulation* under The *Health Services Insurance Act*.

All fee-for-service claims must be submitted electronically. The submission of paper claims is permitted on a limited basis and only with the prior approval of MHSAL. Fee-for-service claims must be received within six months of the date upon which the physician rendered the service.

5.3 PAYMENTS TO HOSPITALS

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operating agreements between regional health authorities and the operators of hospitals and personal care homes, defined as "health corporations" under the Act.

Pursuant to the provisions of division 3.1, regional health authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that: enables the health services to be provided by the health corporation; enables the funding to be provided by the regional health authority for the health services; sets out the terms of the agreement; and includes a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request that the Minister 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.

There are three regional health authorities which have hospitals operated by health corporations in their health regions. The regional health authorities have required agreements with health corporations that enable the regional health authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities. In all other regions, the hospitals are operated by the *Regional Health Authorities Act*. The allocation of resources by regional health authorities for providing hospital services is approved by MHSAL through the approval of regional health plans, which the regional health authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that regional health authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan (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 a regional health authority, the regional health authority is required to pay each hospital in accordance with any agreement reached between the regional health authority and the hospital operator.

No legislative amendments to the Act or the Regulations in 2016–2017 had an effect on payments to hospitals.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Manitoba regularly recognizes the federal role regarding the contributions provided under the Canada Health Transfer (CHT) in public documents. Federal transfers are identified in the Estimates of Expenditures and Revenue (Manitoba Budget) document and in the Public Accounts of Manitoba. Both documents are published annually by the Manitoba government.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	1,271,388	1,289,268	1,317,861	1,320,343	1,339,308[1]

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	96	96	96	96	96
3. Payments for insured health services ($)	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	1	1	0[2]	0[2]	0[2]
5. Payments to private for-profit facilities for insured health services ($)	1,928,985	2,040,914	0[2]	0[2]	0[2]

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	2,690	2,978	2,829	2,507	2,458
7. Total payments, in-patient ($)	25,548,935	29,138,109	25,458,440	27,875,311	28,194,575
8. Total number of claims, out-patient (#)	31,270	33,999	32,083	30,485	30,412
9. Total payments, out-patient ($)	10,073,238	11,830,872	11,010,715	10,542,720	11,535,541

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	628	722	614	616	589
11. Total payments, in-patient ($)	4,317,523	1,826,483	1,697,912	5,162,892	3,148,170
12. Total number of claims, out-patient (#)	11,408	12,145	12,028	11,982	10,842
13. Total payments, out-patient ($)	3,193,548	3,080,536	3,344,999	3,790,531	3,652,283

[1] Population as of June 1st, 2016.

[2] Beginning in 2014–2015, HSAL no longer has arrangements with private for-profit facilities. These facilities are accessible through Regional Health Authorities. This is reflected retrospectively in a revised figure for 2014–2015.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	2,354	2,354	2,510	2,533	2,660
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	not applicable	not applicable	not applicable	not applicable	not applicable
17. Total payments for services provided by physicians paid through all payment methods ($)	988,164,000	1,082,193,000	1,134,521,000	1,204,757,000	1,283,742,000
18. Total payments for services provided by physicians paid through fee-for-service ($)	593,129,217	659,208,383	742,136,000	784,398,000	867,122,000

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	238,400	226,473	244,903	263,393	254,395
20. Total payments ($)	11,127,080	11,137,758	11,963,709	12,545,113	13,062,681

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	7,984	8,216	7,785	7,995	6,641
22. Total payments ($)	1,148,432	888,084	1,048,275	1,269,879	1,042,755

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	160	166	190	207	227
24. Number of opted-out dentists (#)[a]					not available
25. Number of non-participating dentists (#)[a]					not available
26. Number of services provided (#)	5,236	5,656	6,397	6,561	7,249
27. Total payments ($)	1,231,972	1,493,071	2,083,453	1,531,281	1,851,615

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

SASKATCHEWAN

Saskatchewan's Ministry of Health focus in health care is driven by our patient first agenda—where we concentrate on better health, better care, better value, and better teams for Saskatchewan people. The Ministry continually explores innovative approaches to meet the needs and respect the values of patients and families in both the planning and delivery of care.

Part of that innovation includes a transition from 12 Regional Health Authorities to the single Saskatchewan Health Authority, scheduled to be in place December 2017. The move to a single provincial health authority is being driven by the commitment to improve frontline patient care for Saskatchewan people. One provincial health authority that is focused on better coordination of health services across the province will ensure patients receive high quality, timely health care, regardless of where they live in Saskatchewan.

Saskatchewan's health care delivery system also includes the Saskatchewan Cancer Agency, eHealth Saskatchewan, 3S Health (Shared Services Saskatchewan), the Athabasca Health Authority, affiliated health care organizations, and a diverse group of professionals, many of whom are in private practice. There are 26 self-regulated health professions in the province and the health system as a whole employs more than 42,000 people who provide a broad range of services.

The Ministry will continue to provide effective strategic oversight to the Saskatchewan Health Authority Board of Directors and the Saskatchewan Cancer Agency and encourages leadership from boards, management, and health professionals at all levels.

The Ministry will continue partnerships with local, regional, provincial, national and international organizations, as those partnerships are fundamental to providing all Saskatchewan residents with access to quality health care services.

Visit www.saskatchewan.ca for more information about Ministry programs and services.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of the *Health Administration Act* authorizes that the 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*, implemented in 2002, provides the authority to establish 12 regional health authorities.

Sections 3 and 9 of the *Cancer Agency Act* provide the authority for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Ministry of Health, regional health authorities and the Saskatchewan Cancer Agency are outlined in the *Health Administration Act*, the *Regional Health Services Act* and the *Cancer Agency Act*.

1.2 REPORTING RELATIONSHIP

The Ministry 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* requires that the Minister of Health submit an annual report concerning the medical care insurance plan to the Legislative Assembly.

The *Regional Health Services Act* requires that each 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.

Pursuant to legislation, these reports and corresponding statements are then provided by the Minister to the Legislative Assembly.

Section 54 of the *Regional Health Services Act* requires that regional health authorities and the Cancer Agency submit to the Minister any reports that the Minister may request from time to time. Regional health authorities and the Cancer Agency are required to submit various financial documents and a health service plan to the Saskatchewan Ministry of Health.

1.3 AUDIT OF ACCOUNTS

The Provincial Auditor conducts an annual audit of government ministries and agencies, including the Ministry of Health. The audit of the Ministry of Health includes a review of Ministry payments including, but not limited to, payments made to regional health authorities, the Saskatchewan Cancer Agency, and physicians and dental surgeons for insured physician and surgical-dental services.

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 a regional health authority and the Saskatchewan Cancer Agency, audit the accounts of a regional health authority or the Saskatchewan Cancer Agency at least once in every fiscal year. Each regional health authority and the Saskatchewan Cancer Agency must annually submit to the Minister of Health a detailed, audited set of financial statements.

The most recent audits were for the year ending March 31, 2017. The regional health authorities and Saskatchewan Cancer Agency each table annual reports in the Saskatchewan Legislature each year which include their audited financial statements. The Government of Saskatchewan tables its audited financial statements (Public Accounts) in the Legislature each year as well. The reports are available to the public directly from each entity and are available on their websites.

The Office of the Provincial Auditor for Saskatchewan provides independent assurance (audit reports) and advice on the Government's management of and accountability practices for the public resources entrusted to it. They inform the Legislative Assembly about the reliability of the Government's financial and operational information, the Government's compliance with legislative authorities and the adequacy of the Government's management of public resources. Their reports are available on the Provincial Auditor's website at: www.auditor.sk.ca.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

Section 8 of the *Regional Health Services 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 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 the accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual financial and health service plans for ministerial approval (section 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.

A comprehensive range of insured services is provided by hospitals. These may include: public ward accommodation; necessary nursing services; the use of operating room and case room facilities; required medical and surgical materials and appliances; x-ray, laboratory, radiological and other diagnostic procedures; radio-therapy facilities; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all drugs, biological and related preparations required for hospitalized patients; and services rendered by individuals who receive remuneration from the hospital.

Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals, so people know what they can expect at each hospital. While not all hospitals will offer the same kinds of services, reliability and predictability means:

- it is widely understood which services each hospital offers; and
- these services will be provided on a continuous basis, subject to the availability of appropriate health providers.

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, available health providers and financial resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, which takes into account such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. A regional health authority initiates the process and, depending on the specific service request, it could include consultations involving several branches within the Ministry of Health as well as external stakeholder groups such as other regional health authorities, service providers and the public.

2.2 INSURED PHYSICIAN SERVICES

Sections 8 and 9 of the *Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. All fee items for physicians can be found in the Physician Payment Schedule at www.saskatchewan.ca. As of March 31, 2017, there were 2,491 physicians licensed to practise in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 1,301 (52.2 per cent) were family practitioners and 1,190 (47.3 per cent) were specialists. Physicians may choose to not participate in the Medical Services Plan (known in Saskatchewan legislation as opting out), but if doing so, they must fully opt out of all insured physician services. As per legislation the non-participating physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2017, there were no non-participating physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Ministry of Health, and are listed in the *Physician Payment Schedule of the Saskatchewan Medical Care Insurance Payment Regulations (1994)* of the *Saskatchewan Medical Care Insurance Act.*

A process of formal discussion and negotiation between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service, or a change is made to an existing service, the changes are reflected in the Physician Payment Schedule. A regulatory amendment to the *Saskatchewan Medical Care Insurance Payment Regulations* is required to provide the authority to pay updated rates to physicians and new insured services.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Medical Services Plan.

2.3 INSURED SURGICAL-DENTAL SERVICES

Dentists may choose to not participate in the Medical Services Plan (known in Saskatchewan legislation as opting out), but if doing so, they must opt out of all insured surgical-dental services. The non-participating dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

There were no non-participating dentists in Saskatchewan as of March 31, 2017.

Insured surgical-dental services are limited to: services in connection with maxillo-facial surgery required as a result of trauma; treatment services for the orthodontic care of cleft palate; extraction of teeth when medically required; surgical treatment for temporomandibular joint dysfunction; dental implants in exceptional circumstances (tumours and congenital) upon request from specialist in oral maxillofacial surgery and prior approval from Medical Services Branch; and certain services in connection with abnormalities of the mouth and surrounding structures. All dental anaesthetic for beneficiaries under age 14 is insured.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion, consultation and negotiation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service. Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

As of March 31, 2017, there were approximately 500 practicing dentists and dental surgeons located in all major centres in Saskatchewan. Seventy-eight provided services insured under the Medical Services Plan.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Uninsured hospital, physician and surgical-dental services in Saskatchewan include: in-patient and out-patient hospital services provided for reasons other than medical necessity; services prescribed to be an "uninsured service" in legislation; the extra cost of private and semi-private hospital accommodation not ordered by a physician; physiotherapy and occupational therapy services not provided by or under contract with a regional health authority; services provided by health facilities other than hospitals unless through an agreement with a regional health authority and licensed under the *Patient Choice Medical Imaging Act* or the *Health Facilities Licensing Act*; non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval; non-medically required elective physician services; surgical-dental services that are not medically necessary; and services received under other public programs including the *Workers' Compensation Act*, the federal Department of Veteran Affairs and the *Mental Health Services Act*.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. There are no charges allowed in Saskatchewan for insured hospital, physician or surgical-dental services. Charges for enhanced medical services or

products are permitted only if the medical service or product is not deemed medically necessary and/or not deemed to be an insured service. Compliance is monitored through consultations with regional health authorities, physicians and dentists.

Insured hospital services are typically de-insured by the government if they were determined to be no longer medically necessary and/or clinically appropriate. The process involves discussions among stakeholders, practitioners, and officials from the Ministry of Health.

Insured physician services could be de-insured if they were determined not to be medically required and/or clinically appropriate. The process involves consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Insured surgical-dental services could be de-insured if they were determined not to be medically necessary and/or clinically appropriate. The process involves discussion and consultation with the dental surgeons of the province, and is managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

Effective July 1, 2017 chiropractic services were de-insured.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

The *Saskatchewan Medical Care Insurance Act* (sections 2 and 12) and the *Medical Care Insurance Beneficiary and Administration Regulations* define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage.

While the Regulations set out classes of beneficiaries exempt from insured services under the Act, it is possible for individual residents to request that the Health Registry not issue a provincial health card in certain cases (e.g., for religious reasons).

Eligibility is limited to residents. A "resident" means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor-in-Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students, and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not covered under Saskatchewan's Medical Services Plan:

- members of the Canadian Forces, federal inmates, refugee claimants, visitors to the province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

Individuals who are not successful when applying for a provincial health card may appeal the decision by submitting to Health Registries—eHealth Saskatchewan, a Saskatchewan Health Services Card Application—Appeal Form.

The number of persons registered for health services in Saskatchewan on June 30, 2016, was 1,176,932.

3.2 OTHER CATEGORIES OF INDIVIDUALS

Other categories of individuals who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, study permit or Minister's permit issued by Immigration, Refugees and Citizenship Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with a study or work permit, Minister's permit or permanent resident or landed immigrant record.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of the *Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada.

In 2015–2016 Saskatchewan amended Regulations to increase the amount of time residents are allowed to be out-of-province while still maintaining their health care benefits. Residents are now able to maintain health coverage after spending a maximum of seven months outside of Saskatchewan. Residents were only allowed to be absent for a maximum of six months over any 12 month period before their health benefits were discontinued. The new policy took effect January 1, 2016.

Section 6.6 of the *Health Administration Act* provides the authority for paying in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of the *Saskatchewan Medical Care Insurance Payment Regulations (1994)* provides payment for physician services to Saskatchewan beneficiaries temporarily residing outside the province.

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 (confirmation by the facility of full-time student status and expected graduation date are required);
- employment of up to 12 months (no documentation required); and
- vacation and travel of up to 12 months.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services. Quebec does not participate in reciprocal billing of physician services.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* of the *Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers, vacationers and travelers 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 (confirmation by the facility of fulltime student status and expected graduation date are required);
- contract employment of up to 24 months; and
- vacation and travel of up to 12 months.

Section 3 of the *Medical Care Insurance Beneficiary and Administration Regulations* provides open-ended temporary absence coverage for persons whose principal place of residence is in Saskatchewan, but who are not able to satisfy the annual six months physical presence requirement because the nature of their employment requires travel from place to place outside Canada (e.g., cruise line workers).

Section 6.6 of the *Health Administration Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

4.4 PRIOR APPROVAL REQUIREMENT

Out-of-Province

The Saskatchewan Ministry of Health covers most hospital and medical out-of-province care received by its residents in Canada through reciprocal billing arrangements. These arrangements mean that residents do not need prior approval and may not be billed for most 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, rehabilitation, problem gambling services, home care, and certain rehabilitative services.

Prior approval from the Ministry must be obtained by the patient's specialist.

Out-of-Country

If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of the Ministry of Health. The Saskatchewan Cancer Agency is consulted for out-of-country cancer treatment requests. If approved, the Ministry of Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

In Saskatchewan, the Health Services Review Committee (HSRC) is an arms-length panel that reviews government decisions made on requests for out-of-province and out-of-country medical coverage, ensuring legislation, policy, and guidelines are followed appropriately.

The Ministry of Health informs eligible applicants of their right to request a review by the HSRC upon denial of their out-of-province or out-of-country coverage request. A person can request a review by the HRSC only if the coverage request was for out-of-province medical health services, elective out-of-country medical services (physician and hospital care) or community care programs (mental health, alcohol and drug, problem gambling, and rehabilitative services).

If a case is ineligible for HSRC or if HSRC upholds the Ministry's coverage decision, a person may contact the Provincial Ombudsman for another review.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons, and user charges by hospitals for insured health services are not allowed in Saskatchewan.

Pursuant to section 18(1.1) of the *Saskatchewan Medical Care Insurance Act*, no physician or other person who provides an insured service to a beneficiary shall demand or accept payment for that service in an amount that he knows exceeds the payment to be made for that service prescribed in the *Saskatchewan Medical Care Insurance Regulations*.

When requests are made by a beneficiary to reimburse monies paid directly to a physician for insured physician services that are extra-billing charges, correspondence is sent to the beneficiary (copying the physician) advising them of Section 18 (1.1) of the *Saskatchewan Medical Care Insurance Payment Act* that a physician must accept the negotiated rate as payment in full for insured services provided to a beneficiary. Once they have received payment from Medical Services for the eligible service(s), reimbursement for any difference in the amount charged by the practitioner and the amount paid by Medical Services should be collected directly from the practitioner. If further complaint is made, the beneficiary is directed to address complaints to the Saskatchewan College of Physicians and Surgeons.

There is no subsequent disciplinary action on the part of the Ministry against those who levy extra billing or user charges.

Building on the success of the Saskatchewan Surgical Initiative which significantly reduced patient wait times for surgery, the health system is working to strengthen coordination, communication, and referral guidelines to better coordinate services to ensure patients have timely access to the most appropriate specialist and diagnostic services. By reducing the wait time for a consult with a specialist or diagnostic services (such as MRI and CTs), patients will be able to access treatment sooner.

In May 2009, the Government of Saskatchewan released the Physician Recruitment Strategy in an effort to address province-wide physician shortages. In 2015–2016 funding supported several recruitment initiatives:

- The provincial plan for distributed medical education continued to be developed and rolled out with the goal of increasing the number of medical seats in rural centres. Post-graduate seats were offered in Regina, Prince Albert, Swift Current, North Battleford, La Ronge and Moose Jaw.
- The Physician Recruitment Agency of Saskatchewan (saskdocs), created in 2009, continued to provide recruitment expertise to communities, physician practices and health agencies.
- The Saskatchewan International Physician Practice Assessment program worked to ensure that foreign-trained physicians were assessed with sufficient rigor and patients received safe, high-quality care.

Other Programs

The Family Physician Comprehensive Care Program is intended to support recruitment and retention of family physicians by recognizing those physicians who provide a full range of services to their patients and the continuity of care that result from these comprehensive services.

5.2 PHYSICIAN COMPENSATION

Section 6 of the *Saskatchewan Medical Care Insurance Payment Regulations (1994)* outlines the obligation of the Minister of Health to make payments for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salary, and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services. Total expenditures for in-province physician services and programs in 2016–2017 amounted to $1.048 billion: $557.3 million for fee-for-service billings; $31.7 million for Specialist Emergency Coverage Programs; and $393.5 million in non-fee-for-service expenditures. There was also an additional $65.7 million for other Saskatchewan Medical Association and bursary programs.

Saskatchewan physicians do not charge block fees.

5.3 PAYMENTS TO HOSPITALS

Funding to regional health authorities is 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, and surgical services).

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

Federal contributions provided through the Canada Health Transfer are publicly acknowledged by the Government of Saskatchewan in the Ministry of Health's 2016–2017 Annual Report, the 2016–2017 Provincial Budget and related documents, the 2015–2016 Public Accounts, and the Quarterly and Mid-Year Financial Reports. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged in news releases and issue papers, and in speeches and remarks made at various conferences, meetings and public policy forums.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	1,090,953	1,121,755	1,152,330	1,154,257	1,176,932[1]

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	66	66	66	66	66
3. Payments for insured health services ($)[2]	1,777,208,000	1,846,795,000	1,889,855,000	1,943,748,000	1,976,162,750

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	4	4	4	5	5
5. Payments to private for-profit facilities for insured health services ($)	Not Available	Not Available	Not Available	Not Available	Not Available[3]

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	5,433	4,845	4,113	4,923	4,376
7. Total payments, in-patient ($)	54,483,700	53,004,700	42,834,000[4]	67,838,500	49,817,000
8. Total number of claims, out-patient (#)	74,201	67,387	66,006	77,250	68,995
9. Total payments, out-patient ($)	26,716,300	24,736,300	24,130,100	28,739,900	27,218,000

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	388	374	358	350	340
11. Total payments, in-patient ($)	2,007,000	2,271,900	4,529,900	1,299,700	936,000
12. Total number of claims, out-patient (#)	1,938	1,730	1,488	1,581	1,296
13. Total payments, out-patient ($)	1,511,300	1,606,100	480,300[5]	1,136,300	1,133,000

[1] Saskatchewan's numbers as of June 30, 2017.

[2] This number includes estimated government funding to regional health authorities in their annual audited financial statements.
- Includes acute care services, specialized hospital services, and in-hospital specialist services.
- Does not include inpatient mental mental health, or addiction treatment services.
- Does not include payments to Saskatchewan Cancer Agency for out-patient chemotherapy and radiation.

