Health Canada Santé Canada

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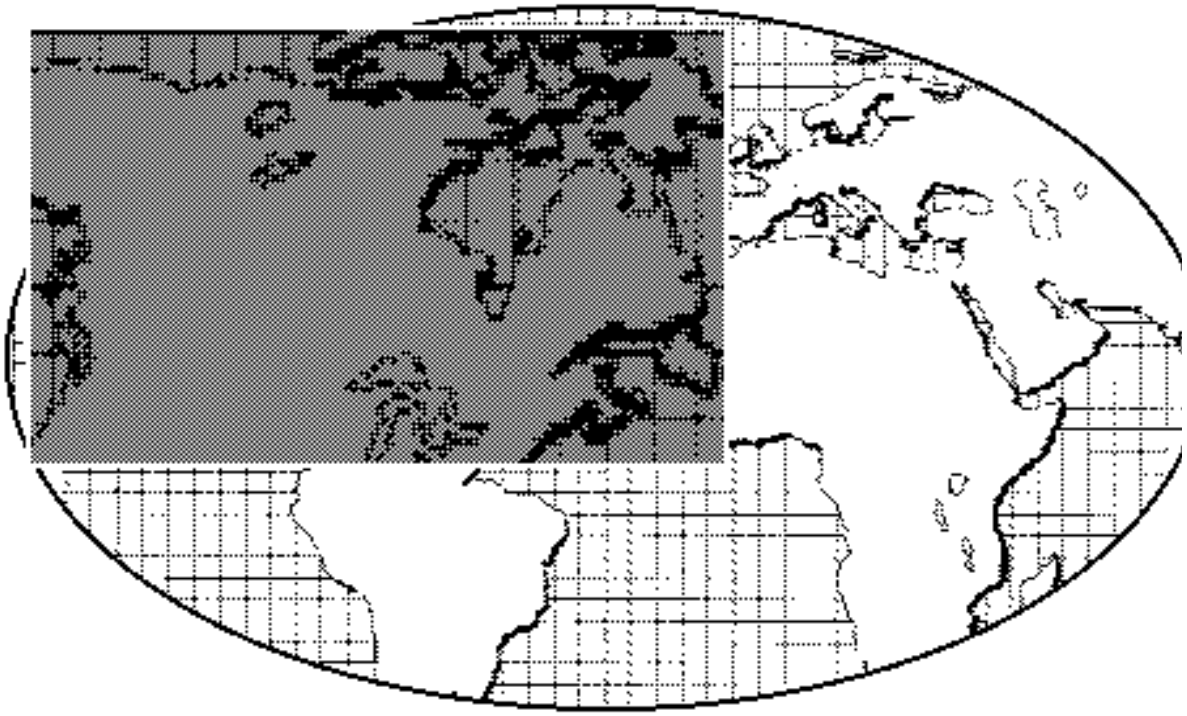

Canada Health Act Annual Report

Canada

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His Excellency, the Right Honourable Roméo LeBlanc, Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year ended March 31, 1997.

Respectfully submitted,

Allan Rock

Minister of Health

Preface

It is clear that Canadians highly value their universal, single-payer health care system. This has been demonstrated in survey after survey. It is also clear that Canadians are growing more concerned about access to quality health care services in view of the health system restructuring that has been taking place in recent years.

I recognize that health system changes have perhaps created the perception of a decline in access to high quality care. Canadians want their health system to be maintained and they support a strong federal role in this regard. I assure all Canadians that the preservation and enhancement of the health care system are clear objectives for the federal government. As Minister of Health, my watchwords are openness, collaboration, pragmatism and innovation, and I intend to abide by these standards in my work with my provincial and territorial counterparts as we continue to renew the health care system.

A pivotal event in determining a renewed federal approach to the challenges facing the health care system was the release in February 1997 of the report of the National Forum on Health, *Canada Health Action: Building on the Legacy*. The National Forum on Health was launched in October 1994 by the Right Honourable Jean Chrétien, Prime Minister of Canada, to strike up a dialogue with Canadians about health and health issues, and to advise the federal government on innovative ways to improve our health system and the health of the population.

The Forum report confirmed the value that Canadians place on their health care system and the recognition that renewal must take place. The report also noted that the principles of the *Canada Health Act* are "critical to preserving medicare, yet flexible enough to accommodate organizational reforms." In addition, the Forum concluded that, as a nation, we spend enough money on health care. What is needed is more effective and efficient use of our current resources, which is expected to occur as the restructuring process continues. In looking at the pressures faced by the provinces and territories as they restructure, the Forum recommended that the federal government assist the process by increasing the cash floor level for federal transfer payments and by providing predictable, stable funding.

In its recommendations for preserving and modernizing the health care system, the Forum suggested targeting investment today towards innovative health system delivery. Recommendations included setting up a transition fund to test and evaluate models for a renewed health care system, and developing a strategy to integrate existing health information into a national health information network.

The February 1997 Budget continued the theme of sustaining and improving the health care system by reconfirming unequivocal federal commitment to the principles of the *Canada Health Act*, and by responding to key Forum recommendations. In responding to the targeted investment recommended by the National Forum on Health, the Budget provided $300 million over the next three years devoted toward the delivery of better health services to Canadians: $150 million over three years for the creation of a Health Transition Fund to support provincial and territorial pilot projects in areas such as primary care, home care and pharmacare, in keeping with the principles of the *Canada Health Act*; $50 million over three years to begin developing a national strategy for an integrated Canadian Health Information System in collaboration with the provinces and territories; and increased funding of $100 million over three years for two current federally funded community-based programs directed to improving the health of children—the Community Action Program for Children and the Canada Prenatal Nutrition Program.