[3] CT and MRI services are not considered insured services in Saskatchewan within the meaning of the Saskatchewan *Medical Care Insurance Act*. Private facilities providing surgical, MRI and CT services receive payments for these services under contract with regional health authorities. The Ministry of Health does not provide payments to these facilities.

[4] Decrease in 2014–15 due to decrease in in-patient claims and corresponding mix of procedure cost.

[5] Decrease in 2014–15 was due to a decrease in out-of-country treatments.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	2,044	2,165	2,224	2,375	2,491
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)	823,656,225	873,484,838	898,584,963	941.409,025	982,568,484
18. Total payments for services provided by physicians paid through fee-for-service ($)	480,173,762	488,651,587	507,079,008	535,162,606	557,334,395[6]

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	659,994	697,161	714,648	753,736	785,072
20. Total payments ($)	33,658,928	35,703,160	37,220,270	40,339,800	42,855,888

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	not available	not available	not available	not available	not available
22. Total payments ($)	1,199,100	1,484,200	1,416,300	996,600	707,800

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	88	82	79	79	78
24. Number of opted-out dentists (#)[a]					0
25. Number of non-participating dentists (#)[a]					0
26. Number of services provided (#)	18,123	16,014	17,346	18,777	13,139
27. Total payments ($)	1,710,397	1,669,803	1,870,512	2,146,101	1,688,771

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

[6] Figure is composed of fee-for-service billing and funding for the Emergency Rural Coverage Program which is paid through the fee-for-service program.

ALBERTA

The Minister of Health, the Associate Minister of Health, the Department of Health (Alberta Health) and the Regional Health Authority (Alberta Health Services) play key roles in Alberta's health care system. All persons and entities work together to deliver better care and improve population outcomes in a sustainable way. The goal is for Albertans to get the right care, in the right place, at the right time.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

Alberta Health administers and operates the Alberta Health Care Insurance Plan (AHCIP) in accordance with the *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* has governed the operation of the AHCIP. The Minister of Health, working in conjunction with the appropriate stakeholders, determines which services are covered by the AHCIP.

1.2 REPORTING RELATIONSHIP

The Minister of Health is accountable for the AHCIP. The *Fiscal Planning and Transparency Act* (which replaced the *Fiscal Management Act* in 2015), provides a framework for government budgeting and fiscal planning. The Minister is required to prepare an annual report, which must include the audited financial statements. The 2016–2017 Annual Report of the Ministry of Health was released to the public on June 29, 2017.

1.3 AUDIT OF ACCOUNTS

The Auditor General of Alberta audits 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 of Alberta completed an audit of the Ministry of Health on June 2, 2017, and indicated that the consolidated financial statements present fairly, in all material respects, the financial position and results of operations for the year that ended March 31, 2017.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

In Alberta, Alberta Health Services (AHS) is the entity responsible to the Minister of Health for ensuring the provision of insured hospital services. The *Hospitals Act*, the *Hospitalization Benefits Regulation (AR 244/1990)*, the *Health Care Protection Act*, and the *Health Care Protection Regulation (AR 208/2000)* govern the provision of insured services by hospitals or designated non-hospital surgical facilities. During 2016–2017, no amendments were made to the legislation regarding insured hospital services. A directory of approved hospitals in Alberta can be found at: www.health.alberta.ca/services/health-benefits-services.html.

The publicly funded services provided by approved hospitals in Alberta include all of the hospital services listed in the *Canada Health Act*. The insured hospital services range from the most advanced levels of diagnostic and treatment services for in-patients and out-patients, to routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are established in the *Hospitalization Benefits Regulation (AR 244/1990)*. The Regulation is available at: www.health.alberta.ca/about/health-legislation.html.

The list of insured services included in the Regulations is intended to be both comprehensive and generic thereby limiting the need for routine review and updating. Any listing or delisting of an insured service is undertaken without public consultation.

2.2 INSURED PHYSICIAN SERVICES

The *Alberta Health Care Insurance Act* governs the payment of physicians for insured physician services under section 6. Only physicians who meet the requirements stated in the Act are permitted to make a claim for payment of benefits for providing insured services under the Alberta Health Care Insurance Plan (AHCIP).

Alberta had 9,684 physicians participating under the AHCIP as of March 31, 2017. Within this, 8,009 physicians were paid exclusively under fee-for-service, 848 were compensated solely through an Alternative Relationship Plan and the remaining 827 physicians received compensation from both fee-for-service and through an Alternative Relationship Plan. As of March 31, 2017, there was one non-participating physician in the province.

Before being registered with the AHCIP, a physician must complete the appropriate registration forms and include a copy of his or her licence issued by the College of Physicians and Surgeons of Alberta.

Under section 8 of the Act, all physicians are deemed to participate in the AHCIP. Under section 8(2) a physician may choose to not participate in the AHCIP by (a) notifying the Minister in writing indicating the effective date of not participating, (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the physician practises, and (c) posting a notice of the proposed non-participation in a part of the physician's office to which patients have access at least 180 days prior to the effective date of not participating. Legal requirements are set out in section 8(3) of the Act for a physician who has not previously practised in Alberta. Under 8(3) the physician may choose to not participate in the plan prior to commencing practice by (a) notifying the Minister in writing indicating the date on which the physician will commence non-participating practice, and (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the physician intends to practise.

By not participating in the AHCIP, a physician agrees that, commencing on the effective date, they will not participate in the publicly funded health system. This means that the physician cannot make a claim from the AHCIP for payment for providing what would otherwise be publicly funded health services and the patient cannot seek reimbursement for any amounts paid by the patient for receiving health services from the non-participating physician.

Section 12 of the *Alberta Health Care Insurance Regulation* lists services that are not considered basic or extended health services. The *Medical Benefits Regulation* establishes the benefits payable for insured medical services provided to a resident of Alberta. Descriptions of those services are set out in the Schedule of Medical Benefits, which can be accessed at www.health.alberta.ca/professionals/SOMB.html.

During 2016–2017, nine services were added to the Schedule:

- Physician to patient secure email communication;
- Physician to patient secure videoconference;
- Family conference via telephone, in regard to a community patient;
- Anal Papanicolaou Smear;
- Therapeutic corneal cross-linking examination for progressing cases of keratoconus or pellucid marginal degeneration, per eye;
- Biliary drain exchange;
- Intraperitoneal Chemotherapy;
- Retroperitoneal Mass Biopsy; and,
- Additional benefit for use of ultrasound guidance during injection of soft tissue (trigger point), peripheral nerve, muscle, tendon, ligament, bursa or joint.

The Ministry of Health is committed to having a Schedule of Medical Benefits that supports continuous improvement and is responsive to health reform. The medical community is continuously engaged and health services codes are created to ensure the Schedule reflects the current standard of practice within Alberta.

2.3 INSURED SURGICAL-DENTAL SERVICES

In Alberta, a small number of medically necessary oral surgical and dental procedures are insured. These are listed in the Schedule of Oral and Maxillofacial Surgery Benefits, available at: https://open.alberta.ca/publications/schedule-of-dental-benefits. Routine dental care is not covered by the AHCIP.

The majority of dental procedures that can be billed to the AHCIP can only be performed by a dentist certified as an oral and maxillofacial surgeon who meets the requirements stated in the *Alberta Health Care Insurance Act*. Insured dental-surgical services must be performed in either a hospital or a designated non-hospital surgical facility. As of March 31, 2017, there were 217 dentists participating under the AHCIP and no dentists were non-participating.

Although there is no formal agreement with dentists, the Ministry of Health meets with members of the Alberta Dental Association and College to discuss changes to the Schedule of Oral and Maxillofacial Surgery Benefits. There is no public consultation. All changes to the benefit schedule require the approval of the Minister of Health.

Under section 7 of the Act, all dentists are deemed to participate in the AHCIP. Under section 7(2) a dentist may choose to not participate in the AHCIP by (a) notifying the Minister in writing indicating

the effective date of not participating; (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the dentist practises; and, (c) posting a notice of the proposed non-participation in a part of the dentist's office to which patients have access at least 30 days prior to the effective date of not participating. Legal requirements are set out in section 7(3) of the Act for a dentist who has not previously practised in Alberta. Under 7(3) the dentist may choose to not participate in the plan prior to commencing practice by (a) notifying the Minister in writing indicating the date on which the dentist will commence non-participating practice, and (b) publishing a notice of the proposed non-participation in a newspaper having general circulation in the area in which the dentist intends to practise.

By choosing to not participate in the AHCIP, a dentist agrees that, commencing on the effective date, they will not participate in the publicly funded health system. This means that the dentist cannot make a claim from the AHCIP for payment for providing what would otherwise be publicly funded surgical-dental services and the patient cannot seek reimbursement for any amounts paid by the patient for receiving surgical-dental services from the non-participating dentist.

2.4 UNINSURED HOSPITAL, PHYSICIAN, AND SURGICAL-DENTAL SERVICES

Section 12 of the *Alberta Health Care Insurance Regulation* lists services that are not considered basic or extended health services unless otherwise approved by the Minister. Section 4(2) and Section 5(2) of the *Oral and Maxillofacial Surgery Benefits Regulation* indicate no benefits are payable for oral and maxillofacial surgery services provided to an Alberta resident in another province or territory of Canada or outside of Canada if they are not insured services in Alberta. Section 4(2) of the *Hospitalization Benefits Regulation* provides a list of hospital services that are not considered to be insured. Services not covered by the AHCIP include cosmetic surgery, ambulance services, prescription drugs, routine dental care, routine eye examinations for residents 19 to 64 years of age, and third party medical services, such as medicals for employment, insurance and sports.

The Preferred Accommodation and Non-Standard Goods or Services Policy describes the Government of Alberta's expectations of AHS and guides the provision of preferred accommodation, and enhanced or non-standard goods and services. This policy framework requires AHS to provide 30 days advance notice to the Minister of Health's designate regarding the categories of preferred accommodation offered and the charges associated with each category. AHS is also required to provide 30 days advance notice to the Minister of Health's designate regarding any goods or services that will be provided as non-standard goods or services. AHS must also provide information about the associated charge for these goods or services, and when applicable, the criteria or clinical indications that may qualify patients to receive it as a standard good or service. Alberta's policy for Preferred Accommodation and Non-Standard Goods or Services is available at https://open.alberta.ca/publications/preferred-accommodation-and-non-standard-goods-or-services.

Health services that are deleted from the Schedule of Medical Benefits are those services that the medical community has identified as obsolete. The process to engage the medical community is completed through consultation with the Alberta Medical Association and AHS. The Alberta Medical Association acts as the representative for each physician section. AHS is engaged in this decision process in order to understand how changes may impact current service delivery models or the health system at a macro level.

No services were de-insured in 2016–2017; however, eight health service codes were deleted. Of the eight, four were items that have little or no utilization and have been deemed by the medical community as an obsolete service:

- Excision of deep fascia of calf in association with varicose vein operation, additional benefit;
- Columella lengthening;
- Hip pinning; and,
- Interoperative choledochoscopy.

The remaining four items have been collapsed into other amended services or items that have been deleted and replaced with new items that are defined slightly differently:

- Introduction of arterial catheter for pressure monitoring and/or blood gas monitoring percutaneous or by cut down;
- Lobectomy of liver;
- Anastomosis of common bile duct to intestine; and,
- Other partial pancreatectomy.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

Under the terms of the *Alberta Health Care Insurance Act*, Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan (AHCIP). A resident is defined as a person who is lawfully entitled to be or to remain in Canada, who makes the province their home and is ordinarily present in Alberta, and any other person deemed by the Regulations to be a resident. The term "resident" does not include a tourist, transient or visitor to Alberta.

Persons moving permanently to Alberta from outside Canada are eligible for coverage if they have permanent resident status, are returning landed immigrants, or are returning Canadian citizens. Persons in Alberta on an approved Canada entry document may also be eligible for coverage under the AHCIP, and their eligibility is reviewed on a case-by-case basis.

A resident is not entitled to AHCIP coverage if the resident is a member of the Canadian Armed Forces or a person serving a term in a federal penitentiary as defined in the *Corrections and Conditional Release Act*. These residents receive health care coverage from the federal government. Spouses or partners and dependants of these residents are provided with AHCIP coverage if they are Alberta residents.

The AHCIP will cover individuals released within Alberta from the Canadian Armed Forces or federal penitentiaries, effective the date of release, if notified within three months. If individuals are released in another part of Canada, they are eligible for coverage on the first day of the third month after becoming a resident of Alberta.

In order to access insured services under the AHCIP, Alberta residents are required to register themselves and their eligible dependants. Family members are registered on the same account. Persons moving to Alberta should apply for coverage within three months of arrival or effective dates may be affected. For persons moving to Alberta from within Canada, their registration is effective on the first day of the third month after they become an Alberta resident. For persons moving to Alberta from outside Canada, their registration is effective the day they become an Alberta resident. The process for registering Albertans and issuing replacement health cards requires registrants to provide documentation that proves their identity, legal entitlement to be in Canada, and Alberta residency.

When a cancellation or denial of AHCIP coverage is questioned, an individual may contact the AHCIP by phone, e-mail, or mail to discuss the issue. If it cannot be resolved by front-line staff, it is escalated to a supervisor, then a manager, if needed. The manager will conduct a thorough investigation and send a letter with reasons for the decision, as it relates to legislation.

Individuals can choose not to participate in the AHCIP by filing a "Declaration of Election to Opt Out" at any time for themselves and their dependants. Coverage is cancelled for 36 months or until the declaration is revoked by the individual. A new declaration is required every 36 months of non-participation.

As of March 31, 2017, there were 4,529,842 Alberta residents registered with the AHCIP and 234 Alberta residents who were non-participants.

3.2 OTHER CATEGORIES OF INDIVIDUALS

Under the *Alberta Health Care Insurance Regulation*, a person may be deemed a resident for the purpose of AHCIP coverage if they are residing in Alberta to work, study, or are the spouse or partner or dependant of someone who is here to work or study. A Canada Entry Document such as a Work Permit, Study Permit or Visitor Record (that limits length of stay) is required as proof of their legal entitlement to be, and remain, in Canada. Deemed residents must intend on residing in Alberta for 12 months or more. There were 71,473 people covered by the AHCIP under these conditions as of March 31, 2017.

Individuals who hold a Study Permit that does not indicate a school in Alberta are required to provide proof of registration from the accredited school they are attending. Open or employer-specific work permits must be valid for six months or more. Employer-specific work permits must state the individual is employed by a company operating in Alberta. With the exception of clergy, athletes or members of the British army, individuals with a Visitor Record must be the spouse, partner or dependant of an eligible resident or deemed resident.

Individuals whose Canada Entry Document has the remark 'does not confirm resident status', are not eligible for AHCIP coverage. Landed immigrants who have a landed status document or proof of Permanent Resident Status and Convention Refugees who have a positive Notice of Decision letter are eligible for AHCIP coverage. Refugee Claimants are not eligible.

Children of non-entitled residents (e.g., residents on a Visitor Record, with expired permits, or Refugee Claimants) who are born in Canada and meet residency requirements are eligible for AHCIP coverage. Children born to Canadian citizens who are temporarily absent from Alberta (and have maintained their coverage) are also eligible, however, documentation may be required.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

Under the Alberta Health Care Insurance Plan (AHCIP), generally, persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following the date they establish residency in Alberta.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

The AHCIP provides coverage under the *Alberta Health Care Insurance Regulation* for eligible Alberta residents who temporarily leave Alberta for other parts of Canada. A person is considered temporarily absent from Alberta if the person stays in another province or territory for a period that will not exceed 12 consecutive months and where the person intends to return to and maintain permanent residence in Alberta on the conclusion of their stay outside Alberta.

Individuals who are routinely absent from Alberta every year normally must spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy the Ministry of Health of their permanent and principal place of residence within the province. Individuals may also remain eligible for coverage if, on a recurring basis, they are absent from Alberta for up to 212 days in a 12-month period for the purpose of vacation.

Alberta participates in the interprovincial hospital and medical reciprocal billing agreements. All provinces and territories, except Quebec, participate in medical reciprocal agreements. These agreements were established to minimize complex billing processes and to help ensure timely payments to physicians and hospitals when they provide services to residents from other provinces or territories. Under these agreements, where an eligible Albertan receives an insured physician service or hospital service in another participating province or territory, Alberta will reimburse for the insured service provided at the host province's or territory's rates for medical services and the applicable rate for hospital services.

In 2016–2017, no amendments were made to the legislation regarding portability within Canada. More information on coverage during temporary absences outside Alberta is available at: www.health.alberta.ca/AHCIP/outside-coverage.html.

Section 16 of the *Hospitalization Benefits Regulation* addresses payment for hospital services obtained outside of Alberta but within Canada. Section 4 of the *Medical Benefits Regulation* addresses payment of physician services obtained outside of Alberta but within Canada. These sections were not amended in 2016–2017.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The AHCIP provides coverage under the *Alberta Health Care Insurance Regulation* to eligible Alberta residents who are temporarily absent from Canada. A person is considered to be temporarily absent from Alberta if the person stays outside Canada for a period that will not exceed six consecutive months, and the person intends to return to and maintain permanent residence in Alberta on the conclusion of their stay outside Alberta.

Individuals who are routinely absent from Alberta every year normally must spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Exceptions may be

considered by the Ministry of Health depending on the individual circumstance. Individuals may also remain eligible for coverage if, on a recurring basis, they are absent from Alberta for up to 212 days in a 12-month period for the purpose of vacation.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for 24 to 48 consecutive months. Students attending an accredited educational institute outside Canada on a full-time basis are entitled to coverage for the duration of their studies providing they intend to reside in Alberta at the conclusion of their studies.

The maximum amount payable for out-of-country in-patient hospital services is $100 (CAD) per day (not including day of discharge). The maximum hospital out-patient visit rate is $50 (CAD), with a limit of one visit per day. The only exception is haemodialysis received as an out-patient, which until March 31, 2017, was paid at a maximum of $462 per visit, with a limit of one visit per day. Effective April 1, 2017, the rate increased to $478 per visit. Physician and dental specialist or oral surgeon services are paid according to Alberta rates. Funding may also be available through the Out-of-Country Health Services Committee. The Committee evaluates requests made by Alberta physicians or dentists for eligible Alberta residents to be considered for funding of insured services covered under the AHCIP that are not available in Canada. More information on coverage during temporary absences outside Canada is accessible at: www.health.alberta.ca/AHCIP/coverage-outside-Canada.html.

Section 16 of the *Hospitalization Benefits Regulation* also addresses payment for goods and services provided by hospitals or approved facilities outside of Canada. Section 5 of the *Medical Benefits Regulation* addresses payment of physician services obtained outside Canada. These sections were not amended in 2016–2017.

4.4 PRIOR APPROVAL REQUIREMENT

Prior approval is not required for elective (non-emergency) insured services received in another Canadian province or territory, except for high-cost items not included in reciprocal agreements such as gamma knife surgery.

Prior application is required for elective services received out-of-country and approval may only be given through the Out-of-Country Health Services Committee for insured services that are medically required, are not experimental, and are not available in Alberta or elsewhere in Canada.

Decisions made by the Committee can be appealed. Appeals may be submitted by the Alberta physician or dentist who submitted the application for the Alberta resident, or by the Alberta resident. The Out-of-Country Health Services Appeal Panel, established under the *Alberta Health Care Insurance Regulation,* reviews the application, the Committee decision, and determines whether to uphold the decision or rule in favour of the applicant.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

The Government of Alberta is committed to meeting the health care needs of all Albertans. To ensure Albertans have the best possible access to primary health care services, the Ministry funds Primary Care Networks (PCNs). PCNs are inter-disciplinary teams made up of family physicians and other health care

professionals who work with Alberta Health Services (AHS) to coordinate the delivery of primary health care services for their patients. Each PCN has the flexibility to develop programs and provide services to meet the specific needs of patients. Access to health care services can be limited by geography, hours of operation, and wait times. As of March 31, 2017, there were 42 PCNs operating in Alberta, over 3.6 million Albertans were enrolled in a PCN, and of 4,795 general practitioners, 4,150 general practitioners were registered providers in PCNs.

In June 2016, a review of a representative sample of PCNs was completed to assess their financial practices and service delivery approaches. In response to the findings of this review, the Government of Alberta is updating PCN policies to strengthen governance, financial accountability and service responsibilities in order to support comprehensive, integrated, team-based primary health care service delivery including expanding after-hours access, to ensure that primary care providers are available to Albertans during after-hours.

Section 9 of the *Alberta Health Care Insurance Act* prohibits extra-billing. No physician or dentist who participates in the Alberta Health Care Insurance Plan (AHCIP) and who provides insured services to a person shall charge or collect from any person an amount in addition to the benefits payable by the Minister for those insured services.

Section 11 of the Act indicates no person shall charge or collect from any person:

(a) an amount for any goods or services that are provided as a condition to receiving an insured service provided by a physician or dentist who is participating in the AHCIP; or

(b) an amount the payment of which is a condition to receiving an insured service provided by a physician or dentist who is participating in the AHCIP

where the amount is in addition to the benefits payable by the Minister for the insured service.

When an individual questions extra-billing or user charges, they may contact AHCIP staff by phone, e-mail, or mail. If the behaviour cannot be resolved through communication or education, it may proceed to a compliance review.

The Ministry of Health monitors and enforces compliance with the Act through a dedicated compliance unit. The focus of a compliance review is on assessing compliance, recoveries of inappropriately paid funds, and physician and dentist education. Where the compliance review uncovers evidence of possible non-compliance with sections 9 or 11 of the Act, sections 9, 11, 12, 13 and 14 set out the fines and steps that may be taken.

Health infrastructure is important in ensuring current and future health care needs are met. The Ministries of Health and Infrastructure share the responsibility for planning and management of the Health Capital Plan and projects. The Ministry of Health is responsible for setting strategic directions and implementing health policy, legislation, standards and providing global operating funding to AHS. AHS identifies and prioritizes health service needs requiring capital development. The Government of Alberta supports health infrastructure by funding capital development and the Infrastructure Maintenance Program. The Ministry of Infrastructure is responsible for the design, construction and delivery of major health capital projects throughout the province. Health legislation also stipulates the requirements for the purchase and disposition of assets and properties and the general provisions for health infrastructure.

In Budget 2016, the Government of Alberta committed a total of $578 million for 2016–2017 for a total of 30 approved health facilities and capital equipment projects and programs to repair aging infrastructure and/or build new health infrastructure. Several health infrastructure projects were completed during 2016–2017, including: the Edson Healthcare Centre and High Prairie Health Complex; renovations for a new Concurrent Disorder Capable Treatment Continuum program at the Royal Alexandra Hospital in Edmonton, which provides additional addictions and mental health treatment capacity; and, a new addition to the Medicine Hat Regional Hospital. In addition, the Government of Alberta provides annual funding to AHS through the Infrastructure Maintenance Program to maintain health facilities across the province. In 2016–2017, $145.7 million was spent to preserve and maintain health facilities throughout Alberta to support the delivery of publicly funded health programs and services.

The Ministry of Health and AHS have undertaken foundational work to improve access to care and develop capability to better monitor and report on access to care. This foundational work will be leveraged and incorporated into the future AHS Clinical Information System, which will replace aging and obsolete information technology platforms across all AHS Zones. Several other related department and AHS initiatives launched and continued in 2016–2017, including https://myhealth.alberta.ca, a website with valuable, easy-to-understand health information and tools made for Albertans; Strategic Clinical Networks, which are developing integrated care pathways that will support patient access; the relaunch of the Alberta Wait Time Reporting website (www.waittimes.alberta.ca); and, AHS reporting of estimated wait times in Edmonton, Calgary and Red Deer emergency departments.

In February 2017, the Government of Alberta launched the Nurse Practitioner Demonstration Project, a three-year initiative which supports the integration and increased use of nurse practitioners and other providers in the community, particularly in areas that serve vulnerable, high-need populations.

5.2 PHYSICIAN COMPENSATION

The *Alberta Health Care Insurance Act* governs the payment of physicians for the provision of insured medical services. Physicians are compensated through the AHCIP on a volume-driven, fee-for-service basis or through the use of Clinical Alternative Relationship Plans and the Academic Medicine and Health Services Program implemented in 2017. In November 2016, the Government of Alberta and the Alberta Medical Association signed amendments to the Alberta Medical Association Agreement and related consultation agreements which included a commitment to a new compensation model for some primary-care physicians. The new compensation model will blend fee-for-service and capitation payments.

Under the *Oral and Maxillofacial Surgery Benefits Regulation*, benefits are payable in accordance with the regulations under the Act for oral and maxillofacial surgery services provided to a resident of Alberta by a dentist.

In Alberta, the College of Physicians and Surgeons of Alberta enforces standards of practice for charging for uninsured professional services (non-insured services under the Act), which include rules related to block billing by physicians. Block billings are not addressed in Alberta legislation, but all non-insured services must be billed in accordance with the Act.

The Academic Medicine and Health Services Program has accountability and reporting expectations for physicians participating in the program, as well as for the Faculties of Medicine at both the University of Alberta and Calgary, AHS and the Ministry of Health. Key performance themes include access, quality and safety, and specific indicators have been identified to measure performance within these themes on an annual basis.

Alternative Relationship Plans and the Academic Medicine and Health Services Program are used by specialists and family physicians and offer alternative compensation models or arrangements to the traditional fee-for-service payment system. Their purpose is to enhance physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction, and value for money. They also support innovative health care delivery, which will result in better health outcomes. The predictable funding provided through Alternative Relationship Plans and the Academic Medicine and Health Services Program enables physician groups to recruit new physicians to their programs and retain their services while in some cases providing additional funding to support service delivery.

The Government of Alberta and the Alberta Medical Association entered into the Alberta Medical Association Agreement in 2013, which was retroactive to April 1, 2011. Certain financial terms of the Agreement establish set increases to the insured services rates for seven years (from 2011 to 2018). The Ministry of Health and the Alberta Medical Association will negotiate certain new financial terms for April 1, 2018 onwards.

To ensure accountability with the *Alberta Health Care Insurance Act*, the Ministry of Health conducts regular reviews of claims filed by physicians to assess their compliance within the Act. The Ministry of Health uses statistical and risk assessment methodologies to identify errors or issues in the claims that were paid under the AHCIP. Compliance reviews can be initiated for a practitioner or group of practitioners to determine compliance with specific legislative, program or contractual requirements. Additionally, a compliance review may be triggered as a result of a specific complaint about a physician from an external party.

5.3 PAYMENTS TO HOSPITALS

Alberta's public hospitals are operated by AHS or by faith-based voluntary organizations under service agreements with AHS. In Alberta, public hospitals are operated in accordance with the *Hospitals Act*. The *Health Care Protection Act* prohibits the operation of private hospitals.

The *Regional Health Authorities Act* governs the funding of AHS, Alberta's single regional health authority. The Ministry of Health funds AHS through base operating funds provided twice each month. AHS determines funding for individual hospitals and designated Non Hospital Surgical Facilities.

The *Health Care Protection Act* governs the provision of insured and uninsured surgical services performed in public hospitals and Non Hospital Surgical Facilities. The Act prohibits queue jumping. Specifically, no person shall give or accept any money or other valuable consideration, pay for or accept payment for enhanced medical goods or services or non-medical goods or services, or provide an uninsured surgical service for the purpose of giving any person priority for the receipt of an insured surgical service. Access to insured surgical services is based on medical need of patients and determined by physicians and dentists.

The Minister of Health is required to approve a service agreement between a Non Hospital Surgical Facility operator and AHS in order for the facility to provide insured surgical services. Ministerial designation of a Non Hospital Surgical Facility and accreditation by the College of Physicians and Surgeons of Alberta is also required.

According to the *Health Care Protection Act*, Ministerial approval for a proposed facility services agreement shall not be given unless the Minister is satisfied:

- that the provision of insured surgical services as contemplated under the proposed agreement would be consistent with the principles of the *Canada Health Act*;
- that there is a current need and that there will likely be an ongoing need in the geographical area to be served for the provision of insured surgical services as contemplated under the proposed agreement;
- that the provision of the insured surgical services as contemplated under the proposed agreement would not have an adverse impact on the publicly funded and publicly administered health system in Alberta;
- that there is an expected public benefit in providing the insured surgical services as contemplated under the proposed agreement, considering factors such as (i) access to such services, (ii) quality of service, (iii) flexibility, (iv) the efficient use of existing capacity, and (v) cost effectiveness and other economic considerations;
- that the health authority has an acceptable business plan in respect of the proposed agreement showing how the health authority will pay for the facility services to be provided;
- that the proposed agreement indicates performance expectations and related performance measures for the insured surgical services and facility services to be provided; and,
- that the proposed agreement contains provisions showing how physicians' compliance with the *Health Professions Act* and regulations under the Act, the bylaws of the College of Physicians and Surgeons of Alberta, the code of ethics and standards of practice adopted by the council of the College of Physicians and Surgeons of Alberta under the Act as they relate to conflict of interest and other ethical issues in respect of the operation of the facility, will be monitored.

Pursuant to the terms of any agreement between AHS and a Non Hospital Surgical Facility operator, AHS agrees to pay a contracted "facility fee." This fee covers certain services specified under the *Health Care Protection Act* that are medically necessary and are directly related to the provision of a surgical service at an approved surgical facility. Physicians who provide insured surgical services to patients within an accredited Non Hospital Surgical Facility are paid on a fee-for-service basis through the AHCIP. These fees are the same regardless of whether the physician provides the insured service in a public hospital setting or in a Non Hospital Surgical Facility.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Alberta publicly acknowledged the federal contribution provided through the Canada Health Transfer in its 2016–2017 publications.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	4,068,062	4,228,125	4,354,660	4,449,483	4,529,842

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	226	225	225	225	228
3. Payments for insured health services ($)	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services ($)	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY[1]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	5,657	6,221	6,297	6,787	7,059
7. Total payments, in-patient ($)	37,628,241	42,196,441	42,466,396	48,651,644	48,492,921
8. Total number of claims, out-patient (#)	112,703	119,873	127,995	135,369	147,350
9. Total payments, out-patient ($)	31,763,550	35,627,462	37,809,358	43,000,306	50,582,365

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA[1,2]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	4,921	4,209	3,679	4,216	3,855
11. Total payments, in-patient ($)	472,489	393,925	359,377	407,398	372,724
12. Total number of claims, out-patient (#)	5,461	5,128	4,440	5,008	4,945
13. Total payments, out-patient ($)	440,188	487,055	419,295	479,625	458,265

[1] Data reported reflect claims processed up to three months after the close of the fiscal year. Any claims processed after this date are not reflected in the presented information.

[2] These data do not include claims/payments for Alberta residents who have received health services through the Out-of-Country Health Services Committee application process.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY[3]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)[4]	8,100	8,466	8,873	9,331	9,684[5]
15. Number of opted-out physicians (#)[6]	0	0	0	0	0
16. Number of non-participating physicians (#)	0	1	1	1	1
17. Total payments for services provided by physicians paid through all payment methods ($)	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($)	2,584,944,346	2,778,382,882	3,033,392,142	3,336,009,256	3,531,947,298

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	751,061	663,164	694,373	795,738	840,246
20. Total payments ($)	27,940,698	30,710,409	32,203,224	34,639,878	37,906,996

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA[7]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	39,317	33,804	36,290	32,980	not available
22. Total payments ($)	2,435,305	2,189,233	2,580,363	2,589,749	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	224	218	221	215	217
24. Number of opted-out dentists (#)[a,8]	0	0	0	0	0
25. Number of non-participating dentists (#)[a]	0	0	0	0	0
26. Number of services provided (#)	23,014	24,995	28,443	31,309	34,603
27. Total payments ($)	7,077,327	7,317,869	8,208,000	9,185,042	9,756,738

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

[3] Data for this section reflect claims processed up to three months after the close of the fiscal year. Any data pertaining to expenditures and physicians processed after this date are not reflected in the presented information.

[4] The physician count includes physicians who are fee-for-service, in Alternative Relationship Plans or receive compensation from both fee-for-service and Alternative Relationship Plans.

[5] 8,009 of these are paid under fee-for-service, 848 under an Alternative Relationship Plan and the remaining 827 received compensation from both fee-for-service and alternative relationship plans.

[6] Alberta's legislation provides that all physicians are deemed to be participating in the Alberta Health Care Insurance Plan, unless they opt out in accordance with the procedure set out in section 8 of the *Alberta Health Care Insurance Act*.

[7] These data do not include Alberta residents who have received health services through the Out-of-Country Health Services Committee application process. Additionally, following a methodology change in 2015-2016, there is a one-year lag from fiscal year end to date of payment for out-of-country data. This means data for out-of-country physician services are still being processed for 2016–2017.

[8] Alberta's legislation provides that all dentists are deemed to be participating in the Alberta Health Care Insurance Plan, unless they opt out in accordance with the procedure set out in section 7 of the *Alberta Health Care Insurance Act*.

BRITISH COLUMBIA

British Columbia has a progressive and integrated health system that includes a health care insurance plan that provides publicly funded health-care services to residents of British Columbia in accordance with the guiding principles of the *Canada Health Act*. The Ministry of Health has overall responsibility for ensuring that quality, appropriate, and timely health services are available to all British Columbian residents.

To read more about British Columbia's publicly funded health system, please refer to the Ministry of Health's 2017/18–2019/20 Service Plan: http://bcbudget.gov.bc.ca/2017_Sept_Update/sp/pdf/ministry/hlth.pdf

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

The Ministry of Health (Ministry) sets goals and standards and enters into performance agreements for provincial health service delivery and works with the six health authorities throughout the province to provide quality, appropriate, and timely health services to British Columbians. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of province-wide health programs and services. The Ministry also works in partnership with the First Nations Health Authority to improve the health status of Indigenous Peoples in British Columbia.

The British Columbia Medical Services Plan (MSP), which is administered by the Ministry on behalf of the Medical Services Commission (MSC) covers medically required services provided by enrolled medical practitioners and health-care practitioners, including medically required diagnostic procedures.

The *Medicare Protection Act* (MPA) is the governing legislation for MSP. The purpose of the MPA is to preserve a publicly managed and fiscally sustainable health-care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay.

The MSC reports to the Minister of Health (Minister), in accordance with the MPA and the regulations enacted under the MPA. The function and legislative mandate of the MSC is to facilitate reasonable access to quality medical care, health-care, and prescribed diagnostic services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of British Columbia, three representatives from the British Columbia Medical Association (operating as the Doctors of BC), and three members from the public who have been jointly nominated by the Doctors of BC and government.

General hospital services are publicly funded in British Columbia; however, these are not covered by MSP. General hospital services are provided under the *Hospital Insurance Act* (section 8) and the *Hospital Act* (section 4).

Medically required laboratory services are publicly funded under the *Laboratory Services Act*. The Minister is responsible for all matters related to laboratory services (including the facility approval process), governance, accountability and provision of benefits for all laboratory services in the province. The Agency for Pathology and Laboratory Medicine, a clinical division of the BC Clinical Support Services Society, is accountable to the Minister. Its mandate is to provide laboratory system oversight and ensures that clinical laboratory services are sustainable, quality driven, innovative, and support British Columbia's residents and clinicians with access to laboratory services.

1.2 REPORTING RELATIONSHIP

The Ministry provides information in the Annual Service Plan Report on the performance of British Columbia's publicly funded health-care system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act*.

The MSC is accountable to the Government of British Columbia through the Minister; a report that provides an annual accounting of the business of the MSC, its subcommittees, and other delegated bodies is published annually for the prior fiscal year. This report is available at: www.gov.bc.ca/msppublications

Regional health authorities, the Provincial Health Services Authority, and the BC Clinical Support Services Society report to the Minister.

1.3 AUDIT OF ACCOUNTS

The Ministry's accounts and financial transactions are subject to audit as follows:

- Internal Audit and Advisory Services (IAAS), the government's internal auditor, determines the scope of the internal audits and timing of the audits. IAAS reports can be located on the following website link: https://www2.gov.bc.ca/gov/content/governments/services-for-government/internal-corporate-services/internal-audits
- The Office of the Auditor General (OAG) of British Columbia is responsible for conducting annual financial audits as well as special audits and reports. The OAG reports its findings to the Legislative Assembly. The OAG initiates its own audits and determines the scope of its audits. The Select Standing Committee on Public Accounts of the Legislative Assembly reviews the recommendations of the OAG.

The OAG's annual audit of the Ministry's accounts and financial transactions are reflected in the OAG's overall review and opinion related to the BC Public Accounts, which can be found at the following website link: www.fin.gov.bc.ca/OCG/pa/16_17/Pa16_17.htm

The OAG's special audits and reports can be located at the following link: www.bcauditor.com/pubs

1.4 DESIGNATED AGENCY

Since 2005, the Ministry has contracted with MAXIMUS Canada to deliver the operations of MSP and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). MAXIMUS Canada administers the province's medical and drug insurance plans under the Health Insurance BC (HIBC) program. Policy and decision-making

functions remain with the Ministry.

HIBC submits monthly reports to the Ministry, reporting performance on service levels to the public and health-care providers. HIBC also posts reports on its website on the performance of key service levels. These reports are available at: www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-insurance-bc

HIBC processes payments for health-care services against fee items approved by the Ministry.

MSP requires premiums to be paid by beneficiaries. HP Advanced Solutions performs revenue management services, including account management, billing, remittance, and collection on behalf of the Province of British Columbia (Ministry of Finance) under the Revenue Services of British Columbia (RSBC) program. The Province remains responsible for and retains control of all government administered collection actions.

HIBC and RSBC are required to comply with all applicable laws, including the:

- *Ombudsperson Act*;
- *Business Practices and Consumer Protection Act*;
- *Financial Administration Act*; and
- Freedom of Information legislation (i.e., *Freedom of Information and Protection of Privacy Act*, the *Personal Information Protection Act* and the equivalent federal legislation, if applicable).

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

The *Hospital Act* and *Hospital Act Regulation* provide authority for the Minister to designate facilities such as hospitals, to license private residential care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* and the *Hospital Insurance Act Regulations* provide the authority for the Minister to make payments to health authorities for the purpose of operating hospitals. They also outline who is entitled to receive publicly funded services and define the "general hospital services," which are to be provided as benefits.

Hospital services are publicly funded benefits when they are provided to a beneficiary in a public hospital, and are medically required and recommended by the attending physician, midwife, nurse practitioner, or oral and maxillofacial surgeon. There is no scheduled or regular process to review publicly funded hospital services, as these services are intended to be inclusive.

When medically required, the following are provided to beneficiaries who are in-patients in a general hospital:

- accommodation and meals at the standard or public ward level;
- necessary nursing service;

- laboratory and radiological procedures and the necessary interpretations, together with such other diagnostic procedures as are approved by the Minister in a particular hospital, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of illness, injury or disability;
- drugs, biologicals and related preparations, when administered in a general hospital;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- other services approved by the Minister that are rendered by persons who receive remuneration therefor from the hospital;
- use of radiotherapy facilities where available;
- use of physiotherapy facilities where available.

When medically required, the following are provided as benefits to out-patients who are beneficiaries:

- emergency service and minor surgery;
- daycare surgical services;
- cancer therapy provided by the BC Cancer Agency;
- psychiatric services;
- cytology services;
- rehabilitation services;
- diabetic day care services;
- dietetic counselling services;
- dialysis services;
- psoriasis services;
- abortion services; and
- MRI services.

Medically required in-patient and out-patient laboratory services are provided as benefits under the *Laboratory Services Act* (LSA).

Publicly funded hospital services are provided to beneficiaries without charge, with a few exceptions. Exceptions include: incremental charges for preferred (but not medically required) medical/surgical supplies and nonstandard accommodation (when not medically required and standard accommodation is available), and daily fees for residential care patients in extended care or general hospitals.

Some facilities providing residential care services (in this case, the term "extended care" is often used) are regulated under Part 2 of the *Hospital Act*. Health authorities and hospital societies are required to follow home and community care policies to determine benefits in such cases.

2.2 INSURED PHYSICIAN SERVICES

Unless specifically excluded, the following medical services are publicly funded as benefits under the *Medicare Protection Act* or the LSA:

- Medically required services provided to beneficiaries (residents of British Columbia who are enrolled in MSP in accordance with section 7 of the MPA) by a practitioner enrolled with the Medical Services Plan;
- Medically required diagnostic services performed in an approved diagnostic facility under the supervision of an enrolled physician; and
- Medically required laboratory services performed in an approved laboratory facility.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for publicly funded services, they must be enrolled with MSP. In the fiscal year 2016–2017, 11,001 physicians were enrolled with MSP and received payments through fee-for-service (FFS).