The federal government also heeded the advice of the Forum by increasing the cash floor of the federal transfer payment—the Canada Health and Social Transfer—from $11 billion to $12.5 billion. This will take effect in 1998-1999. A stable and predictable federal funding structure is now in place. Transfer payments will not be reduced again.

Canada's total health expenditures as a percentage of Gross Domestic Product are decreasing (from 9.8 percent in 1994 to 9.6 percent in 1995 to 9.5 percent in 1996), and it is restraint in public sector spending that has achieved these decreases. Even though spending has been reduced, the quality of health care has not deteriorated. This is what efficiency is all about. Our universal, publicly funded health care system is the best tool we have for controlling costs and ensuring quality care for all Canadians.

I want to continue working with my provincial and territorial counterparts to preserve and renew Medicare to better reflect new realities in health care delivery and to improve the effectiveness and efficiency of the system. I do not believe that the *Canada Health Act* impedes health system renewal. I do agree, however, that the process of interpretation and enforcement of the *Act* can be made more transparent, and to this end I am working with my counterparts in a spirit of openness and collaboration.

Allan Rock
Minister of Health

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Introduction

The *Canada Health Act (CHA)*, passed by Parliament in 1984, is the cornerstone of the Canadian health system, affirming the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The *CHA* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis. The provinces and territories are given criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers.

The purpose of this report is to meet the requirements stated in section 23 of the *Canada Health Act*, namely that

> *"The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act, and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed."*

Provinces* are required to provide information as the Minister may deem necessary for the purposes of the *Act* on the operation of their health care plans as they relate to these criteria and conditions.

Much of this report contains provincial/territorial descriptions of each health insurance plan as it relates to the criteria and conditions. In order to further fulfill the conditions of the *Act*, extended health care services activities are described at the end of each provincial section.

The report also describes the key provisions of the *Act*, the federal administration of the *Act*, the consultation process, and the federal-provincial financing arrangements.

Detailed quantitative information is available through the Policy and Consultation Branch of Health Canada and from Statistics Canada.

*Any reference to provinces includes the territories, unless otherwise specified.

Canada Health Act Overview

The *Canada Health Act* received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The *Act*, which came into force on April 1, 1984, repealed the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*.

The purpose of the *Canada Health 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."

The criteria, conditions and provisions relating to **extra-billing** and **user charges** are set out in sections 7 through 12 and sections 13, 18 and 19 of the *Act*. The criteria and extra-billing and user charge provisions apply to insured health services only, and do not pertain to extended health care services (EHCS). Only the conditions, as set out in section 13, relate to both insured health services and EHCS. The insured health services defined by the *Canada Health Act* include all medically necessary hospital services and medically required physician services, as well as medically or dentally required surgical-dental services requiring a hospital for their proper performance.

Extended health care services as specified in the *Canada Health Act*, means nursing home intermediate care, adult residential care, home care and ambulatory health care. The services are part of a broad range of health and social services offered by a variety of community and institutional programs and facilities to residents of a province. The majority of residents using these services are aged 65 and over.

The criteria and conditions that each provincial health insurance plan must meet in order to receive full federal cash contributions under the Canada Health and Social Transfer (CHST) in each fiscal year are:

Criteria

1. Public Administration

Pursuant to section 8, the health care insurance plan must be administered and operated on a non-profit basis by a public authority, responsible to the provincial government and subject to audit of its accounts and financial transactions.

2. Comprehensiveness

Pursuant to section 9, the plan must insure all insured health services provided by hospitals, medical practitioners or dentists, and, where permitted, services rendered by other health care practitioners.

3. Universality

Section 10 requires that 100 percent of the insured persons of a province be entitled to the insured health services provided for by the plan on uniform terms and conditions.

4. Portability

In accordance with section 11, residents moving to another province must continue to be covered for insured health services by the home province during any minimum waiting period imposed by the new province of residence, not to exceed three months. For insured persons, insured health services must be made available while they are temporarily absent from their own provinces on the basis that:

a) insured services received outside a province, but still in Canada, are to be paid for by the home province at host province rates unless another arrangement exists between the provinces;

b) out-of-country services are to be paid, as a minimum, on the basis of the amount that would have been paid by the home province for similar services rendered in that province.

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, while temporarily absent from the province, if the services are available on a substantially similar basis in that province.

5. ACCESSIBILITY

By virtue of section 12, the health care insurance plan of a province must provide for:

a) insured health services on uniform terms and conditions and reasonable access by insured persons to insured health services unprecluded or unimpeded, either directly or indirectly, by charges or other means;

b) reasonable compensation to physicians and dentists for all insured health services rendered;

c) payments to hospitals in respect of the cost of insured health services.

Conditions

In addition to the aforementioned criteria, the conditions that provincial governments must meet to be eligible for the full cash portion of the federal contribution and payment of insured health services and extended health care services, are:

1. the provision of information that the Minister of Health may require for the purposes of this *Act*, at the times and in the manner prescribed by the regulations;

2. the appropriate recognition of the Canada Health and Social Transfer relating to insured health services and extended health care services in the province.

Other

The *Canada Health Act* also prescribes a consultation process in the case of compliance concerning the criteria or the information and visibility conditions. In the event that the federal minister is of the opinion that a provincial plan does not satisfy any of the criteria, or the information and visibility conditions, reductions to federal contributions may be made. Prior to referring the matter to the Governor in Council, the Minister must notify the province, seek clarification from the province, report on the findings, and, if requested by the provincial health minister, meet to discuss the matter. Only upon satisfaction of the Governor in Council that the province has ceased to satisfy any one of the criteria or conditions may an order be issued to reduce or withhold cash contributions.

Regulations

The *Act* provides for the making of regulations for its administration, including regulations on:

A. EXTENDED HEALTH CARE SERVICES

The extended health care services regulations would provide for the definition in greater detail of those services listed in the *Act* as "extended health care services." The *Act* requires the agreement of each province prior to any regulations being made, unless the regulations are substantially the same as those made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

B. HOSPITAL SERVICES EXCLUSIONS

Hospital Services are defined in the *Act* (section 2) to be all medically necessary in- and out-patient services provided at a hospital, except those specifically excluded by regulations. Under the *Hospital Insurance and Diagnostic Services Act*, agreements between Canada and the provinces provided for certain "exclusions" to coverage. The purpose of the Hospital Services Exclusions Regulations under the *Canada Health Act* would be to embody established precedents and list services that may be delivered in a hospital setting, but that would not be considered insured hospital services.

Under the *Canada Health Act*, agreement is required by all provinces in order to make regulations in respect of these exclusions. To date, no regulations for "Extended Health Care Services" or "Hospital Services" exclusions have been promulgated.

C. INFORMATION

Regulations may be established to prescribe the types of information the Minister may require for the purposes of the *Act*, and the times at which and the manner in which the information shall be provided. Prior to regulations being made, the Minister must consult with the ministers responsible for health care in the provinces. The Extra-Billing and User Charges Information Regulations are regulations of this type.

D. RECOGNITION OF CONTRIBUTIONS AND PAYMENTS BY CANADA

Regulations may be made regarding the form and manner in which the provinces are required to recognize federal contributions and payments under the Canada Health and Social Transfer. Prior to enactment of these regulations, the Minister must consult with the provincial health ministers.

Federal Contributions and Payments

Federal-Provincial-Territorial Health Financing Arrangements

Through fiscal year 1995-96, the federal government contributed to the operation of provincial/territorial health insurance plans according to the provisions of the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*. Under this Act, provinces and territories were entitled to equal per capita federal health contributions ($526.41 per capita in 1995-96), escalated annually. The escalator, a three-year compound moving average rate of increase in nominal Gross National Product per capita, was applied to the 1975-76 federal contributions per capita to provincial hospital and medical insurance plans, then multiplied by the population of each province to determine the provincial entitlement.

In past years, adjustments were made to the escalator because of the need to restrain federal expenditures. In 1986-87, Established Programs Financing (EPF) growth was limited to the rate of growth as determined by the escalator, less two percentage points. The February 20, 1990 federal budget froze per capita transfers for 1990-91 and 1991-92 at the 1989-90 level. This meant that the transfer payments for 1990-91 and 1991-92 would be adjusted only according to changes in the population of each province, or an estimated one percent increase nationally. The February 26, 1991 budget further extended the 1989-90 level freeze to 1994-95. For 1995-96, legislation provided for EPF entitlements to grow in accordance with the escalator, less three percentage points.

Health contributions to the provinces consist of both cash and an equalized tax transfer. Under EPF, the federal government transferred a total of 13.5 personal income tax points and one corporate income tax point to all provinces in support of post-secondary education and health programs. In the case of Quebec, an additional 8.5 personal income tax points were transferred under Part VII of the Act as a special abatement originating under the *Established Programs (Interim Arrangements) Act*.

In order to determine cash amounts payable to the provinces for health care, the total value of the tax transfer was first determined. This equalized tax transfer was then subtracted from the total provincial health entitlement in respect of insured health services. The difference was paid in the form of a monthly cash contribution to each province, provided the provincial plan satisfied the criteria and conditions set out in the *Canada Health Act*.

Provinces also received equal per capita cash payments in respect of extended health care services. These services are defined in the *Canada Health Act*. This payment, which was initially set at $20 per capita in 1977-78, was escalated annually by the same escalator applied to the health contributions. In 1995-96, this payment was $51.32 (part of the $526.41 per capita contribution mentioned above). It was payable to the provinces provided the two conditions of information and recognition set out in the *Canada Health Act* were satisfied.

The *Canada Health and Social Transfer* (CHST) was introduced in the 1995 Budget Bill. The consequential amendments to the *Canada Health Act* did not affect any of the criteria or conditions of the Act, nor any of the provisions for their enforcement.

The CHST replaces federal social assistance funding previously made under the *Canada Assistance Plan* and health and post-secondary education funding made under the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*. Any penalties to be levied under the *Canada Health Act* will result in deductions to the CHST. Details relating to the type and amount of those deductions are reported in the following table.