Practitioners other than physicians and dentists who may enroll and provide benefits under MSP include midwives, nurse practitioners, optometrists and other supplementary benefit practitioners. The Supplementary Benefits Program assists premium assistance beneficiaries (see section 3.3 of this report), and others, to access the following services: acupuncture, massage therapy, physiotherapy, chiropractic, naturopathy, and podiatry (non-surgical services). The program contributes $23.00 towards the cost of each patient visit to a maximum of ten visits per patient per annum summed across the six types of providers.

Practitioners enrolled in MSP may choose to be opted-in or opted-out. Opted-in practitioners are practitioners who are enrolled in MSP and who elect to bill MSP directly for MSP benefits provided to MSP beneficiaries. An opted-in practitioner may not bill a patient directly for a benefit. Opted-out practitioners are enrolled in MSP and elect to opt out and bill patients directly for benefits. Enrolled practitioners wishing to opt out of MSP must give written notice to the Medical Services Commission. In this case, patients may apply to MSP for reimbursement of the fee for benefits rendered. By law, an opted-out physician may not charge a patient more for a benefit than the prescribed MSP fee amount. In 2016–2017, MSP had two opted-out physicians.

Under the Physician Master Agreement (PMA) between the government, the MSC and Doctors of BC, modifications to the MSC Payment Schedule such as additions, deletions or fee changes are made by the MSC upon advice from Doctors of BC or the government. To modify the payment schedule, the parties must submit proposals to the Doctors of BC Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by the MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2016–2017, 14 physician services were added to the MSC Payment Schedule as MSP benefits to reflect current practice standards including, for example, the introduction of a new fee for laparoscopic internal drainage or anastomosis of pancreatic pseudocyst of the gastrointestinal tract.

2.3 INSURED SURGICAL-DENTAL SERVICES

In certain circumstances, in-patient or out-patient hospitalization is medically required for the safe and proper completion of surgical-dental services. In such cases, the surgical-dental component is publicly funded if the service is listed in the Dental Payment Schedule and the hospitalization component is funded by the health authority.

Included as publicly funded 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. Additions or changes to the list of benefits are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes to the Dental Payment Schedule must be approved by the MSC.

Any general dentist who is in good standing with the British Columbia College of Dental Surgeons, is enrolled in MSP, and has hospital privileges, may provide surgical-dental benefits in a hospital or in certain other approved facilities. There were 192 dentists enrolled with MSP in 2016–2017 (including general dentists, paediatric dental specialists, oral surgeons, oral medicine dental specialists, and orthodontists billing through MSP).

In 2015, it was clarified that dental services provided in surgical facilities under contract with a health authority and listed in the Dental Payment Schedule are benefits under MSP.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Medical necessity is the criterion for public funding of hospital and medical services.

Out-patient take-home drugs and any drugs not clinically approved by the hospital are excluded from coverage.

Procedures not publicly funded under the *Hospital Insurance Act* (HIA) and *Hospital Insurance Act Regulations* include: services of medical personnel not employed or contracted by a hospital; treatment for which WorkSafeBC, the Department of Veterans Affairs or any other agency is responsible; services or treatment that the Minister (or a person designated by the Minister) determines, on a review of the medical evidence, that the beneficiary does not require; and excluded illnesses or conditions. Non-publicly funded hospital services also include: preferred accommodation at the patient's request when not medically required; preferred medical/surgical supplies/devices; televisions, telephones, and private nursing services; and dental care that could safely be provided in a dental office, including prosthetic and orthodontic services. Health authorities are required by Ministry policy to fund medically necessary transfers between acute care hospitals within British Columbia, but patients are required to pay a user fee to partially off-set costs when an ambulance or contracted alternative service provider is used for transport in other situations.

Services not covered under MSP include: those covered by the *Workers' Compensation Act* or by other federal or other provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; telephone advice unrelated to publicly funded visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

The MPA (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be a publicly funded benefit. Section 17 prevents extra billing by prohibiting persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry and the MSC respond to complaints of extra billing made by patients and take appropriate actions to correct identified situations.

With respect to MSP, the MSC has authority to determine which services are benefits and to remove benefits. Consultation may take place through a sub-committee of the MSC and usually includes a review by Doctors of BC's Tariff Committee.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

Section 7 of the *Medicare Protection Act* defines the eligibility and enrollment of beneficiaries for publicly funded services. Part 2 of the *Medical and Health Care Services Regulation* details residency requirements. A person must be a resident of British Columbia to qualify for provincial health-care benefits.

Section 1 of the MPA defines a resident as a person who:

- is 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 for at least six months in a calendar year, or for a prescribed shorter period of time; and
- is deemed under the regulations to be a resident (does not include a tourist or visitor to British Columbia).

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see section 3.2 of this report), but this does not include a tourist or visitor to British Columbia.

Residents who do not want to participate in the province's health-care plan may choose to opt out of the publicly funded program. Individuals are required to file an Election to Opt Out statement and submit that statement to the Medical Services Commission. A statement, once signed, is irrevocable and results in the resident being responsible for paying the entire cost of all hospital, medical and other health-care services he/she may receive during the 12-month opted-out period. Residents cannot opt out retroactively, and must reapply to opt out at the expiry of each 12-month period.

All residents are entitled to medically required hospital and medical care coverage. Those residents who are members of the Canadian Forces and those serving a term of imprisonment in a federal penitentiary as defined in the *Corrections and Conditional Release Act*, are eligible for federally funded health insurance. The Medical Services Plan provides first-day coverage to discharged members of the Canadian Forces and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

It is possible for a beneficiary's enrollment to be cancelled. Section 11 of the MPA requires that prior to making an order cancelling a beneficiary's enrolment, the beneficiary must be notified that he or she has a right to a hearing. If he or she requests a hearing, the hearing is conducted by a delegate of the MSC.

MSC members, or delegates of the MSC, may conduct hearings related to the exercise of the MSC's statutory decision-making powers. Some hearings are required by the MPA, and some have been implemented by the MSC to afford individuals affected by its decisions the opportunity to be heard in person. Hearings are governed by the duty to act fairly. Decisions of the MSC or its delegates may be judicially reviewed by the Supreme Court of British Columbia.

The number of residents registered with MSP as of March 31, 2017 was 4,827,696.

3.2 OTHER CATEGORIES OF INDIVIDUALS

Some holders of Minister's Permits, Temporary Resident Permits, study permits, work permits and applicants for permanent resident status who are the spouse or child of an eligible resident may be eligible for benefits when deemed to be residents under the MPA and section 2 of the *Medical and Health Care Services Regulation*.

3.3 PREMIUMS

The MPA and the *Medical and Health Care Services Regulation* provide authority for the MSC to collect premiums from beneficiaries.

Enrolment in MSP is mandatory (subject to an adult's rights to opt out) and payment of premiums is ordinarily a requirement for coverage. Outstanding premium debt is not a barrier to receiving coverage.

In 2016–2017, the *Medical and Health Care Services Regulation* was amended to remove provisions that specified an adult beneficiary's enrolment in MSP would be cancelled should they fail to renew enrolment prior to February 10, 2018.

MSP monthly premium rates for the first part of the 2016–2017 fiscal year were $75 for one person, $136 for a family of two, and $150 for a family of three or more. Effective January 1, 2017, there are no MSP premiums for children under the age of 19 and for those dependent post-secondary students enrolled in full-time studies (this includes trade, technical or high schools). MSP monthly premium rates effective January 1, 2017, are $75 for one adult and $150 for two adults in a family.

MSP has two programs that offer assistance with the payment of premiums based on financial need. Effective January 1, 2017, regular premium assistance has several levels of assistance and is based on a person's net income for the preceding tax year, combined with that of the person's spouse, if applicable, less MSP deductions. Premium assistance rates are no longer calculated to include children. Effective January 1, 2017, a person with an adjusted net income of $24,000 or less, and his or her qualifying spouse, pay no MSP premium. The threshold maximum income for premium assistance eligibility was increased from $30,000 adjusted net income per year to $42,000, and the sum net income of a beneficiary and spouse when one spouse is in long-term care was increased from $42,000 to $54,000, thereby allowing more beneficiaries to apply for and receive premium assistance.

A short term, up to 100 per cent subsidy is offered under the temporary premium assistance program based on current, unexpected financial hardship. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or a holder of permanent resident (landed immigrant) status under the federal *Immigration and Refugee Protection Act*.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month in which residence is established plus two additional months. For example, if an eligible person applies during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former health insurance plan during the waiting period.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

Sections 3, 4 and 5 of the *Medical and Health Care Services Regulation* define portability provisions for persons temporarily absent from British Columbia with regard to publicly funded services.

Residents who spend part of every year outside British Columbia must be physically present in British Columbia at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. As of January 1, 2013, longer term vacationers who are deemed residents may qualify for a total absence of up to seven months per calendar year for vacation purposes only, provided they give prior notice to the Medical Services Commission and continue to meet the other requirements such as maintaining their home in British Columbia.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible to retain their medical coverage for up to 24 consecutive months provided that they receive prior approval of the MSC and meet other requirements of section 4 of the *Medical and Health Care Services Regulation*. Approval is limited to once in five years for absences exceeding six months in a calendar year. When a beneficiary stays outside British Columbia longer than the approved period, there is a requirement to fulfill a waiting period upon re-establishing residence in the province before coverage can be renewed. Students and extended family of students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial/territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to British Columbia residents who are eligible for Medical Services Plan coverage, upon presentation of a valid CareCard or BC Services Card. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved for each hospital by the Assistant Deputy Ministers Policy Advisory Committee. For out-patient services, the payment is at the inter-provincial/territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled through inter-provincial/territorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from the BC government.

British Columbia pays host provincial rates for publicly funded services according to rates established by the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The provisions that define portability of health insurance during temporary absences outside Canada are the *Hospital Insurance Act*, section 24; *the Hospital Insurance Act Regulations*, Division 6; the *Medicare Protection Act*, sections 5 and 29; and the *Medical and Health Care Services Regulation*, section 35.

Residents who leave British Columbia temporarily to attend school or university are eligible for MSP coverage for the duration of their studies provided they were physically present in Canada for six of the 12 months immediately preceding departure, and are in full-time attendance at a recognized educational facility. Beneficiaries who have been studying outside British Columbia must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe should contact MSP.

In some circumstances, while temporarily outside the province for work or vacation, an individual may be deemed an eligible resident during an 'extended absence' of up to 24 consecutive months once in a five-year period. To qualify, he or she must obtain prior approval for status as a resident during the absence, continue to maintain their home in British Columbia, be physically present in Canada for six of the 12 months immediately preceding departure and have not been granted an extended absence in the previous five calendar years. In addition, they must not have taken advantage of the additional one month absence available to vacationers during the year the extended absence begins, or during the calendar year prior to the start of the extended absence. In certain situations, if a person's employment requires them to routinely travel outside of British Columbia for more than six months per calendar year, they can apply to the MSC for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances may be deemed residents for up to an additional 12 months if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

British Columbia residents who are eligible for coverage while temporarily absent from British Columbia may receive reimbursement from MSP for out-of-country medical expenses. MSP provides coverage for out-of-country emergency physician services up to the British Columbia physician fee rates. Reimbursement for out-of-country emergency hospital services is limited to a maximum benefit of $75.00 per day. Any excess cost is the responsibility of the beneficiary. Reimbursements are made in Canadian dollars.

4.4 PRIOR APPROVAL REQUIREMENT

No prior approval is required for medically required procedures that are covered under interprovincial reciprocal agreements with other provinces. Prior approval from the MSC is required for procedures that are excluded under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are: surgery for alteration of appearance (cosmetic surgery); gender reassignment surgery; surgery for reversal of sterilization; routine periodic health examinations such as routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation, moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies (e.g., Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada); services requested by a third party; team conferences; genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

All non-emergency procedures performed outside Canada or outside British Columbia but within Canada require approval from the MSC before the procedure is performed in order to be eligible for reimbursement under the publicly funded program. All such applications for reimbursement are to be submitted to the Ministry of Health or its designate, Health Insurance BC. The beneficiary is notified of the decision in writing.

If a decision is made to deny the application for funding, the beneficiary may request an administrative review of the denial.

If, after the administrative review is concluded, the application for funding under MSP is denied again, the beneficiary may request a review of the decision. For out-of-country applications, the review is conducted by an MSC Review Panel. The panel consists of three members – one delegate representing the Ministry of Health, one delegate representing the Doctors of BC and one delegate representing the general public. This tripartite structure ensures that decisions affecting administration of the provincial health-care system reflect the best interest of all concerned. For out-of-province but inside Canada applications, the review is conducted by an advisory committee of the MSC.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

Beneficiaries in British Columbia, as defined in section 1 of the *Medicare Protection Act*, are eligible for all publicly funded health-care services as required. To ensure equal access to all, regardless of income, the MPA, sections 17 and 18, prohibits extra-billing by enrolled practitioners. Similarly, section 15 of the *Laboratory Services Act* prohibits extra-billing to beneficiaries for medically required laboratory services provided at an approved laboratory facility, and section 12 of the *Hospital Insurance Act* prohibits extra-billing for hospital services.

If a benefit is provided by an enrolled medical practitioner who has opted-out of the Medical Services Plan, the amount paid exceeding the amount allowed under the legislation to be payable must be refunded. Amounts to be refunded are debts recoverable by court action. The Medical Services Commission may apply for an injunction restraining a person from contravening the extra billing provisions of the MPA.

Access to publicly funded services continues to be enhanced:

- The Alternative Payments Program funds regional health authorities to contract with or hire general practitioners (GPs) and/or specialists in order to deliver publicly funded clinical services.
- The Full-Service Family Practice Incentive Program continues to be expanded as the Ministry of Health and physicians continue to work together to develop incentives aimed at helping to support and sustain full-service family practice.
- The Ministry provides funding through the Medical On-Call Availability Program to health authorities to enable them to contract with groups of physicians to provide "on-call" coverage necessary for hospitals to deliver emergency health-care services to unassigned patients in a reliable, effective, and efficient manner.
- The Ministry continued and implemented several programs under the 2014 Rural Practice Subsidiary Agreement, which were continued in the Physician Master Agreement to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. An outline of these programs can be obtained at: www.health.gov.bc.ca/pcb/rural.html.

Infrastructure and Capital Planning

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry maintains a ten year capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

5.2 PHYSICIAN COMPENSATION

The Physician Master Agreement (PMA) is a formal agreement signed by the Government of British Columbia, the Doctors of BC, and the MSC. In December 2014, doctors in British Columbia voted in favour of a new agreement with government. The new five-year agreement (term April 1, 2014 to March 31, 2019) supports ongoing efforts to recruit and retain physicians while also improving access to specialists and care in rural and remote communities.

The PMA gives the Doctors of BC the exclusive right to represent the interests of all physicians who receive payment for the medical services they provide to beneficiaries. The PMA establishes mechanisms that promote enhanced collaboration and accountabilities between the Province and Doctors of BC through various joint committees. It also provides a formal conflict management process at both the local and provincial levels and language limiting physician service withdrawals. The role of health authorities in the planning and delivery of health-care services are reinforced in the PMA.

The PMA establishes the compensation and benefit structure for physicians who provide publicly funded medical services whether on fee-for-service, contracted service or population based funding model service. Through the PMA, the Province also provides targeted financial support for areas such as: rural physician incentive programs; access to specialist services; supporting full service family practices; and shared care models involving GPs, specialists, and other health-care professions.

Physicians are registered by the College of Physicians and Surgeons of British Columbia, a body established under the *Health Professions Act*. The PMA provides processes for monitoring and managing the funding established by the MSC under section 25 of the MPA for publicly funded medical services provided by physicians on a FFS basis. Mechanisms for revisions to the MSC Payment Schedule and for the payment of physicians are detailed in the PMA.

Dentists are registered by the College of Dental Surgeons of British Columbia, which is also a body established under the *Health Professions Act*. The Province and the British Columbia Dental Association (BCDA) have entered into a Dentistry Master Agreement for the period April 1, 2014 to March 31, 2019 that covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; paediatric dental services; and dental technical procedures. Both the Province and the BCDA meet through a Dentistry Liaison Committee for the duration of the agreement.

Payment for medical services delivered in the province is made through MSP to individual practitioners who submit claims under fee-for-service, to health authorities who contract and employ physicians for providing services to patients, and to health authorities and/or physician groups who provide patient services under the population based funding model. The government funds health authorities to enter into alternative payment arrangements with other physicians.

The MSC is authorized to monitor the billing and payment of claims in order to manage expenditures for medical and health-care benefits on behalf of MSP beneficiaries. The Ministry's Billing Integrity Program monitors, audits and investigates billing patterns and practices of medical and health-care practitioners to detect and deter inappropriate and incorrect billing of MSP claims. The Billing Integrity Program develops and analyses practitioner's profiles, monitors trends, conducts audits, and in accordance with the legislation, where appropriate seeks recovery of inappropriately paid monies.

In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) with the health authorities or with the Province. Physicians paid by these alternative mechanisms may also be eligible to provide some benefits on a FFS basis.

5.3 PAYMENTS TO HOSPITALS

Funding for publicly funded hospital services is included within annual funding allocations to health authorities, as well as specifically targeted funding from time to time. This funding allocation is used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. Annual funding allocations to health authorities are determined as part of the Ministry's annual budget process in consultation with the Ministry of Finance and Treasury Board. The current year funding allocations and notional out-year allocations are conveyed to health authorities by means of annual funding letters.

The HIA, *Hospital Insurance Act Regulations*, and the *Health Authorities Act* govern payments made by government to health authorities. These statutes establish the authority of the Minister to make payments to regional health authorities and the Provincial Health Services Authority and specify in broad terms what services are publicly funded when provided within a hospital and in delivering regional and other health-care services.

The British Columbia Tripartite Framework Agreement on First Nation Health Governance and other negotiated agreements, provide the basis for the Ministry of Health to provide funding to the First Nations Health Authority. Funding to support the Nisga'a Nation health-care services and programs is provided to the Nisga'a Valley Health Authority under the terms of the 1999 Nisga's Valley Health Board Transitional Funding Agreement.

The Ministry does not specifically fund hospitals directly; instead health authorities are funded and provide operating budgets to hospitals within their region to deliver specified services. The exception to this is when funding provided to health authorities (again not directly to hospitals) is targeted for specific priority projects (e.g,. to fund wages or to provide operating funding to support large hospital construction projects coming on stream). Since it is specifically targeted, it must be reported on separately.

Annual incremental funding is allocated to health authorities using the Ministry's Population Needs-Based Funding model and other funding allocation methodologies (targeted funding allocations directed to specific health authorities e.g,. for wage costs related to collective bargaining). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry, such as payments to physicians through the MSP and payments for prescription drugs covered under PharmaCare.

The accountability mechanisms associated with government funding for hospitals are part of several comprehensive documents that set expectations for health authorities. These include the annual funding letters, annual service plans, mandate letters, and annual bi-lateral agreements. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2016–2017, these documents included:

- Estimates, Fiscal Year Ending March 31, 2017, available at: http://bcbudget.gov.bc.ca/2016/estimates/2016_Estimates.pdf
- Budget and Fiscal Plan 2016–2017 to 2018–2019, available at: http://bcbudget.gov.bc.ca/2016/bfp/2016_Budget_and_Fiscal_Plan.pdf
- Public Accounts 2016–2017, available at: www.fin.gov.bc.ca/OCG/pa/16_17/Pa16_17.htm

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	4,594,940	4,625,653	4,672,899	4,746,685	4,827,696

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)[1]	120	120	120	120	120
3. Payments for insured health services ($)[2]	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services ($)	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	6,886	7,038	6,053	7,159	5,270
7. Total payments, in-patient ($)	68,904,638	73,641,805	64,421,846	67,261,694	56,882,669
8. Total number of claims, out-patient (#)	97,088	93,382	81,547	71,313	76,662
9. Total payments, out-patient ($)	28,643,797	29,362,893	28,402,123	29,450,951	28,619,689

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	4,091	2,689	2,271	2,418	2,000
11. Total payments, in-patient ($)	4,520,778	4,747,415	3,128,917	4,530,508	6,350,623
12. Total number of claims, out-patient (#)	2,915	2,709	3,713	3,189	2,601
13. Total payments, out-patient ($)	1,646,810	2,098,735	1,599,213	2,961,790	3,525,019

[1] As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

[2] BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $10.1 billion in 2012–2013, $10.5 billion in 2013-2014, $10.8 billion in 2014–2015, $11.2 billion in 2015–16 and $11.5 billion in 2016–17.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)[3]	9,947	10,119	10,411	10,705	11,001
15. Number of opted-out physicians (#)	4	2	2	2	2
16. Number of non-participating physicians (#)	not available	not available	not available	not available	not available
17. Total payments for services provided by physicians paid through all payment methods ($)	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($)	2,675,003,546	2,764,191,968	2,818,535,925	2,905,823,733	3,023,001,765

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY[4]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	632,056	687,432	711,882	674,554	665,334
20. Total payments ($)	32,607,453	34,060,270	37,307,376	35,998,649	35,225,070

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	85,538	79,861	77,265	60,325	59,189
22. Total payments ($)	4,769,088	4,508,639	4,320,459	3,164,525	3,095,542

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	217	212	214	207	192
24. Number of opted-out dentists (#)[a]	not available	not available	not available	not available	not available
25. Number of non-participating dentists (#)[a]	not available	not available	not available	not available	not available
26. Number of services provided (#)	50,813	54,120	54,053	52,770	55,069
27. Total payments ($)	7,903,742	8,456,773	8,417,735	8,232,622	8,308,740

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

[3] The number of participating physicians in item 14 is for physicians who received payments through fee-for-service.