Table I

Summary of Deductions Pursuant to the *Canada Health Act*

(in dollars)

April 1, 1996 to March 31, 1997

	User Charges	Extra-Billing	Other	Total
Newfoundland	96,000	0	0	96,000
Prince Edward Island	0	0	0	0
Nova Scotia	72,000	0	0	72,000
New Brunswick	0	0	0	0
Quebec	0	0	0	0
Ontario	0	0	0	0
Manitoba	588,000	0	0	588,000
Saskatchewan	0	0	0	0
Alberta	1,266,000	0	0	1,266,000
British Columbia	0	0	0	0
Northwest Territories	0	0	0	0
Yukon	0	0	0	0
CANADA	**2,022,000**	0	**0**	**2,022,000**

Health Insurance Division
Intergovernmental Affairs Directorate
Policy and Consultation Branch
Health Canada

Extra-Billing/User Charges Provisions

The *Canada Health Act* states 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*."

This principle of accessibility is reflected by specific provisions in the *Canada Health Act* intended to discourage extra-billing and user charges.

The *Canada Health Act* stipulates that a province may only qualify for a full cash contribution for insured health services if no payments under the provincial plan have been subject to extra-billing. Additionally, the province must not permit user charges for insured health services under the plan, except as provided for under subsection 19 (2) respecting persons who require chronic care and who are more or less permanently residing in a hospital or other institution. If it has been determined that either extra-billing or user charges, or both, exist in a province, then a mandatory deduction is to be made from the federal cash contribution. The amount of such a deduction for a fiscal year is an amount that, on the basis of information provided by the province in accordance with the Extra-Billing and User Charges Information Regulations, the federal minister of health determines to have been charged through extra-billing or user charges. Where a province does not provide the information according to the Regulations, the amount of the deduction is an amount that the Minister estimates to have been so charged pursuant to subsections 20 (1), 20 (2) and 20 (3) of the *Canada Health Act*.

Subsection 20 (5) of the *Canada Health Act* provided an incentive for the early elimination of these charges. A province that ended extra-billing or user charges within three years of the coming into force of the *Canada Health Act*, that is, before April 1, 1987, was entitled to have the total amount of deductions refunded. All provinces in which direct charges existed did, in fact, establish or revise laws, regulations or practices to comply with the extra-billing and user charge conditions by the established deadline. Consequently, prior withheld funds were paid to the provinces as required under the *Canada Health Act*. Deductions made beginning April 1, 1987 have not been refunded.

Canada Health Act Administration

The *Canada Health Act* aims to ensure that all residents of Canada have access to necessary health care on a prepaid basis, by establishing criteria and conditions for the provinces and territories to qualify for their full share of federal transfers made by the Minister of Finance under the Canada Health and Social Transfer (CHST). The Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges.

On behalf of the Minister, the Health Insurance Division of Health Canada ensures systematic monitoring of the criteria and conditions. Accordingly, during the year under review, a number of issues related to possible non-compliance were identified and resolved, while others are currently under review. As in the past, recommendations concerning potential deductions are presented to the Minister for approval. Once the Minister has authorized deductions, amounts are communicated to the Department of Finance. The Department of Finance makes the actual deductions from the twice-monthly CHST payments to the provinces and territories. The Division also carries out the consultative, analytic and administrative functions of the *Canada Health Act*.

As well as being responsible for the administration of the *Canada Health Act*, officials co-ordinated activities and consulted with provincial counterparts on matters relating to the *Act*, through such mechanisms as the Federal-Provincial Advisory Committee on Health Services. This committee, which consists of senior provincial and territorial officials and representatives of the federal government, serves as a continuing forum for consultation and information exchange.

Coordinating Committee on Reciprocal Billing (CCRB)

The Coordinating Committee on Reciprocal Billing (CCRB) was formed in 1991 to identify issues arising from interprovincial billing arrangements for medical and hospital services. Committee members are also mandated to resolve administrative complexities at the operational level. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements.

The Committee's work spans a wide spectrum of residency and billing issues relevant to interprovincial portability. An ongoing objective is the establishment of fair and reasonable rates for hospital visits, whether on an in-patient or out-patient basis. The Committee has contributed significantly to the development of interprovincial rates for high-cost procedures such as lithotripsy, MRI and vital organ transplants.

Newfoundland, Quebec, Ontario and Alberta are currently members along with the federal government, whose representative chairs the Committee. Other provinces and territories contribute through regular liaison with Committee members. The information exchanges and projects that have flowed from the Committee's work have demonstrated a commitment to ensuring Canadians maintain health care coverage when moving or travelling within Canada.

The Coordinating Committee reports to the Advisory Committee on Health Services.

Health Insurance Supplementary Fund

In rare instances, individuals, through no fault of their own, have lost or been unable to obtain coverage for insured health services under the *Canada Health Act*, and in accordance with the Federal-Provincial Agreement on Eligibility and Portability. The Health Insurance Supplementary Fund was established pursuant to Vote L16b, *Appropriation Act No. 2, 1973*, to assist these individuals. Contributions to the Fund are made by all provinces in proportion to population and are matched by the federal government. The Fund is administered by the Health Insurance Division. During 1996-97, no payments were made from this fund. The balance of the fund on March 31, 1997 was $28,387.

Information

Ministers have agreed that the most efficient approach to information exchange is to fully utilize and, where necessary, build upon existing joint information systems. Extra-Billing and User Charges Information Regulations were promulgated by the Governor in Council. Also, at the request of the Minister of Health, annual statements are provided by provincial health ministers. These statements describe operations of provincial plans in relation to the *Canada Health Act* and are incorporated in the production of this report.