[4] The amounts in items 19, 20, 21 and 22 have been updated to include the most recent information on services and payments made each fiscal year based on the date of the service. The extraction of data has been applied consistently for each fiscal year.
The data for 2016/17 reflects dates of service April 1, 2016 to March 31, 2017, paid as of September 30, 2017.

YUKON

The Yukon Health Care System is committed to ensuring that residents of the Yukon acquire the skills to live responsible, healthy and independent lives. The Minister of Health and Social Services is responsible for delivering all insured health care services with service delivery administered centrally by the Department of Health and Social Services (DHSS).

The Health Services Division of DHSS is responsible for a variety of health care, disease prevention, and treatment services which assist eligible Yukon residents in attaining maximum individual independence within their community. Health Services oversees Community Health Services, Community Nursing, Communicable Disease Control, Health Promotion, Dental Health, Environmental Health and Mental Health Services.

In 2016–2017 DHSS continued to focus on the collaborative care approach for patient care to ensure better and more cost effective services to residents of Yukon. In 2016–2017 this included securing permanent funding for the Referred Care Clinic Yukon. It is anticipated that in 2017–2018 permanent funding will be secured for both the Yukon Women's MidLife Health Clinic and the Yukon Sexual Health Clinic.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

The Insured Health and Hearing Services Branch (IHHS) is responsible for the delivery of health care benefits as set out in *the Health Care Insurance Plan Act* and *Hospital Insurance Services Act*. The overall objective of the IHHS is to ensure access to, and portability of, insured physician and hospital services according to the provisions of these acts.

The Government of Yukon delivers insured health benefits according to the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). Both the YHCIP and YHISP are administered by the Director, Insured Health and Hearing Services. This position is a joint appointment by the Minister of Health and Social Services and the Commissioner of the Yukon Territory.

The Health Care Insurance Plan Act, section 3(2) and section 4, establishes the public authority to operate the health care plan.

The *Hospital Insurance Services Act*, section 3(1) and section 5, establishes the public authority to operate the hospital care plan.

Subject to the Health Care Insurance Plan Act (section 5), the Hospital Insurance Services Act (section 6) and the Regulations, it is the responsibility of the Director, Insured Health and Hearing Services to:

- administer both plans;
- determine eligibility for insured health services;
- establish advisory committees and appoint individuals to advise or assist in the operation of the plans;

- determine the amounts payable for insured health services outside the Yukon;
- conduct surveys and research programs, and obtain statistics for such purposes;
- appoint inspectors and auditors to examine and obtain information from medical records, reports, and accounts; and
- perform any other functions and discharge any other duties assigned by the Minister of Health and Social Services under the Act.

Specific to the Hospital Insurance Services Act, the Director, Insured Health and Hearing Services has the responsibility to:

- enter into agreements on behalf of the Government of Yukon with hospitals in or outside of Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- prescribe the forms and records necessary to carry out the provisions of the Act; and
- perform any other functions and discharge any other duties assigned to the administrator by the Regulations.

There were no amendments to either Act in 2016–2017.

1.2 REPORTING RELATIONSHIP

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the Health Care Insurance Plan Act and section 7 of the Hospital Insurance Services Act require that the Director, Insured Health and Hearing Services make an annual report to the Minister of Health and Social Services respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and is subject to discussion at that level. The Statement of Revenue and Expenditures was tabled in the spring 2017 sitting of the Yukon legislature.

1.3 AUDIT OF ACCOUNTS

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the Auditor of the Government of Yukon in accordance with section 34 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

In 2013, the Office of the Auditor General of Canada released the 2013 Report of the Auditor General of Canada, Capital Projects—Yukon Hospital Corporation. Since that time there were no reports related to the Department of Health and Social Services released by the Office of the Auditor General of Canada.

Further, section 13(2) of the *Hospital Act* requires the Yukon Hospital Corporation to submit a report of their operations for that fiscal year to the Minister within six months after the end of each fiscal year. The report is to include the financial statements of the Corporation and the Auditor's report.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

The *Hospital Insurance Services Act*, sections 3, 4, 5, 6 and 9, establish authority to provide insured hospital services to insured residents. The *Yukon Hospital Insurance Services Ordinance* was first passed in 1960 and came into effect April 9, 1960. No amendments were made to the Act in 2016–2017.

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the legislature and the government to ensure "compliance with appropriate methods of operation and standards of facilities and care." Adopted on November 11, 1994, the annexed *Hospital Standards Regulation* sets out the conditions under which all hospitals in the territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establish and maintain a quality assurance program.

In April 1997, the Yukon Government assumed responsibility for operating health units in rural Yukon communities from the federal government. These health centres are staffed by one or more nurses and auxiliary staff. Primary Health Care Nurses in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services in 11 communities throughout Yukon along with the Whitehorse Health Centre which offers immunization clinics and pre- and postnatal care.

In 2016–2017, insured in-patient and out-patient hospital services were delivered in 14 facilities throughout the territory. These facilities include Whitehorse General Hospital, Watson Lake Community Hospital, Dawson City Community Hospital and 11 Community Health Centres.

The Yukon Hospital Corporation completed their accreditation process in May 2014 as part of a four-year cycle through Accreditation Canada. Whitehorse General Hospital and Watson Lake Community Hospital took part in this process, while Dawson City Community Hospital will take part in the next process in 2018.

Pursuant to the *Hospital Insurance Services Regulations*, section 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to inpatients, namely: accommodation and meals at the standard or public ward level; necessary nursing service; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability; drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; use of radiotherapy facilities where available; use of physiotherapy facilities where available; and services rendered by persons who receive remuneration from the hospital.

Section 2(f) of the Regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident (period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident): necessary nursing service; laboratory, radiological and other procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury; drugs,

biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; services rendered by persons who receive remuneration therefor from the hospital; use of radiotherapy facilities where available; and use of physiotherapy facilities where available.

Pursuant to the *Hospital Insurance Services Regulations*, all in-patient and out-patient services provided in an approved hospital, by hospital employees, are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

On August 31, 2016, DHSS implemented the *Health Information Privacy and Management Act Regulations*. The Act balances protection of personal health information with the information needs of health care workers so that they can provide Yukoners with the best care possible. Regulations for the Act set out standards for how personal health information is secured and what professions or organizations the Act will apply to. In addition, the Act also set out the framework for information systems that will contain and share personal health information, the Yukon Health and Information Network (YHIN).

2.2 INSURED PHYSICIAN SERVICES

Insured physician services in Yukon are defined as medically required services rendered by a medical practitioner. Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7, 10 and 13 of the *Health Care Insurance Plan Regulations* provide for insured physician services. No amendments were made to the Act in 2016–2017.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. In order to participate in the Yukon Health Care Insurance Plan, physicians must:

- register for licensure pursuant to the *Health Professions Act*; and
- maintain licensure, pursuant to the *Health Professions Act*.

The number of resident physicians participating in the Yukon Health Care Insurance Plan in 2016–2017 was 89, along with 43 locums and 40 visiting specialists.

Section 7 of the *Yukon Health Care Insurance Plan Regulations* covers payment for medical services. Subsection 4 allows physicians to make arrangements for payment for insured services on a basis other than fee-for-service. Notice in writing of this election must be submitted to the Director, Insured Health and Hearing Services. In 2016–2017, physicians were remunerated via both the fee-for-service model and alternative payment arrangements.

The process used to add a new fee to the Payment Schedule for Yukon is administered through a committee structure. This process requires physicians to submit requests in writing to the Yukon Health Care Insurance Plan, Yukon Medical Association Liaison Committee. Following review by this committee, a decision is made to include or exclude the service. The relevant 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.

The five-year Memorandum of Understanding (MOU) with the Yukon Medical Association will end on March 31, 2017. Negotiations for the new MOU started in December of 2016.

2.3 INSURED SURGICAL-DENTAL SERVICES

Dentists providing insured surgical-dental services under the Health Care Insurance Plan of Yukon must be licensed pursuant to the *Dental Professions Act* and are given billing numbers to bill the Yukon Health Care Insurance Plan for providing insured dental services. The Plan is also billed directly for services provided outside the territory.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Health Care Insurance Plan Regulations. The procedures must be performed in a hospital.

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of *the Health Care Insurance Plan Regulations*. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services administers this process.

There were no new insured surgical-dental services added in 2016–2017.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act and Regulations* and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured.

Uninsured hospital services include: non-resident hospital stays; special or private nurses requested by the patient or family; additional charges for preferred accommodation unless prescribed by a physician; crutches and other such appliances; nursing home charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital).

Section 3 of the *Yukon Health Care Insurance Plan Regulations* contains a list of services that are prescribed as non-insured. Uninsured physician services include: advice by telephone; medical-legal services; testimony in court; preparation of records, reports, certificates and communications; services or examinations required by a third party; services, examinations or reports for reasons of attending university or camp; examination or immunization for the purpose of travel, employment or emigration; cosmetic services; services not medically required; giving or writing prescriptions; the supply of drugs; dental care except procedures listed in Schedule B; and experimental procedures.

Physicians in Yukon may bill patients directly for non-insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include but are not limited to: completion of employment forms; medical-legal reports; transferring records; third-party examinations; some elective services; and telephone prescriptions, advice or counseling.

Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

Uninsured dental services include procedures considered restorative and procedures that are not performed in a hospital under general anaesthesia.

All Yukon residents have equal access to services. Third parties, such as private insurers or the Worker's Compensation Health and Safety Board, do not receive priority access to services through additional payment. The purchase of non-insured services, such as fiberglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

Yukon has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services to monitor usage and service concerns.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows:

Physician services—the Yukon Health Care Insurance Plan, Yukon Medical Association Fee Liaison Committee is responsible for reviewing changes to the Payment Schedule for Yukon including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing. The Director, Insured Health and Hearing Services, manages this process. No services were removed in 2016–2017.

Hospital services—an amendment by Order-in-Council to sections 2(e) and 2(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2017, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. 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 Health Care Insurance Plan Regulations is required. A service could be de-insured if determined not medically necessary or is no longer required to be carried out in a hospital under general anesthesia. The Director, Insured Health and Hearing Services manages this process. No surgical-dental services were de-insured in 2016–2017.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act and Regulations*, sections 2 and 4, and the *Hospital Insurance Services Act and Regulations*, sections 2 and 4. There were no changes to the legislation in 2016–2017.

Subject to the provisions of these acts and regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in Yukon, but does not include a tourist, transient, foreign student or visitor. Pursuant to section 4(1) of the *Yukon Health Care Insurance Plan Regulations* and the Yukon Hospital Insurance Services Regulations, an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory. All persons returning to or establishing residency in Yukon are required to complete this waiting period. The only exception is for children adopted by insured persons, and for newborns. The following persons are not eligible for coverage in Yukon:

- persons entitled to coverage from their home province or territory (e.g., students and workers covered under temporary absence provisions);
- visitors to Yukon;
- refugee claimants;
- convention refugees;
- inmates in federal penitentiaries;
- study permit holders, unless they are a child and they are listed as the dependent of a person who holds a one year work permit; and
- employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

- establish residency in Yukon;
- become a permanent resident; or
- for inmates at the Whitehorse Correctional Centre, the day following discharge or release if stationed in or a resident in Yukon.

The number of registrants in the Yukon Health Care Insurance Plan as of March 31, 2017 was 39,997.

3.2 OTHER CATEGORIES OF INDIVIDUALS

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals, as follows:

Returning Canadians: waiting period is applied

Permanent Residents: waiting period is applied

Minister's Permit: waiting period is applied, if authorized

Foreign Workers: waiting period is applied, if holding Employment Authorization

Clergy: waiting period is applied, if holding Employment Authorization

Employment Authorizations must be in excess of 12 months.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

Where applicable, the eligibility of all persons is administered in accordance with the Interprovincial Agreement on Eligibility and Portability. Under section 4(1) of both Regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory." All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted by insured persons (see section 3.1), and newborns.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the *Yukon Health Care Insurance Plan Regulations* and sections 6, 7(1), 7(2) and 9 of the *Yukon Hospital Insurance Services Regulations*.

The Regulations state that, "where an insured person is absent from the Territory and intends to return, he/she is entitled to insured services during a period of 12 months continuous absence." Persons leaving Yukon for a period exceeding three months are advised to contact Yukon Insured Health Services and complete a Temporary Absence form. Failure to do so may result in cancellation of coverage.

Students attending educational institutions full-time outside Yukon remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services (the Director) may approve other absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director may approve absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures.

Yukon participates fully with the Interprovincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories with the exception of Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and submit claims to the Yukon Health Care Insurance Plan for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the territory are paid at the rates established by the host province.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the *Yukon Health Care Insurance Plan Regulations* and sections 6, 7(1), 7(2) and 9 of the *Yukon Hospital Insurance Services Regulations*.

Sections 5 and 6 currently state that, where an insured person is absent from Yukon and intends to return, the person is entitled to insured services during a period of 12 months continuous absence. Similarly, to general temporary absences, regulatory work on coverage during temporary absences outside Canada is currently underway and will receive further public input prior to enacting changes.

Persons leaving Yukon for a period exceeding three months are advised to contact Yukon Health Care Insurance Plan and complete a Temporary Absence form. Failure to do so may result in cancellation of the coverage.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada (see section 4.2 of this report).

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. For 2016–2017 the in-patient rate was set at $2,462 per day at Whitehorse General Hospital and $1,106 per day at Watson Lake Community Hospital and Dawson City Community Hospital. These rates are set annually by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

4.4 PRIOR APPROVAL REQUIREMENT

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Yukon or outside Canada.

When treatment is provided outside Yukon or outside Canada plan members will only be reimbursed the amounts as described in Sections 4.2 and 4.3.

Prior approval by the Director of Insured Health Services is required for full reimbursement of services sought outside of Canada.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

There are no user fees or 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. There is no extra-billing in Yukon for any services covered by the Plan.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program or the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

To improve access to insured health services, the number of visiting specialists continues to increase to better serve patients in the territory.

Additionally IHS provides extended health benefits to eligible Yukon residents which include the Travel for Medical Treatment Program, the Children's Drug and Optical Program, the Chronic Disease and Disability Benefits Program, Pharmacare Program, Extended Benefits Program and Hearing Services Program.

The Yukon Hospital Corporation operates the three hospitals in the territory: Whitehorse General Hospital, WGH, Watson Lake Community Hospital and Dawson City Community Hospital. In 2016–2017 construction continued at WGH to expand the Emergency Department and provide expansion of the Radiology Department along with providing a permanent location for the MRI program. The expansion project is scheduled to be completed in January of 2018.

5.2 PHYSICIAN COMPENSATION

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon before entering into negotiations with the Yukon Medical Association (YMA). The YMA and the government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties. The current Memorandum of Understanding will expire on March 31, 2017.

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 2016–2017.

The fee-for-service system is used to reimburse the majority of physicians providing insured services to residents. Other systems of reimbursement include contract payments and sessional payments, and for services in Whitehorse as well as rural communities in the territory.

5.3 PAYMENTS TO HOSPITALS

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital, Watson Lake Community Hospital, and Dawson City Community Hospital) through contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated and adjusted based on operational requirements 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.

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 2016–2017.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in its 2016–2017 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1) (d) and (e) of the *Health Care Insurance Plan* Act and section 3 of the *Hospital Insurance Services Act* acknowledge the contribution of the Government of Canada.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	37,048	38,054	38,261	38,831	39,997

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES[1]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	15	15	15	15	14
3. Payments for insured health services ($)[2]	58,081,700	66,231,349	68,019,857	68,688,217	64,756,767

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY[3]

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	1,173	1,197	1,205	1,242	1,217
7. Total payments, in-patient ($)	15,890,700	16,562,129	16,703,371	17,882,023	18,863,790
8. Total number of claims, out-patient (#)	14,036	15,493	15,659	14,686	14,869
9. Total payments, out-patient ($)	4,425,670	4,730,725	5,074,139	4,906,418	5,413,490

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	18	8	13	19	15
11. Total payments, in-patient ($)	70,556	39,293	56,722	52,879	157,287
12. Total number of claims, out-patient (#)	61	44	64	44	37
13. Total payments, out-patient ($)	19,823	9,951	15,889	11,410	11,454

[1] Public facilities are the 11 health centres (Beaver Creek, Carcross, Carmacks, Destruction Bay, Faro, Haines Junction, Mayo, Old Crow, Pelly Crossing, Ross River, and Teslin) and 3 hospitals (Whitehorse, Dawson City and Watson Lake). As Whitehorse, Dawson City and Watson Lake all have hospitals, the health centres in these communities are classified as a Public Health Offices.

[2] Includes monies paid to hospitals and community nursing stations.

[3] Hospitals have up to a year from date of service to bill jurisdictions (information is based upon date of service; therefore, 2016–2017 reporting period is still open until March 31, 2018).

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	70	71	70	78	89
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)	22,690,228	24,409,655	26,949,206	28,115,103	31,462,766
18. Total payments for services provided by physicians paid through fee-for-service ($)[4]	18,660,715	18,817,879	20,295,869	19,994,380	21,839,959

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	59,962	57,178	61,331	61,733	52,451
20. Total payments ($)	3,563,528	3,503,179	3,718,480	3,919,741	3,990,399

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	not available	not available	not available	not available	not available
22. Total payments ($)	not available	not available	not available	not available	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	3[5]	2	2	2	2
24. Number of opted-out dentists (#)[a]	not available	not available	not available	not available	not available
25. Number of non-participating dentists (#)[a]	not available	not available	not available	not available	not available
26. Number of services provided (#)	26[5]	6	6	5	2
27. Total payments ($)	21,845	3,827	8,117	1,781	9,641

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

[4] Includes Visiting Specialists, Member Reimbursements, Locum Doctors, and Optometrist testing paid through fee-for-service. Excludes services and costs provided by alternative payment agreements.

[5] Includes direct billings for insured surgical-dental services received outside the territory.

NORTHWEST TERRITORIES

During the reporting period, the Department of Health and Social Services (DHSS) worked with the Health and Social Services Authorities (HSSAs) to administer, manage, and deliver insured services in the Northwest Territories (NWT).

During the 2016–2017 fiscal year, DHSS carried out the following legislative activities related to health care services:

- Amendments to t*he Hospital Insurance and Health and Social Services Administration Act* came into force August 1, 2016. The amendments allowed for the establishment of a territorial health and social services authority, and amalgamated six of the existing Health and Social Services Authorities. The Act requires that the Minister of Health and Social Services develop a territorial plan for health and social services. Together these changes are intended to improve patient care, system integration and accountability.
- Drafting regulations under the *Health and Social Services Professions Act* continued. The Act will allow for the regulation of several health and social services professions under one legislative model. This will modernize existing legislation, resulting in greater efficiency and consistency.
- Drafting regulations in order to bring the new *Mental Health Act* into force. Once in force, the Act will provide for a more modern legislative framework that is similar to legislation across Canada.

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

The Northwest Territories Health Care Plan consists of the Medical Care Plan and the Hospital Insurance Plan.

The public authority responsible for the administration of the Medical Care Plan is the Director of Medical Insurance, appointed by the Minister of Health and Social Services (the Minister), under the *Medical Care Act*. The Minister establishes the Northwest Territories Health and Social Services Authority and Health and Social Service Authorities' Boards of Management as pursuant to the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA) to, among other things, administer the Hospital Insurance Plan.

1.2 REPORTING RELATIONSHIP

During the reporting period, up to August 1, 2016, there were eight Health and Social Service Authorities (HSSAs): Tlicho Community Services Agency (TCSA), Stanton Territorial Health Authority, Yellowknife HSSA, Sahtu HSSA, Beaufort-Delta HSSA, Deh Cho HSSA, Fort Smith HSSA and Hay River HSSA.

As of August 1, 2016, amendments to the *Hospital Insurance and Health and Social Services Administration Act* came into force, allowing for the establishment of a Northwest Territories Health and Social Services Authority (Territorial Authority) whose affairs are directed by a Territorial Board of Management. Six Regional Wellness Councils provide advice to the Territorial Board of Management which is composed of the Regional Wellness Council chairpersons and the chairpersons of the TCSA and Hay River Health and Social Services Authority which remained as Boards of Management. The Territorial Board of Management and the remaining Boards of Management are accountable to the Minister of Health and Social Services.

The Territorial Authority and the remaining Boards of Management are responsible for the delivery of health and social services and for the management, control and operation of facilities and services throughout the NWT. The Territorial Authority and the Boards of Management are required under legislation to comply with the territorial plan which is set by the Minister.

The Minister appoints the Director of Medical Insurance who is responsible for administering the *Medical Care Act* and its Regulations. The Director prepares an annual report for the Minister on the operation of the Medical Care Plan. This report can be found within the DHSS Annual Report.

The Minister appoints a chairperson and members of each Regional Wellness Council, and the Hay River Health and Social Services Authority as well as the Chair of the Territorial Board of Management. The chairpersons and members may serve for three years and may be re-appointed to serve another term. The Minister may appoint a Public Administrator to assume the role of a Board of Management in certain circumstances if the Minister feels it is necessary. At reporting time, a Public Administrator is in place for the Hay River Health and Social Services Authority. The exception to this is the TCSA where the Tlicho community governments are responsible for appointing one member to the Board. The Minister Responsible for Executive and Indigenous Affairs (EIA) appoints a chairperson. Members serve for a maximum of four years and the chairperson's term is fixed by the Minister of EIA. The Director of Medical Insurance and the Boards of Management are responsible to the Minister, as per section 8(1)(b) of the *Canada Health Act*.

1.3 AUDIT OF ACCOUNTS

As part of the Government of the Northwest Territories annual audit, the Office of the Auditor General of Canada audits payments under the Hospital Insurance Plan and the Medical Care Plan.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

Insured hospital services in the Northwest Territories (NWT) are provided under the *Hospital Insurance and Health and Social Services Administration Act*. Amendments to the *Hospital Insurance and Health and Social Services Administration Act* came into force August 1, 2016.

During the reporting period, insured hospital services were provided to in-patients and out-patients by 23 facilities throughout the NWT. Consistent with Section 9 of the *Canada Health Act*, the NWT offers a comprehensive range of insured services to its residents.

Insured in-patient hospital services include:

- meals and accommodation at the ward level;
- required nursing services;
- laboratory, diagnostic and imaging services (along with necessary interpretations);
- drugs, biologicals and other preparations administered in the hospital;
- surgical supplies and use of operating room;
- case room and anesthesiology services;
- radiology and rehab therapy (physio, audio, occupational and speech);
- psychiatric and psychological services within an approved program; and
- detoxification at approved centers.

Insured out-patient hospital services include:

- laboratory tests;
- diagnostic imaging (including interpretations when needed);
- physiotherapy, speech and language pathology therapy and occupational therapy;
- minor medical and surgical procedures and related supplies; and
- psychiatric and psychological services under an approved hospital program.

The Minister may approve additions or deletions to insured services provided in the NWT.

As outlined in the Government of the NWT Medical Travel Policy, travel assistance is provided to residents with a valid NWT Health Care Card who require medically necessary insured services that are not available in their home community or elsewhere in the NWT. This ensures that residents of the NWT have reasonable access to insured hospital and physician services.

2.2 INSURED PHYSICIAN SERVICES

The NWT *Medical Care Act* and the NWT *Medical Care Regulations* provide for insured physician services. Medically necessary services provided in approved facilities by physicians, nurses, nurse practitioners and midwives are considered insured services under the health care plan. These professionals are required by legislation to be licensed to practice in the NWT under the *Medical Profession Act* (physicians), *Nursing Profession Act* (nurses and nurse practitioners) and the *Midwifery Profession Act* (registered midwives).

For the period 2016–2017, there were 348 licensed physicians (resident, locum and visiting) active in the NWT.

Physicians may opt out and collect fees other than under the Medical Care Plan by providing written notice to the Director of Medical Insurance. There were no opted-out physicians in the NWT during the reporting period.

The Medical Care Plan insures all medically necessary physician services such as:

- diagnosis and treatment of illness and injury;
- surgery, including anaesthetic services;
- obstetrical care, including prenatal and postnatal care; and
- eye examinations, treatment and operations provided by an ophthalmologist.

The Director of Medical Insurance is responsible for recommending an insured services tariff for services payable by the NWT Medical Care Plan for the Minister's approval. The Minister ultimately determines if services will be added, altered or removed from the tariff by:

- establishing a medical care plan that provides insured services to insured persons by medical practitioners that will qualify and enable the NWT to receive transfer payments from the Government of Canada under the *Canada Health Act*; and
- approving the fees and charges itemized in the tariff that may be paid in respect to insured services rendered by medical practitioners in the NWT and the conditions under which fees and charges are payable.

2.3 INSURED SURGICAL-DENTAL SERVICES

Licensed oral surgeons may submit claims for insured surgical-dental work in the NWT. The Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits is used as a guide.

Dentists are unable to participate in the NWT Medical Care Plan.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Not all services provided by hospitals, medical practitioners and dentists are covered under the NWT Health Care Plan. Some uninsured services include:

- in-vitro fertilization;
- third party examinations;
- dental services that are not surgical in nature;
- medical-legal services;
- advice or prescriptions done over the phone;
- services rendered to the physician's family; and,
- services carried out by people who usually are not medical practitioners such as osteopaths, naturopaths and chiropractors. Physiotherapy, psychiatry and psychological therapies are not covered if delivered in a non-approved location.

For NWT residents to receive items and/or services that are generally considered uninsured under the health care plan, prior approval is required. A Medical Advisor makes recommendations to the Director of Medical Insurance regarding the appropriateness of the request.

The Workers' Safety and Compensation Committee has several policies that are applied when interpreting workers' compensation acts. These policies are available on their website at www.wscc.nt.ca.

Changes to the list of uninsured hospital, physician and surgical-dental services may be made by the Minister.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

The *Medical Care Act* and the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA) define eligibility for the Northwest Territories (NWT) Health Care Plan. The NWT uses guidelines that are consistent with the legislation and Interprovincial Agreement on Eligibility and Portability to determine eligibility in order to fulfill obligations of section 10 in the *Canada Health Act*.

Every resident is, on the first day of the third month after becoming a resident, eligible for and entitled to payment of benefits in respect of insured services rendered to the resident in accordance with the *Medical Care Act* and regulations.

According to the NWT *Medical Care Act*, a resident is a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territories, but does not include a tourist, transient or visitor to the Territories.

In order to register for the NWT Health Care Plan, residents fill out an application form and provide relevant supporting documentation (e.g., visa, immigration papers, and proof of residency). Residents may register prior to the date they become eligible. Registration is directly linked to eligibility for coverage and claims are only paid if the client has registered.

Coverage begins when a signed application has been approved

Residents can opt out of the Health Care Plan if they choose not to register. There is nothing in the *Medical Care Act* that requires a resident to register for the NWT Health Care Plan.

Individuals ineligible for NWT health care coverage are members of the Canadian Forces, federal inmates and new residents who have not completed the minimum waiting period. For persons moving back to Canada, eligibility is restored when permanent residency is established.

If an application for an NWT Health Care Card is denied, coverage is denied for a procedure or if a person is appealing the decision to cancel their NWT Health Care Card, individuals may appeal to the Director of Medical Insurance. Second level and final appeals may be directed to the Deputy Minister of Health and Social Services.

As of March 31, 2017, there were 42,780 individuals registered with the NWT Health Care Plan.

3.2 OTHER CATEGORIES OF INDIVIDUALS

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and guidelines for health care plan coverage.

Babies born to NWT residents outside of Canada are automatically covered effective on the date of birth if:

- At least one parent is a Canadian citizen;
- The parent(s) has:
  - approved temporary absence coverage under NWT Health Care; and
  - an intended date of return to the NWT.

Foreign students and workers are eligible for coverage if they hold study/work permits valid for a period of 12 months or longer. Those holding permits of less than 12 months are not eligible for coverage.

Permanent residents (landed immigrants) and returning permanent residents are covered on the first day of arrival in the NWT provided the NWT is their first place of residence in Canada, and they intend to reside in the NWT.

Convention refugees are covered provided they provide appropriate documentation.

The following are not eligible for an NWT Health Care Card as they are not considered residents:

- Tourists
- Visitors
- Transients
- Remand clients from other jurisdictions
- Canadian students, who are not NWT residents, attending an educational institution in the NWT (unless the student intends to establish a permanent residence in the NWT). Permanent residence does not include student housing or living on campus.
- A person who works in the NWT but does not intend to maintain a permanent residence (over 12 months) in the NWT (s.7, Interprovincial Agreement on Eligibility and Portability of Hospital and Medical Care Insurance).
- Temporary Resident Permit holders. (Temporary Resident Permits (TRP) are issued by the Federal Immigration Minister and are issued to individuals who, for some reason, do not meet the immigration requirements but are admitted to Canada for compassionate or humanitarian reasons. The duration of the TRP varies but they can be issued for up to 3 years.)
- Individuals without valid documentation from Immigration, Refugees and Citizenship Canada

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

Waiting periods for persons moving to the Northwest Territories (NWT) are consistent with the Interprovincial Agreement on Eligibility and Portability. The waiting period ends the first day of the third month of residency for those moving permanently to the NWT.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

Section 4(2) of the *Medical Care Act* provides NWT residents with access to insured health coverage while temporarily out of the NWT but still in Canada, consistent with section 11(1) (b)(i) of the *Canada Health Act*. The Department of Health and Social Services (DHSS) adheres to the Interprovincial Agreement on Eligibility and Portability as described in the NWT Health Care Plan Registration Manual.

Once an individual has filled out the Temporary Absence form and it is approved by DHSS, NWT residents are covered for up to one year of temporary absence for work, travel or holidays. Full-time students attending post-secondary school are covered as well. The full cost of insured services is paid for all services received in other Canadian jurisdictions.

When a valid NWT health care card is produced, most doctor visits and hospital services are billed directly to the Department. During the reporting period, approximately 27.5 million dollars were paid out for hospital in-patient and out-patient services in other provinces and territories. Reimbursement guidelines exist for patients having to pay up front for medically required services.

The NWT participates in both the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement with other jurisdictions (except Quebec).

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

As per section 4(3) of the *Medical Care Act* and section 11(1)(b) (ii) of the *Canada Health Act*, the NWT provides reimbursement for NWT residents who require medically necessary services while temporarily outside Canada. Individuals are required to pay up front and seek reimbursement upon their return to the NWT. Costs for eligible services, including in-patient services, out-patient services and haemodialysis, rendered outside Canada will be reimbursed up to the amounts payable in the NWT. Residents temporarily out of Canada may receive coverage for up to one year; however, prior approval as well as documentation proving the NWT will be the individual's permanent residence upon return is required.

4.4 PRIOR APPROVAL REQUIREMENT

Prior approval is required for elective services rendered in other provinces and outside Canada. All services from private facilities require prior approval as well.

First level appeals of decisions may be sent to the Director of Medical Insurance. Second level appeals are considered by the Deputy Minister of Health and Social Services. The decision of the Deputy Minister is final.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

The Government of the Northwest Territories (NWT) Medical Travel Policy provides NWT residents with assistance to access medically necessary insured services not available in their home community or in the NWT, consistent with section 12(1)(a) of the *Canada Health Act*.

Diagnostic Imaging/Picture Archiving Communication System (DI/PACS) is available everywhere that digital imaging services are offered. DI/PACS has moved x-rays from film to digital format. Radiologists in Yellowknife and the south can review results in as fast as 35 minutes. This ultimately provides NWT residents with access to specialists in southern Canada without having to spend extended periods of time away from home and family.

Extra-billing is not permitted in the NWT, in adherence to section 18 of the *Canada Health Act* and section 14(1) of the NWT *Medical Care Act*. The only exception is if a medical practitioner opts out of the Medical Care Plan and collects his or her own fees. This did not occur during the reporting period.

User charges are also not permitted under section 14(2) of the NWT *Medical Care Act* in the NWT unless the medical practitioner has opted out of the Medical Care Plan, collects his or her own fees and gives reasonable notice of the intention to collect fees.

The *Medical Care Act* includes a provision to allow the Minister to establish a Benefits Appeal Committee that could address any matter referred to it by the Minister, including complaints where a physician engaged in extra billing and charged user fees. At present, there has been no need to establish this committee because almost all physicians are compensated through contractual agreements with the Government of the NWT.

5.2 PHYSICIAN COMPENSATION

The Department, in close consultation with the NWT Medical Association, sets physician compensation. Generally, family and specialist practitioners are compensated through contractual agreements with the Government of NWT, while the remaining practitioners are compensated on a fee-for-service basis. Fee-for-service rates in the NWT are itemized in the Insured Services Tariff approved by the Minister in accordance with the NWT *Medical Care Act*.

Under the *Medical Care Act*, the Minister may appoint medical and financial inspectors who shall, under the direction of the Director, inspect, examine and audit books, accounts, reports and medical records maintained in hospitals, health facilities, offices of medical practitioners and other health care facilities respecting patients who are receiving or who have received insured services. The Director may reassess an account for insured services submitted by a medical practitioner and make any appropriate adjustment in the amount paid to the medical practitioner in respect of the insured services.

Although physicians may charge for uninsured services in accordance with the Service Fee Policy, there is no ability to charge block fees.

5.3 PAYMENTS TO HOSPITALS

Contribution agreements between the Department of Health and Social Services and the Boards of Management for each Health and Social Service Authority (HSSA) dictate payments made to hospitals. Government budgets, resources and levels of services offered determine the allocated amounts.

Payments to HSSAs providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act*. A comprehensive budget is used to fund hospitals in the NWT.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Federal funding from the Canada Health Transfer has been recognized and reported by the Government of the Northwest Territories (GNWT) through the follow documents: GNWT, *Public Accounts of the Fiscal Year, ended March 31, 2016* (published February 10, 2017); the GNWT, *Annual Business Plan, 2016–2017* (published February 1, 2017); the GNWT, *Main Estimates, 2016–17* (published February 1, 2017); GNWT, *Interim Financial Statements of the Government of the Northwest Territories for the year ended March 31, 2016* (published November 3, 2016), and in a joint GNWT, Government of Yukon and Government of Nunavut news release (January 17, 2017).

The Public Accounts contain the consolidated financial statements of the GNWT, audited by the Auditor General of Canada, and is presented annually to the Legislative Assembly; the Main Estimates and the Business Plan are presented annually to the Legislative Assembly, and interim financial statements are presented to the Legislative Assembly on an ad hoc basis (e.g., post-election transition from one Assembly to the next).

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)	42,786	41,158	43,436	43,430	42,780

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	23	23	23	23	23
3. Payments for insured health services ($)[1]	62,112,381	62,499,951	69,659,642	69,871,142	69,900,840

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)	not applicable	not applicable	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	1,196	1,068	1,200	1,315	1,263
7. Total payments, in-patient ($)	17,527,557	15,685,347	19,034,152	21,897,488	21,904,295
8. Total number of claims, out-patient (#)	11,739	11,220	12,108	12,639	13,338
9. Total payments, out-patient ($)	4,045,585	4,234,805	4,593,956	4,803,719	5,632,089

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	18	17	5	14	8
11. Total payments, in-patient ($)	130,376	231,302	14,800	216,539	92,056
12. Total number of claims, out-patient (#)	66	59	32	45	38
13. Total payments, out-patient ($)	37,765	67,690	37,896	39,388	42,207

All data are subject to future revisions.

[1] Payments for insured health services are estimated and include only those health services occurring within acute care facilities (i.e. hospitals that offer both in-patient and outpatient services).

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)[2]	298	298	330	326	348
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)[3]	48,282,889	50,887,853	53,392,587	53,732,241	55,480,195
18. Total payments for services provided by physicians paid through fee-for-service ($)	1,460,809	1,207,775	1,545,414	1,635,526	1,256,852

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	49,136	48,118	48,994	54,329	61,825
20. Total payments ($)	5,337,927	5,187,881	5,578,215	6,431,903	6,916,939

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	116	111	73	195	93
22. Total payments ($)	18,766	11,348	5,208	171,104	6,900

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	not available	not available	not available	not available	not available
24. Number of opted-out dentists (#)[a]	not applicable	not applicable	not applicable	not applicable	not applicable
25. Number of non-participating dentists (#)[a]	not applicable	not applicable	not applicable	not applicable	not applicable
26. Number of services provided (#)	not available	not available	not available	not available	not available
27. Total payments ($)	not available	not available	not available	not available	not available

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

[2] Estimate based on total active physicians for each fiscal year.

[3] Payments are based on an estimate of expenditures for physician services on NWT residents (including physician remuneration and clinic costs).

NUNAVUT

The Department of Health faces many unique challenges when providing for the health and well-being of Nunavummiut. Of a total population of 37,082[1] approximately one third of the population is under the age of 15 years (11,368 people), however the 55–59 age group had the largest annual growth at 10.1 per cent from July 2015 to July 2016.[2] The territory is made up of 25 communities located across three time zones and divided into three regions: the Qikiqtaaluk (or Baffin), the Kivalliq and the Kitikmeot.

The Government of Nunavut incorporates Inuit societal values into program and policy development, as well as into service design and delivery. The delivery of health services in Nunavut is based on a primary health care model. Nunavut's primary health care providers are family physicians, nurse practitioners, midwives, community health nurses, and other allied health professionals.

In 2016–2017, the territorial operations and maintenance budget for the Department of Health was $371,155,000 including supplementary appropriations.[3] One third of the Department's total operational budget was spent on costs associated with medical travel and treatment provided in out-of-territory facilities. Nunavut is a vast territory with a low population density and limited health infrastructure, therefore, access to a range of hospital and specialist services often requires that residents be sent out of the territory for care.

In 2016–2017, an additional $16, 500,000 was allocated to the Department for capital projects.[4] The Department of Health 2016–2017capital projects included: continued work on the replacement of the Arctic Bay Health Centre and preliminary work of the replacement of the Sanikiluaq Health Centre.[5]

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 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.

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1 Nunavut Bureau of Statistics, Population Estimates July 1, 2016, www.stats.gov.nu.ca/Publications/Popest/Population/Population%20Estimates%20Report,%20July%201,%202016.pdf. Population estimates are based on the 2011 census counts adjusted for net census under coverage. Nunavut totals include unorganized areas and outpost camps.

2 Nunavut Bureau of Statistics, Population Estimates July 1, 2016, www.stats.gov.nu.ca/Publications/Popest/Population/Population%20Estimates%20Report,%20July%201,%202016.pdf. Population estimates are based on the 2011 census counts adjusted for net census undercoverage. Nunavut totals include unorganized areas and outpost camps.

3 Department of Health, Division of Finance Freebalance Report

4 2016/2017 Capital Estimates, Government of Nunavut

5 2016/2017 Financial Management Board ROD # FB-16-15-8(a)

The Department is responsible for delivering health care services to Nunavummiut, including the operation of community health centres, regional health centres, and a hospital. There are three regional offices that manage the delivery of health services at a regional level. Iqaluit operations are administered separately. The Government of Nunavut opted for decentralization to regional offices to support front-line workers and community based delivery of a wide range of health programs and services.