PROVINCIAL AND TERRITORIAL

HEALTH CARE INSURANCE PLANS

Newfoundland

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Hospital Insurance Plan is operated by a division of the provincial Department of Health.

The Medical Care Plan is operated by the Newfoundland Medical Care Commission, a public authority appointed by the provincial government and responsible to the Minister of Health. Both plans are non-profit and all transactions are audited by the Auditor General of the province.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured services provided by hospitals and community health centres include in- and out-patient services. In-patient services include accommodation and meals at the standard or public ward level; nursing services; laboratory, radiological and other diagnostic procedures; drugs; medical and surgical use of operating room, case room and anaesthetic facilities; and rehabilitative service, i.e., physiotherapy, occupational therapy, speech language pathology and audiology.

Out-patient services include laboratory, radiological and other diagnostic procedures; rehabilitative services; out-patient and emergency visits; and day surgery.

Hospital services not covered by the Plan include preferred accommodation at the patient's request; cosmetic surgery and other services deemed to be medically unnecessary; ambulance or other patient transportation prior to 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 and appliances issued for use after discharge from hospital; bedside telephones, radios or television sets for personal, non-teaching use; fibreglass splints; services covered by Workers' Compensation legislation or by other federal or provincial legislation; and services relating to therapeutic abortions performed outside Canada.

The Department of Health administers the Emergency Air Ambulance Program for the transportation of patients within the province and to hospitals outside the province where warranted. Also included are the conveyance of patients, medical staff, and equipment to and from isolated communities. The Ground Emergency Ambulance Program assists in making ambulance services available to all residents at a reasonable rate. Users are required to pay co-payment charges in both cases.

Kidney donors and bone marrow/stem cell donors are eligible for financial assistance when the recipient is a Newfoundland* resident eligible for coverage under the Newfoundland Hospital Insurance Plan and the Medical Care Plan.

MEDICAL CARE PLAN

Insured services include a wide range of medically required general and specialist physician services, including office, hospital or home visits; diagnosis and treatment of illness and injuries; care and treatment surrounding operations, including anaesthesia; and radiology services. A limited number of in-hospital surgical-dental services are covered, including the administration of general anaesthesia for other non-insured dental-surgical procedures carried out in hospitals.

Services not covered by the Plan are the dispensing by a physician of medicines, drugs or medical appliances and the issuing of prescriptions; examinations such as those for employment or insurance purposes not necessitated by illness; cosmetic surgery; acupuncture; eyeglasses; drugs, vaccines and cost of materials; services rendered by practitioners such as optometrists, chiropractors, podiatrists, osteopaths, denturists, psychologists, physiotherapists, audiologists and paramedical personnel; ambulance services and other forms of patient transportation; testimony in court; any

* Any reference to Newfoundland includes Labrador.

services rendered by a physician to the spouse and children of the physician; the time taken or expenses incurred in travelling to consult a beneficiary; reversal of sterilization procedures; *in vitro* fertilization; vaccination for travelling purposes; preparation of records, reports and certificates or advice by telephone; and services covered by Workers' Compensation legislation or other federal or provincial legislation.

Dental Health Plan

In addition to the basic insured health services, the provincial government provides a Children's Dental Health Plan that provides basic dental coverage up to and including 12 years of age. Basic services are also available for social assistance recipients aged 13 to 17. Relief of pain and infection services are available for adult recipients of social assistance.

Seniors' Drug Subsidy Plan

The provincial Department of Health provides a senior citizens' drug subsidy program for all residents over 65 years of age who are in receipt of the Guaranteed Income Supplement from the federal government and who are registered with Old Age Security.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

All insured residents of the province are entitled to coverage, with the exception of regular members of the Canadian Forces, members of the Royal Canadian Mounted Police and persons serving a prison term in a federal penitentiary. No premium payment exists. Registration under the Medical Care Plan and possession of a valid Medical Care Plan card are required in order to have access to insured services.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

Insured persons moving to Newfoundland from other provinces or territories are entitled to coverage as of the first day of the third month following the month of arrival, whereas persons arriving from outside Canada to establish residence are entitled to coverage as of the day of arrival, as are discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the Medical Care Plan. Immediate coverage is provided to persons from outside Canada who are authorized to work in the province for one year or more.

Persons must reside within the province for a minimum of four months each year in order to qualify for coverage. However, persons temporarily absent from the province may be granted an extension of 12 months' coverage, providing satisfactory evidence is given that they intend to return.

Payment Arrangements In Canada

Hospital costs incurred in other provinces or territories are paid for through reciprocal billing, an arrangement established between the provinces and territories. In-patient costs are paid at rates approved by the host province or territory and out-patient costs are paid at the approved standard interprovincial or interterritorial rates.

With the exception of Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing arrangement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the Newfoundland Medical Care Commission for payment at host province rates.

Payment Arrangements Outside Canada

Out-of-country hospital in-patient and out-patient services are covered for emergency or sudden illness at established rates. Elective hospital services are also insured when they are not available in the province or in the country.

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 $220 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergency or sudden illness, and are also insured for elective services, when they are not available in the province or in the country. They are paid at the same rate as would be paid in Newfoundland for the same service. If the services are not available in Newfoundland, they are usually paid at Ontario rates, or at rates that apply in a province in which they are available.

If a resident of the province has to seek specialized hospital care outside Canada because the insured service is not available in Canada, the provincial health insurance plan will pay the costs of these services. However, it is necessary in these circumstances for such referrals to receive prior approval from the Department of Health. In these cases, the referring physicians must contact the Department of Health and the Medical Care Plan.

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

Permanent Moves Out of the Province

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure. Coverage is immediately discontinued when residents move permanently to other countries.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

There are no co-insurance charges for hospital services and no extra-billing by physicians in the province. 1996-97 acute beds staffed and in operation totalled 1877 and the average length of stay for acute care services was 8.0 days.

An incentive plan is in place to attract physicians to remote areas and specialty practices. During fiscal year 1996-97 $551,530 was paid out under this program by the Medical Care Plan.

Payment to Hospitals

Hospitals in Newfoundland are paid on the basis of operating budgets approved by the Hospital Services Division. Approximately one-twelfth of the total annual operating budget is advanced to Regional Health Institution Boards each month, with a final settlement after year-end. Deficits are not reimbursed, but these facilities may retain any surplus. Payments by the provincial plan in 1996-97 to Regional Health Boards in Newfoundland totalled $579,886,400. Out-of-province hospital service payments totalled $17,947,000.

System of Payment for Medical Care

Physicians are paid in accordance with the Newfoundland Medical Care Commission payment schedule. Total payments are reduced to stay within a negotiated annual budget.

Reasonable Compensation

Fees are negotiated from time to time between the Medical Care Commission of the provincial government and the Newfoundland Medical Association.

During 1996-97 payments to in-province physicians totalled $136,533,601. This figure includes salaried physician payments in the amount of $28,041,895 as well as the incentive payments of $551,530 described above. The Commission paid $4,020,780 for physician services provided outside the province.

Extended Health Care Services (EHCS)

Institutional long term care primarily for persons 65 years and older and persons with debilitating diseases is promoted in community health centres and nursing homes operated primarily by regional health boards that also deliver acute care services. Seven nursing homes remain under independent boards. However, discussions are being finalized regarding regional governance for these facilities. Residents pay a maximum of $2800 per month based on a financial assessment. The balance of funding required to operate these facilities is provided by the Department of Health.

In 1993 the provincial government began a major initiative to consolidate community-based health services under the direction of regional community

health boards. This reorganization is now complete. The focus of the Department of Health's activities in reorganizing and strengthening community health services was to provide more appropriate preventive, support and home care services to help people avoid illness, and delay or reduce the need for institutional care, as well as to strengthen population health-focused programs and services throughout the province.

Within its mandate, the regional boards have implemented a single-entry system to continuing care services. This has facilitated the co-ordination and delivery of a wide range of professional and support services to community health clients, including home care, assessment and placement, school and home support, palliative care, emergency response, rehabilitation and respite services.

Further strengthening of community services will occur when, in April 1998, Child Welfare and Community Corrections and Family and Rehabilitative Services will be transferred from the Department of Human Resources and Employment to the new Department of Health and Community Services. These social service programs will be integrated with community health programs and delivered under Regional Health and Community Services Boards. The focus of this initiative is to strengthen the continuum of services available to children and families, thereby reducing service gaps that currently exist, and to prioritize prevention and early intervention services as an investment in healthy child development and healthy families in the communities.

Prince Edward Island

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Both plans are administered and operated on a non-profit basis by the Health and Community Services Agency. The Agency is accountable to the provincial legislature. Accounts and transactions are audited annually by the provincial auditor general.

Comprehensiveness

HOSPITAL INSURANCE PLAN

The Prince Edward Island Hospital Plan insures hospital services as defined under section 2 of the *Canada Health Act*, including accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy and physiotherapy services, where available.

The following hospital services are not insured: hospital admission chest x-rays; syphilis serology; personal conveniences, including telephones and televisions; 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 purposes; and drugs, biologicals, and prosthetic and orthotic appliances for use by an in-patient or out-patient after discharge from hospital.

In addition to the insured hospital benefits, Prince Edward Island also provides a breast prosthesis program.

MEDICAL CARE PLAN

The Medical Care Plan insures all medically necessary physician services and surgical-dental services (for example, surgical removal of impacted teeth, root resection) provided to insured persons.

The following services are not insured: services that persons are eligible for under other provincial or federal legislation; mileage or travel, unless approved by the Agency; advice or prescriptions by telephone except anticoagulant therapy supervision; examinations required in connection with employment, insurance, education, etc.; group examinations, immunizations or inoculations, unless prior approval is received from the Agency; preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility; testimony in court; surgery for cosmetic purposes unless medically required; dental services other than those procedures included as basic health services; dressings, drugs, vaccines, biologicals and related materials; eyeglasses and special appliances; physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments; reversal of sterilization procedures; *in vitro* fertilization (partially covered); services performed by another person when the supervising physician is not present or not available; services rendered by a physician to members of his/her own household unless approval is obtained from the Agency; laboratory or radiology services provided for under the provincial *Hospital and Diagnostic Services Insurance Act* and any other services that the Agency may, upon the recommendation of the Medical Advisory Committee, declare to be non-insured.