1.2 REPORTING RELATIONSHIP

Legislation governing the administration of health services in Nunavut was carried over from the Northwest Territories (as Nunavut statutes) pursuant to the *Nunavut Act*. The *Medical Care Act* governs who is covered by the Nunavut Health Care Plan and the payment of benefits for insured medical services. Section 23(1) of the *Medical Care Act* requires the Minister responsible for the Act to appoint a Director of Medical Insurance.

The Director is responsible for the administration of the Act and Regulations. Section 24 requires the Director to submit an annual report on the operation of the Nunavut Health Care Plan to the Minister for tabling in the Legislative Assembly. On November 4, 2016 the Director of Medical Insurance Annual Report 2015–2016 was tabled in the Legislative Assembly.

1.3 AUDIT OF ACCOUNTS

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Nunavut. The most recent audited report was issued November 7, 2016.

2.0 COMPREHENSIVENESS

2.1 INSURED HOSPITAL SERVICES

Insured hospital services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and Regulations, sections 2 to 4. No amendments were made to the Act or Regulations in 2016–2017.

In 2016–2017, insured hospital services were delivered in 28 facilities across Nunavut including: one general hospital (Iqaluit); two regional health facilities (Rankin Inlet and Cambridge Bay); 22 community health centres; two public health facilities (Iqaluit and Rankin Inlet); and one family practice clinic (Iqaluit). Rehabilitative treatment is available through the Timimut Ikajuksivik Centre located in Iqaluit or via contracted services in other regions.

The Qikiqtani General Hospital (QGH) is currently the only acute care facility in Nunavut providing a range of in-and out-patient hospital services as defined by the *Canada Health Act*. QGH offers 24-hour emergency services, in-patient care (including obstetrics, paediatrics and palliative care), surgical services, laboratory services, diagnostic imaging, respiratory therapy, and health records and information.

Currently, Rankin Inlet is providing 24-hour care for in-patients; out-patients receive care by on-call staff. Cambridge Bay is providing daily clinic hours, and emergency care is available, on-call, 24-hours a day. There are also a limited number of birthing beds at both facilities. Other community health centres provide public health services, out-patient services and urgent treatment services.

Public health services are provided at public health clinics located in Rankin Inlet and Iqaluit. Public health programing is provided in the remaining communities through the local health centre. The Department also operates a Family Practice Clinic, led by Nurse Practitioners, in Iqaluit.

The Family Practice Clinic has the ability to consult physicians and specialists as needed. It was established in 2006 with funding from the Primary Health Care Transition Fund, and has been successful in helping to reduce pressure on the emergency and out-patient departments of the QGH during working hours. The clinic provides a steady source of primary care appointments and initiatives, such as a Diabetes Clinic and a Sexual Health Program.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities in the territory.

Insured in-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case-room and anaesthetic facilities; use of radiotherapy and physiotherapy services where available; psychiatric services provided under an approved program; and services rendered by persons who are paid by the hospital.

Out-patient services include: laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy, limited audiology and speech therapy services in an out-patient facility or in an approved hospital; and psychiatric services provided under an approved hospital program.

The Department makes the determination to add insured hospital services based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Financial Management Board. No new services were added in 2016–2017 to the list of insured hospital services.

2.2 INSURED PHYSICIAN SERVICES

The Medical Care Act, section 3(1), and *Medical Care Regulations*, section 3, provide for insured physician services in Nunavut. No amendments were made to the Act or Regulation in 2016–2017. The *Nursing Act* allows for licensure of nurse practitioners in Nunavut; this permits nurses to deliver insured services in Nunavut.

Upon initial registration physicians must be in good standing with a College of Physicians and Surgeons from a Canadian jurisdiction, and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. Nunavut recruits and contracts its own family physicians, and accesses specialist services primarily from its main referral centres in Ottawa, Edmonton, Winnipeg, and Yellowknife. Recruitment of full-time family physicians has improved significantly and there are 26 family physician positions, covered by a combination of locums and full-time physicians, funded through the Department, providing over 7,501 days of service annually across the territory.

Of the 26 full-time family physician positions in Nunavut, 16 are in the Qikiqtaaluk region; 7.5 in the Kivalliq region; and 2.5 in the Kitikmeot region. There are also 1.5 general surgeon positions, one anaesthetist position, and 2.5 paediatricians positions at the QGH. Visiting specialists, general practitioners and locums also provide insured physician services; these arrangements are made by each of the Department's three regions.

Physicians can elect to collect fees other than those under the Medical Care Plan in accordance with section 12(2) (a) or (b) of the *Medical Care Act* by notifying the Director 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 2016–2017, no physicians provided written notice of this election. All physicians practicing in Nunavut are under contract with the Department. In 2016–2017, 155 physicians provided service in Nunavut.

Insured physician services refer to all services rendered by medical practitioners that are medically required. Where insured services are unavailable in some places in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has health service agreements with medical and treatment centres in Ottawa, Winnipeg, Churchill, Yellowknife and Edmonton. These are the out-of-territory sites to which Nunavut mainly refers its patients to access medical services not available within the territory.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service. Then the decision of the group would be presented to Cabinet for approval. No insured physician services were added or deleted in 2016–2017.

2.3 INSURED SURGICAL-DENTAL SERVICES

Dentists providing insured surgical-dental services under the Nunavut Health Care Plan must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999). Billing numbers are provided for billing the Plan regarding the provision of insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance; for example, orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis, but on rare occasions, for medically complicated situations, patients are flown out of the territory.

The addition of new surgical-dental services to the list of insured services requires government approval. No new services were added to the list in 2016–2017.

2.4 UNINSURED HOSPITAL, PHYSICIAN AND SURGICAL-DENTAL SERVICES

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include: yearly physicals; cosmetic surgery; services that are considered experimental; prescription drugs; physical examinations done at the request of a third party; optometric services; dental services other than specific procedures related to jaw injury or

disease; the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and physiotherapy, speech therapy and psychology services received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include: hospital charges above the standard ward rate for private or semi-private accommodation; services that are not medically required, such as cosmetic surgery; services that are considered experimental; ambulance charges (except inter-hospital transfers); dental services, other than specific procedures related to jaw injury or disease; and alcohol and drug rehabilitation, without prior approval.

In 2016–2017, the Qikiqtani General Hospital charged a $2,458 per diem rate for services provided for non-Canadian resident stays. The inpatient rate charged in Rankin Inlet and Cambridge Bay was $1,381.

When residents are sent out of the territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see section 4.2 below). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program, on behalf of 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, Yellowknife and Iqaluit), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.

3.0 UNIVERSALITY

3.1 ELIGIBILITY

Eligibility for the Nunavut Health Care Plan is briefly defined under sections 3(1), (2), and (3) of the *Medical Care Act*. The Department also adheres to the Interprovincial Agreement on Eligibility and Portability, as well as internal guidelines. No amendments were made to the Act or Regulations in 2016–2017.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be in or to remain in Canada, who makes his or her home and is ordinarily present in Nunavut, but does not include a tourist, transient or visitor to Nunavut. Eligible residents receive a health card with a unique health care number.

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. To streamline document processing, a staggered renewal process is used. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province or territory is required.

Coverage generally begins the first day of the third month after arrival in Nunavut, but first-day coverage is provided under a number of circumstances, for example, newborns whose mothers or fathers are eligible for coverage. Permanent residents (landed immigrants), returning Canadians, repatriated

Canadians, returning permanent residents, and non-Canadians who have been issued an employment visa for a period of 12 months or more, are also granted first-day coverage.

Members of the Canadian Armed Forces and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Interprovincial Agreement on Eligibility and Portability, individuals in Nunavut who are temporarily absent from their home province or territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

On March 31, 2017, 38,662 individuals were registered with the Nunavut Health Care Plan, up by 898 from the previous year. There are no formal provisions for Nunavut residents to opt out of the Nunavut Health Care Plan, and no legislated appeals process or policy related to appeals of residency or coverage decisions.

3.2 OTHER CATEGORIES OF INDIVIDUALS

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers, and individuals holding a Minister's Permit (with the possible exception of those holding a temporary resident permit who may be reviewed on a case by case basis) are not eligible for coverage. When unique circumstances occur, assessments are done on an individual basis. This is consistent with section 15 of the Northwest Territories' Guidelines for Health Care Plan Registration, which was adopted by Nunavut in 1999.

4.0 PORTABILITY

4.1 MINIMUM WAITING PERIOD

Consistent with section 3 of the Interprovincial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months, or the first day of the third month following the establishment of residency in a new province or territory, or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 COVERAGE DURING TEMPORARY ABSENCES IN CANADA

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut, but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister 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 2016– 2017 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continuing coverage. 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 individual.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability. Nunavut participates in physician and hospital reciprocal billing. As well, special bilateral agreements are in place with Ontario, Manitoba, Alberta, and the Northwest Territories. The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the territory. High-cost procedure rates, newborn rates, and out-patient rates are based on those established by the Interprovincial Health Insurance Agreements Coordinating Committee. The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

4.3 COVERAGE DURING TEMPORARY ABSENCES OUTSIDE CANADA

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or emergency services, the payment for hospital services is $2,458 per day and for out-patient care it is $335 per day.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the territory. Reimbursement is made to the insured individual or directly to the provider of the insured service.

4.4 PRIOR APPROVAL REQUIREMENT

Prior approval is required to receive reimbursement for elective services provided in private facilities in Canada or in any facility outside the country. There are no processes related to pre-approval appeals for out-of-jurisdiction coverage.

5.0 ACCESSIBILITY

5.1 ACCESS TO INSURED HEALTH SERVICES

The Medical Care Act, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services in Inuktut are also provided to patients. There is no legislated complaints process for patient charges. Patients can direct any complaints to the Office of Patient Relations of the Department of Health.

The Qikiqtani General Hospital (QGH) in Iqaluit is currently the only acute care hospital facility in Nunavut. The hospital has a total of 35 beds available for acute, rehabilitative, palliative and chronic care services but currently only 20 general purpose beds are in use due to capacity and need. There are also four birthing rooms and six day surgery beds. The facility provides in-patient, out-patient and 24-hour emergency services. On-site physicians provide emergency services on rotation. Medical services provided include: an ambulatory care/out-patient clinic emergency stabilization services, and general medical, maternity and palliative care. Surgical services provided include ophthalmology, urology, orthopaedics, gynaecology, paediatrics, general surgery, emergency trauma, otolaryngology and dental surgery under general anesthesia and conscious sedation. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include: radiology, laboratory, electrocardiogram and CT scans.

Outside of Iqaluit, out-patient and 24-hour emergency nursing services are provided by local health centres in Nunavut's 24 other communities.

Nunavut has three Continuing Care Centres located in Gjoa Haven, Igloolik and Cambridge Bay. These facilities provide full time nursing and personal care to adults. The Gjoa Haven and Igloolik facilities have 10 beds each, and the Cambridge Bay facility has 8 beds.

Nunavut has agreements in place with a number of out-of-territory regional health authorities and specific facilities to provide medical specialists and other visiting health practitioner services. The following specialist services were provided in Nunavut during 2016–2017 under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics/gynecology, urology, respirology, cardiology, total joint assessment clinic (TJAC), sleep study, oral surgery, and allergist. Visiting specialist clinics are held depending on demand and availability of specialists.

Nunavut's Telehealth network, linking all 25 communities, allows for the delivery of a broad range of services over distances including specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counseling sessions; family visitation; and continuing medical education. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options, and allowing service providers and communities to use existing resources more effectively.

For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions.

5.2 PHYSICIAN COMPENSATION

All full-time physicians in Nunavut work under contract with the Department. The terms of the contracts are set by the Department. Visiting consultants are paid a daily contract rate for their professional services. Rates vary based on services rendered. The Department of Health complies with the *Financial Administration Act* (FAA) and Financial Administration Manual (FAM) in monitoring or auditing remuneration.

5.3 PAYMENTS TO HOSPITALS

Funding for the Qikiqtani General Hospital, regional health facilities and community health centres is provided through the Government of Nunavut's budget process.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Nunavummiut are aware of ongoing federal contributions through press releases and media coverage. The Government of Nunavut has also recognized the federal contribution provided through the Canada Health Transfer in various published documents. For fiscal year 2016–2017, they included:

- 2016–2017 Fiscal and Economic Indicators;
- 2016–2019 Government of Nunavut & Territorial Corporations Business Plan.

REGISTERED PERSONS

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
1. Number as of March 31st (#)[1]	35,041	35,897	36,667	37,764	38,662

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

PUBLIC FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
2. Number (#)	28	28	28	28	28
3. Payments for insured health services ($)	not available	not available	not available	not available	not available

PRIVATE FOR-PROFIT FACILITIES

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
4. Number of private for-profit facilities providing insured health services (#)	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($)	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
6. Total number of claims, in-patient (#)	3,313	3,360	3,440	3,324	3,616
7. Total payments, in-patient ($)	39,244,449	37,494,619	36,005,461	38,830,531	40,804,893
8. Total number of claims, out-patient (#)	21,686	22,113	27,137	24,853	26,790
9. Total payments, out-patient ($)	7,780,896	8,297,900	9,971,833	9,638,408	11,369,138

INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
10. Total number of claims, in-patient (#)	1	1	0	1	0
11. Total payments, in-patient ($)	4,410	20,574	0	2,780	0
12. Total number of claims, out-patient (#)	0	20	14	12	7
13. Total payments, out-patient ($)	0	20,041	25,388	12,411	10,732

[1] The difference in the number of registered Nunavut residents and those covered under the Nunavut Health Care Plan is due to delays in the reconciliation of data on residents who have left the territory.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
14. Number of participating physicians (#)	409	349	289	278	155
15. Number of opted-out physicians (#)	0	0	0	0	0
16. Number of non-participating physicians (#)	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($)	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($)[2]	403,418	348,473	54,501	152,815	502,572[3]

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
19. Number of services (#)	80,311	80,682	96,070	93,365	99,539
20. Total payments ($)	6,341,047	6,855,743	7,607,809	8,088,273	8,694,011[4]

INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA

Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
21. Number of services (#)	15	82	29	14	13
22. Total payments ($)	732	7,346	1,803	667	718

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY

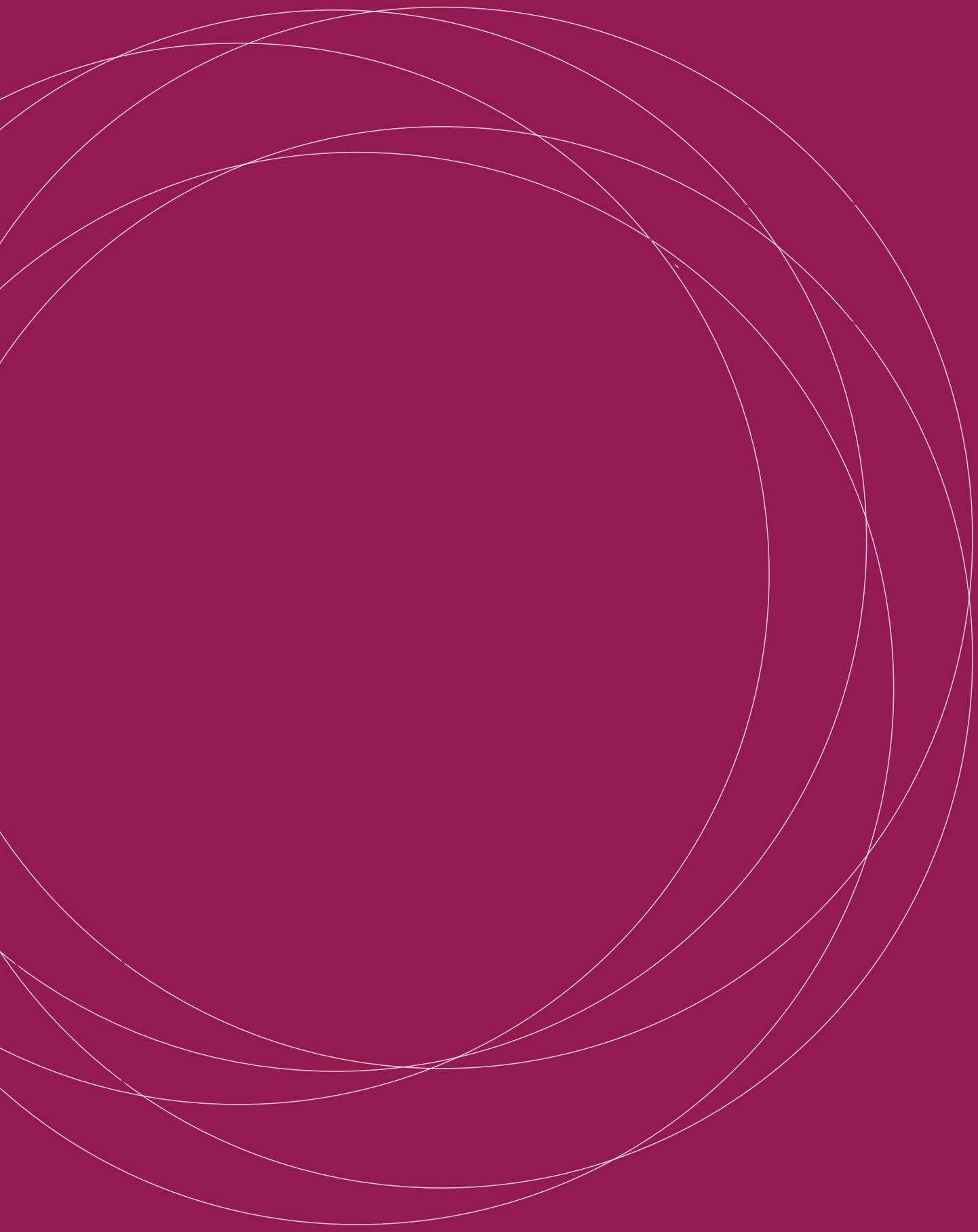
Year	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017
23. Number of participating dentists (#)	not available	not available	not available	not available	not available
24. Number of opted-out dentists (#)[a]	not available	not available	not available	not available	not available
25. Number of non-participating dentists (#)[a]	not available	not available	not available	not available	not available
26. Number of services provided (#)	not available	not available	not available	not available	not available
27. Total payments ($)	not available	not available	not available	not available	not available

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

[2] Typically, Nunavut does not pay its physicians through fee-for-service. Instead, the majority of physicians are compensated through contracted salaries.

[3] For 2016–17 this is the amount for the period April 1, 2016 to March 31, 2017.

[4] For 2016–17 this is the amount as of August 2017. Bills are accepted until March 2018.



ANNEX A

CANADA HEALTH ACT AND *EXTRA-BILLING AND USER CHARGES INFORMATION REGULATIONS*

This annex provides the reader with an office consolidation of the *Canada Health Act* and the *Extra-billing and User Charges Information Regulations*. An office consolidation is a rendering of the original Act, which includes any amendments that have been made since the Act's passage. The only regulations in force under the Act are the *Extra-billing and User Charges Information Regulations*. These regulations require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with any estimated charges can be made. These regulations are also presented in an office consolidation format. This unofficial consolidation is not necessarily current and is provided for the convenience of the reader only. For the official text of the *Canada Health Act*, please contact Justice Canada.

CANADA

CONSOLIDATION

CODIFICATION

Canada Health Act

Loi canadienne sur la santé

R.S.C., 1985, c. C-6

L.R.C. (1985), ch. C-6

Current to December 11, 2017

Last amended on June 29, 2012

À jour au 11 décembre 2017

Dernière modification le 29 juin 2012

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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (2) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence
31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

Inconsistencies in Acts
(2) In the event of an inconsistency between a consolidated statute published by the Minister under this Act and the original statute or a subsequent amendment as certified by the Clerk of the Parliaments under the *Publication of Statutes Act*, the original statute or amendment prevails to the extent of the inconsistency.

NOTE

This consolidation is current to December 11, 2017. The last amendments came into force on June 29, 2012. Any amendments that were not in force as of December 11, 2017 are set out at the end of this document under the heading "Amendments Not in Force".

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (2) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1er juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve
31 (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

Incompatibilité — lois
(2) Les dispositions de la loi d'origine avec ses modifications subséquentes par le greffier des Parlements en vertu de la *Loi sur la publication des lois* l'emportent sur les dispositions incompatibles de la loi codifiée publiée par le ministre en vertu de la présente loi.