In addition to basic insured health services, the province also provides an ambulance subsidy program to ambulance operators in order to reduce the cost to Island residents; routine dental care for children; an ocular prosthesis program for children and youth up to 18 years of age; and a Drug Cost Assistance Plan for seniors and certain other client groups.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Every person permanently residing in Prince Edward Island, with the exception of members of the Canadian Forces (regular), the Royal Canadian Mounted Police, or persons on student visas, who has registered under the Plans and provided the Agency with all information required, is eligible for

insured services. Eligibility is based on permanent residence and full compliance with the interprovincial Agreement on Eligibility and Portability. No premiums are levied.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

Every person registering for insured services under the Plan becomes eligible on the first day of the third month following the date of establishing residence.

Provided registration requirements as set out in the Regulations are complied with, landed immigrants, repatriated Canadians, returning Canadians, returning landed immigrants, Canadian citizens or spouses of Canadian citizens assuming residence in Canada for the first time, persons living in the province under the authority of a work permit issued under the *Immigration Act* (Canada), discharged members of the Canadian Forces and Royal Canadian Mounted Police, and discharged inmates of federal penitentiaries are entitled to benefits, once the date of residence is established.

Regular annual absences of fewer than six months per year are allowed, provided permanent residence does not change. Persons temporarily absent from the province may be granted an extension of up to six months' coverage, provided the Agency is notified in writing.

Payment Arrangements In Canada

All insured persons temporarily absent from the province but still in Canada will have their claims accepted at the rate applicable in the province or territory where such services have been rendered (host province or territory rate), provided the services rendered comply with the regulations regarding medical necessity.

Payment Arrangements Outside Canada

Hospital in-patient insured services received under emergency or sudden illness circumstances are paid in Canadian funds at a rate not exceeding the per diem rate of the Queen Elizabeth Hospital in Charlottetown.

Hospital in-patient elective services not available in Canada are paid, with prior approval of the Health and Community Services Agency, at a rate not to exceed the total amount payable for in-patient services at the hospital, including room and board and medically necessary hospital services, and are payable in appropriate funds, depending on the country of origin.

Hospital out-patient services received under emergency or sudden illness circumstances, are paid in Canadian funds at P.E.I. rates, or appropriate Canadian rates where applicable.

Hospital out-patient elective services not available in Canada are paid at a rate of 100 percent of the approved hospital charges with prior approval of the Health and Community Services Agency.

Physician charges received in circumstances of emergency or sudden illness are payable at the P.E.I. Schedule of Fees, in Canadian funds.

Payment for physician charges for elective services not available in Canada is at 100 percent of physician fees if prior approval has been obtained from the Health and Community Services Agency, and is paid in appropriate funds, depending on the country of origin.

Prior written approval is necessary if the patient is seeking non-emergency medical treatment outside of P.E.I. Requests can come from general practitioners or specialists.

Permanent Moves Out of the Province

Residents are eligible for all benefits under the Plan during the interprovincially agreed-upon waiting period. Residents moving permanently outside Canada are eligible for all benefits under the Plan until the day of departure from Canada.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

Both plans provide for insured services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons. There are no co-insurance charges for hospital services or extra-billing by physicians in the province.

In 1996-97 there were seven acute care hospitals in the province, with a total of 487 beds, excluding those for newborns. Patients admitted during the fiscal year totalled 19,998, excluding newborns, and total patient days were 143,601, excluding newborns.

Payment to Hospitals

The Agency establishes the annual operating budget for each hospital and makes payment thereon, primarily bi-weekly. Unbudgeted expenses are either adjusted by revision of budgets within the current year or are considered for approval after receipt of the hospital's audited financial statements.

For fiscal year 1996-97, hospitals received an estimated $97,914,600 for capital and operating expenses. Other services such as blood transfusion and ambulance services received an estimated $3,904,500. Agency payments for out-of-province hospital services were an estimated $14,214,500.

System of Payment for Medical Care

Each practitioner submits a claim to the Agency, along with any required information to substantiate the claim, as prescribed by the tariff of fees, within six months of the date on which the service was rendered. If the claim is in compliance with the *Hospital and Diagnostic Services Insurance Act*, payment is made to the practitioner on a bi-weekly basis.

Reasonable Compensation

Negotiations with the Medical Society of Prince Edward Island and the Dental Association have resulted in signed agreements relating to tariffs on fees for insured services rendered to residents, for the period April 1, 1995, to March 31, 1998.

During 1996-97, payments to physicians in the province totalled an estimated $29.877 million. For physician services provided out-of-province, the Agency paid approximately $2.753 million.

Extended Health Care Services (EHCS)

Extended care services are primarily provided through the Residential Services Branch within the five Regional Authorities of the Health and Community Services System. Adult residential care and nursing home intermediate care services are primarily available in regionally operated manors and in licensed private nursing homes. The Health and Community Services Agency provides funding to the regions, if necessary, toward 90 percent of beds in government-operated manors and 50 percent of beds in private nursing homes. Sponsorship is according to urgency of need as assessed in both functional and financial terms.

The *Community Care Facilities and Nursing Homes Act, 1988* transferred the licensing of private nursing homes to a board that reports to the Minister of Health and Social Services. The Health and Community Services Agency provides staff support to the board, conducts inspections, and assesses residents for appropriateness of level of care. The same assessment tool is now used for clients at all levels of care in all long-term care facilities.

In addition, home support services are provided by the regional authorities.

Nova Scotia

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Department of Health administers the Hospital Insurance Plan.