NOTE

Cette codification est à jour au 11 décembre 2017. Les dernières modifications sont entrées en vigueur le 29 juin 2012. Toutes modifications qui n'étaient pas en vigueur au 11 décembre 2017 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

TABLE OF PROVISIONS

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

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R.S.C., 1985, c. C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

L.R.C., 1985, ch. C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Preamble

WHEREAS the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de

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:

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

Titre abrégé

1 *Loi canadienne sur la santé.*

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 Transfer that may be provided to a province under sections 24.2 and 24.21 of the *Federal-Provincial Fiscal Arrangements Act*; (*contribution pécuniaire*)

contribution [Repealed, 1995, c. 17, s. 34]

dentist means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person; (*dentiste*)

extended health care services means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,

(b) adult residential care service,

(c) home care service, and

(d) ambulatory health care service; (*services complémentaires de santé*)

extra-billing means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province; (*surfacturation*)

health care insurance plan means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services; (*régime d'assurance-santé*)

Définitions

Définitions

2 Les définitions qui suivent s'appliquent à la présente loi.

assuré Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) [Abrogé, 2012, ch. 19, art. 377]

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés. (*insured person*)

contribution [Abrogée, 1995, ch. 17, art. 34]

contribution pécuniaire La contribution au titre du Transfert canadien en matière de santé qui peut être versée à une province au titre des articles 24.2 et 24.21 de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*. (*cash contribution*)

dentiste Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice. (*dentist*)

frais modérateurs Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé,

health care practitioner means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person; (*professionnel de la santé*)

hospital includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(a) a hospital or institution primarily for the mentally disordered, or

(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children; (*hôpital*)

hospital services means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(b) nursing service,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the hospital,

(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(f) medical and surgical equipment and supplies,

(g) use of radiotherapy facilities,

(h) use of physiotherapy facilities, and

(i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations; (*services hospitaliers*)

insured health services means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation; (*services de santé assurés*)

à l'exception des frais imposés par surfacturation. (*user charge*)

habitant Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province. (*resident*)

hôpital Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants. (*hospital*)

loi de 1977 [Abrogée, 1995, ch. 17, art. 34]

médecin Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice. (*medical practitioner*)

ministre Le ministre de la Santé. (*Minister*)

professionnel de la santé Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit. (*health care practitioner*)

régime d'assurance-santé Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés. (*health care insurance plan*)

services complémentaires de santé Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires. (*extended health care services*)

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

insured person means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,

(b) [Repealed, 2012, c. 19, s. 377]

(c) a person serving a term of imprisonment in a penitentiary as defined in 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; (*assuré*)

medical practitioner means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person; (*médecin*)

Minister means the Minister of Health; (*ministre*)

physician services means any medically required services rendered by medical practitioners; (*services médicaux*)

resident means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province; (*habitant*)

surgical-dental services means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures; (*services de chirurgie dentaire*)

user charge means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing. (*frais modérateurs*)

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11; 2012, c. 19, ss. 377, 407.

être accomplis convenablement qu'en un tel établissement. (*surgical-dental services*)

services de santé assurés Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail. (*insured health services*)

services hospitaliers Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements. (*hospital services*)

services médicaux Services médicalement nécessaires fournis par un médecin. (*physician services*)

surfacturation Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé. (*extra-billing*)

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11; 2012, ch. 19, art. 377 et 407.

Canadian Health Care Policy

Primary objective of Canadian health care policy

3 It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

Purpose

Purpose of this Act

4 The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

Cash Contribution

Cash contribution

5 Subject to this Act, as part of the Canada Health Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36; 2012, c. 19, s. 408.

6 [Repealed, 1995, c. 17, s. 36]

Program Criteria

Program criteria

7 In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;

(b) comprehensiveness;

(c) universality;

(d) portability; and

(e) accessibility.

1984, c. 6, s. 7.

Politique canadienne de la santé

Objectif premier

3 La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

Raison d'être

Raison d'être de la présente loi

4 La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

Contribution pécuniaire

Contribution pécuniaire

5 Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé (ci-après, « Transfert »).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36; 2012, ch. 19, art. 408.

6 [Abrogé, 1995, ch. 17, art. 36]

Conditions d'octroi

Règle générale

7 Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti 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.

Public administration

8 (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9 In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10 In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Gestion publique

8 (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité

9 La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité

10 La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Portability

11 (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Transférabilité

11 (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie 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) prévoie 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.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of *elective insured health services*

(3) For the purpose of subsection (2), ***elective insured health services*** means insured health services other than services that are provided in an emergency or in any

Définition de *services de santé assurés facultatifs*

(3) Pour l'application du paragraphe (2), ***services de santé assurés facultatifs*** s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence

other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Accessibility

12 (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibilité

12 (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie 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) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)c) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa a), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa b), sauf par une loi de la province.

1984, ch. 6, art. 12.

Conditions for Cash Contribution

Conditions

13 In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(b) shall give recognition to the Canada Health Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37; 2012, c. 19, s. 409(E).

Contribution pécuniaire assujettie à des conditions

Obligations de la province

13 Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37; 2012, ch. 19, art. 409(A).

Defaults

Referral to Governor in Council

14 (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

Manquements

Renvoi au gouverneur en conseil

14 (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

(c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15 (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Décret de réduction ou de retenue

15 (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Reimposition of reductions or withholdings

16 In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17 Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

Extra-billing and User Charges

Extra-billing

18 In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19 (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an inpatient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20 (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information

Nouvelle application des réductions ou retenues

16 En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17 Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

Surfacturation et frais modérateurs

Surfacturation

18 Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19 (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20 (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les

provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21 Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21 Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

Regulations

Regulations

22 (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs (a) to (d) of the definition *extended health care services* in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to the Canada Health Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40; 2012, c. 19, s. 410(E).

Règlements

Règlements

22 (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas a) à d) de la définition de *services complémentaires de santé* à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13a) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13b).

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)a) ou b) qu'avec l'accord de chaque province.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)a) s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1er avril 1984.

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)c) ou d) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40; 2012, ch. 19, art. 410(A).

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

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

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.

satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

CANADA

CONSOLIDATION

CODIFICATION

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

Current to December 11, 2017

À jour au 11 décembre 2017

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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (3) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence
31 (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

...

Inconsistencies in regulations
(3) In the event of an inconsistency between a consolidated regulation published by the Minister under this Act and the original regulation or a subsequent amendment as registered by the Clerk of the Privy Council under the *Statutory Instruments Act*, the original regulation or amendment prevails to the extent of the inconsistency.

NOTE

This consolidation is current to December 11, 2017. Any amendments that were not in force as of December 11, 2017 are set out at the end of this document under the heading "Amendments Not in Force".

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (3) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1er juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve
31 (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

[...]

Incompatibilité — règlements
(3) Les dispositions du règlement d'origine avec ses modifications subséquentes enregistrées par le greffier du Conseil privé en vertu de la *Loi sur les textes réglementaires* l'emportent sur les dispositions incompatibles du règlement codifié publié par le ministre en vertu de la présente loi.

NOTE

Cette codification est à jour au 11 décembre 2017. Toutes modifications qui n'étaient pas en vigueur au 11 décembre 2017 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

TABLE OF PROVISIONS

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

TABLE ANALYTIQUE

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

Registration
SOR/86-259 February 27, 1986

CANADA HEALTH ACT

Extra-billing and User Charges Information Regulations

P.C. 1986-499 February 27, 1986

Whereas the Minister of National Health and Welfare has consulted with the Ministers responsible for health care in the provinces respecting proposed *Regulations prescribing the types of information that the Minister may require under paragraph 13(a) of the Canada Health Act in respect of extra-billing and user charges and the times at which and the manner in which such information shall be provided by the government of each province*.

Therefore, Her Excellency the Governor General in Council, on the recommendation of the Minister of National Health and Welfare, pursuant to paragraph 22(1)(c) of the *Canada Health Act*[*], is pleased hereby to make the annexed *Regulations prescribing the types of information that the Minister of National Health and Welfare may require under paragraph 13(a) of the Canada Health Act in respect of extra-billing and user charges and the times at which and the manner in which such information shall be provided by the government of each province*, effective April 1, 1986.

[*] S.C. 1984, c. 6

Enregistrement
DORS/86-259 Le 27 février 1986

LOI CANADIENNE SUR LA SANTÉ

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

C.P. 1986-499 Le 27 février 1986

Vu que le ministre de la Santé nationale et du Bien-être social a consulté ses homologues chargés de la santé dans les provinces quant au projet de *Règlement déterminant les genres de renseignements sur la surfacturation et les frais modérateurs dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province*;

À ces causes, sur avis conforme du ministre de la Santé nationale et du Bien-être social et en vertu de l'alinéa 22(1)c) de la *Loi canadienne sur la santé*[*], il plaît à Son Excellence le Gouverneur général en conseil de prendre, à compter du 1er avril 1986, le *Règlement déterminant les genres de renseignements dont peut avoir besoin le ministre de la Santé nationale et du Bien-être social en vertu de l'alinéa 13a) de la Loi canadienne sur la santé quant à la surfacturation et aux frais modérateurs et fixant les modalités de temps et les autres modalités de leur communication par le gouvernement de chaque province*, ci-après.

[*] S.C. 1984, ch. 6

Regulations Prescribing the Types of Information that the Minister of National Health and Welfare may Require under Paragraph 13(a) of the Canada Health Act in Respect of Extra-Billing and User Charges and the Times at which and the Manner in which such Information shall be Provided by the Government of each Province

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

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 1er 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

provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(a) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(b) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

Times and Manner of Filing Information

5 (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(a) in respect of the estimates referred to in paragraphs 3(a) and 4(a), before April 1 of the fiscal year to which they relate; and

(b) in respect of the financial statements referred to in paragraphs 3(b) and 4(b), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(a) and 4(a) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

Communication de renseignements

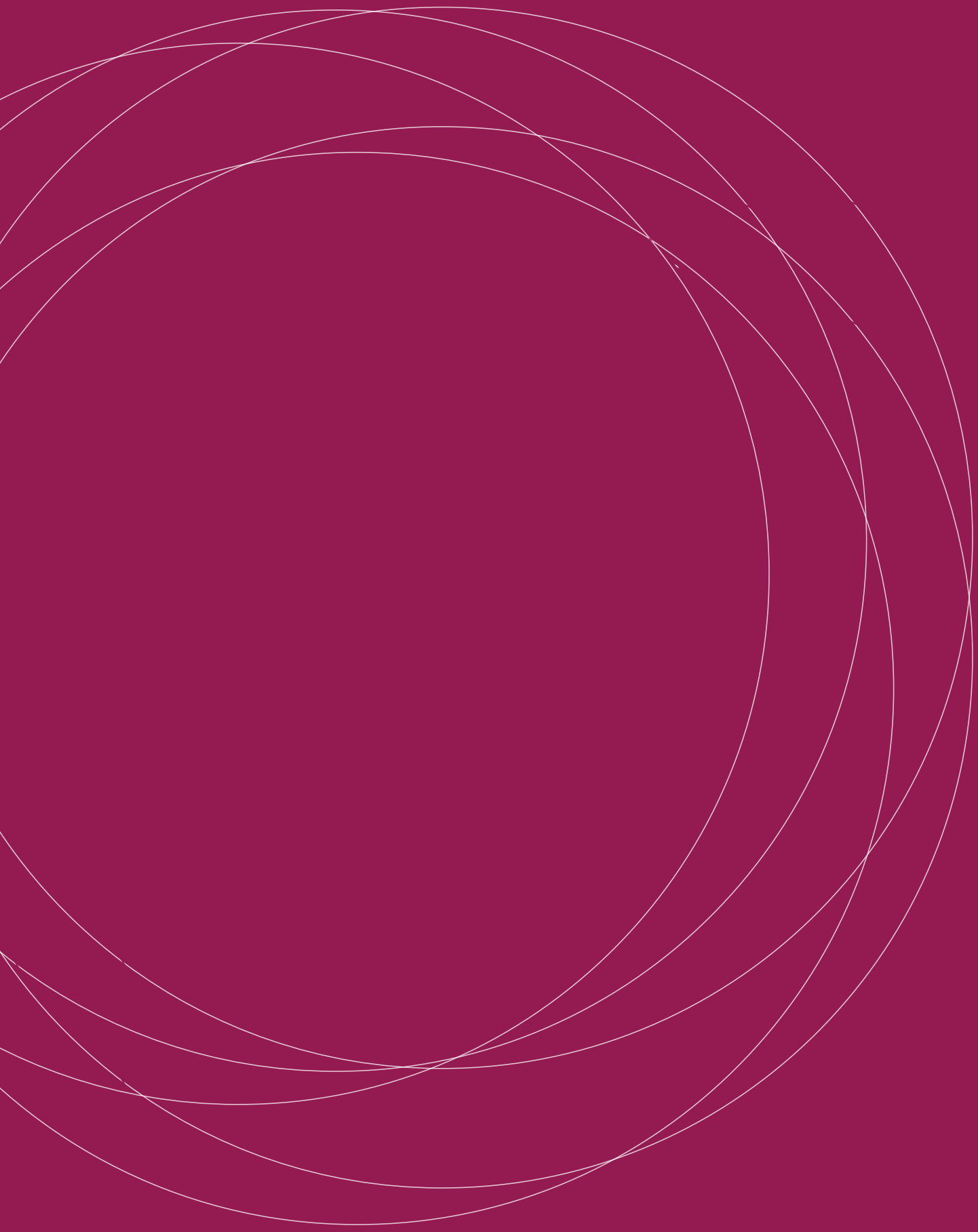
5 (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3a) et 4a), avant le 1er 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 *Canada Health Act*. 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 September 1994 Federal/Provincial/Territorial Health Ministers Meeting 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 facility that provides acute, rehabilitative or chronic care. Thus, when a provincial or 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 bonafide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act*.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bonafide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bonafide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting interprovincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a coordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse

discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

(1) to make as few regulations as possible and only if absolutely necessary;

(2) to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;

(3) to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;

(4) to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership

committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

(1) estimates and statements on extra-billing and user charges;

(2) an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985–86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp
Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate pro-vision 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:

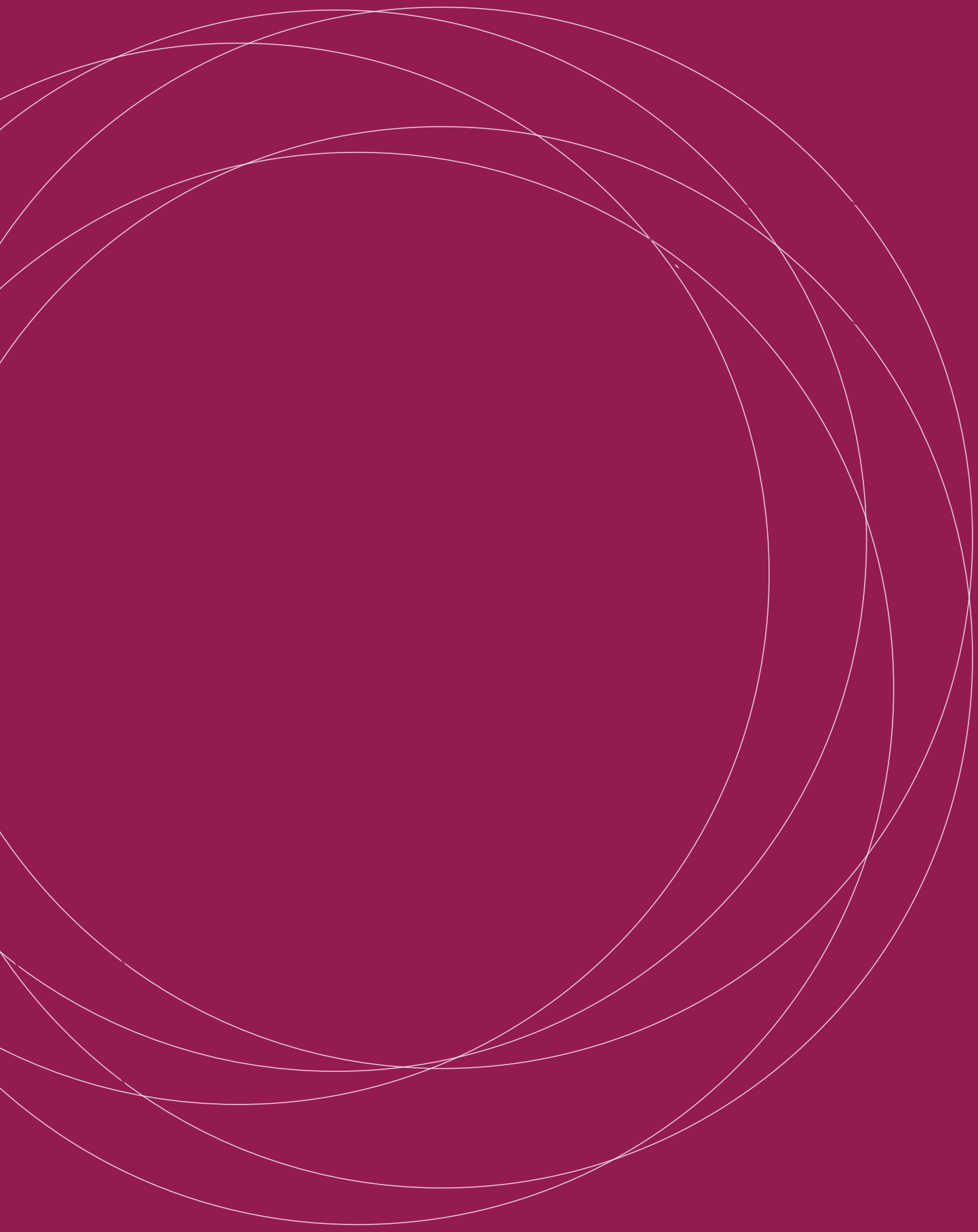
> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

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 *Canada Health Act* Dispute Avoidance and Resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's Letter to the Honourable Gary Mar, as well as a fact sheet on the *Canada Health Act* Dispute Avoidance and Resolution Process.

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act*.

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

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

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and Health Ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,
A. Anne McLellan

FACT SHEET: CANADA HEALTH ACT DISPUTE AVOIDANCE AND RESOLUTION PROCESS

SCOPE

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

DISPUTE AVOIDANCE

To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

DISPUTE RESOLUTION

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact- finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

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

PUBLIC REPORTING

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

REVIEW

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

CONTACT INFORMATION FOR PROVINCIAL AND TERRITORIAL DEPARTMENTS OF HEALTH

Newfoundland and Labrador
Department of Health and Community Services
Confederation Building
P.O. Box 8700
St. John's, NL A1B 4J6
(709) 729-5021
www.gov.nl.ca/health

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

Nova Scotia
Department of Health and Wellness
1894 Barrington Street
P.O. Box 488
Halifax, NS B3J 2R8
(902) 424-5818
1-800-387-6665 (toll-free in Nova Scotia)
1-800-670-8888 (TTY/TDD)
www.novascotia.ca/DHW

New Brunswick
Department of Health
P.O. Box 5100
Fredericton, NB E3B 5G8
(506) 457-4800
www.gnb.ca/health

Quebec
Ministry of Health and Social Services
1075 Sainte-Foy Road
Québec, QC G1S 2M1
(418) 266-7005
www.msss.gouv.qc.ca

Ontario
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1R3
1-800-268-1153
www.health.gov.on.ca

Manitoba
Manitoba Health, Seniors and Active Living
300 Carlton Street
Winnipeg, MB R3B 3M9
1-800-392-1207
www.manitoba.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6
1-800-667-7766
E-mail: info@health.gov.sk.ca
www.saskatchewan.ca

Alberta
Alberta Health
P.O. Box 1360, Station Main
Edmonton, AB T5J 2N3
(780) 427-7164
www.health.alberta.ca

British Columbia
Ministry of Health
1515 Blanshard Street
PO Box 9639 Stn Prov Govt
Victoria, BC, V8W 9P1
Toll free in B.C.: 1-800-663-7867
In Victoria: 250-387-6121
www.gov.bc.ca/health

Yukon
Department of Health and Social Services
Insured Health Services Branch H-2
P.O. Box 2703
Whitehorse, YT Y1A 2C6
1-867-667-5202
www.hss.gov.yk.ca

Northwest Territories
Department of Health and Social Services
P.O. Box 1320
Yellowknife, NWT X1A 2L9
1-800-661-0830 or 1-867-777-7413
www.hss.gov.nt.ca

Nunavut
Department of Health Government of Nunavut
P.O. Box 1000, Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
www.gov.nu.ca/health

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