The Medical Services Insurance Plan has been administered and operated on a non-profit basis by an authority consisting of the Insured Programs Branch of the Department of Health and Maritime Medical Care Incorporated since September 1991. At that time the Health Services and Insurance Commission was integrated with the Department. Legislation was passed in June 1992 to formalize the change. Maritime Medical Care Incorporated, the administrative and fiscal agent of the province for the Medical Services Insurance Program, must submit a report on its accounts and activities concerning the Plan to the Minister for each fiscal year. The books, records and accounts of Maritime Medical Care Incorporated must relate to its duties, functions and responsibilities under its agreement with the Department.

The Auditor General of Nova Scotia conducts an annual audit of all records and books of accounts of the Department of Health, and of Maritime Medical Care Incorporated, as they pertain to both plans.

Comprehensiveness

HOSPITAL INSURANCE PLAN

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

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

Uninsured hospital services include preferred accommodation at patient's request; telephones; televisions; drugs and biologicals ordered after discharge from hospital; cosmetic surgery; reversal of sterilization procedures; surgery for sex reassignment; *in vitro* fertilization; procedures performed as part of clinical research trials; services such as gastric bypass for morbid obesity, breast reduction/augmentation, and newborn circumcision are not insured unless by exception because of medical necessity, and services not deemed medically necessary that are required by third parties such as insurance companies.

The Department of Health administers the Breast Cancer Screening Program.

MEDICAL CARE PLAN

Insured services are defined as “all services rendered by physicians which are medically required or which are deemed to be medically required.” Certain dental-surgical procedures medically required to be rendered in a hospital are also insured.

Uninsured services include services a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation; mileage, travelling or detention time; telephone advice or prescriptions; examinations required by third parties; group immunizations or inoculations unless approved by the Department; preparation of certificates or reports; testimony in court; services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty; cosmetic surgery; acupuncture; reversal of sterilization; and *in vitro* fertilization.

In addition to the basic insured health services, limited coverage is also provided for vision analyses by optometrists for children and seniors;

prescription drugs for seniors; a special drug program for sufferers of a specific chronic disease condition; a children's dental plan; a special dental program for certain client groups; prosthetic services including coverage for breast prostheses; and an ambulance subsidy program.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The legislation provides that all residents of the province, with the exception of members of the Canadian Forces and the Royal Canadian Mounted Police, and inmates of federal penitentiaries, are entitled to receive insured hospital services. In addition, Nova Scotians are insured for emergency services outside the country for insured residents to the limits of the Nova Scotia fee schedule. These hospital and medical services have uniform terms and conditions. This provision ensures coverage for all residents of the province. A resident is defined as "a person who is legally entitled to remain in Canada and who makes his/her home and is ordinarily present in Nova Scotia, but does not include a tourist, a transient or a visitor to Nova Scotia." Eligibility for benefits for residents does not depend upon prior registration. No premiums are levied.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

In compliance with the Agreement on Eligibility and Portability, people from elsewhere in Canada establishing permanent residence in the province are eligible for insured health services on the first day of the third month immediately following the month in which they became residents of Nova Scotia.

First-day coverage is available for certain residents, including discharged members of the Canadian Forces and the Royal Canadian Mounted Police, released inmates of federal penitentiaries, and returning Canadians. In addition, immediate retroactive coverage is provided to people from outside Canada who are in the province on work permits for periods of 12 months or longer.

Those temporarily absent from the province may be granted an extension of coverage to a maximum of 12 months. Students normally resident in Nova Scotia who are in full-time attendance at school outside the province will be covered. Proof of enrolment must be provided annually.

Payment Arrangements In Canada

Nova Scotia participates in the Reciprocal Billing Arrangements. Hospital care services are paid for at the per diem of the host hospital, and medical care services are paid for according to the tariff of the host province or territory. The patient may either pay the physician directly for medical care services and then claim reimbursement from the Plan, or may assign the right of payment to the physician.

Payment Arrangements Outside Canada

Out-of-country in-patient hospitalization as the result of an accident or sudden illness while temporarily absent from Canada, is covered in Canadian funds.

Hospital services are paid for at the lesser of two rates: a rate calculated on the basis of the average per diem of the Halifax metro hospitals at the time services are rendered, or at the per diem of the hospital providing the service.

Unapproved non-emergency or elective treatment, unreferred hospital services received in a psychiatric hospital or addiction centre outside Canada, and hospital out-patient services are excluded from out-of-country coverage.

Out-of-country physician services, as the result of an accident or sudden illness during a temporary absence from Canada, are covered in Canadian funds at Nova Scotia rates.

A Nova Scotia specialist must receive prior consent before referring residents for out-of-country treatment. Approval is not given if the service is available in the province or elsewhere in Canada.

The Nova Scotia Department of Health determines payment for prior approved elective services and for services not available in Canada.

Prior consent is required for residents referred to psychiatric hospitals or addiction centres outside Canada for services not available in Canada.

Permanent Moves Out of the Province

Residents moving permanently to other parts of Canada continue to be covered for insured services for a period of up to three months after residency is established in their new province.

Residents of Nova Scotia moving permanently outside of Canada lose coverage the day of their departure.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

There are no user charges or extra charges applicable under either plan.

More than 90 percent of the population lives within 30 minutes' travel time of the 37 provincial hospitals. A system of regional hospitals throughout the province provides specialty services to residents, in addition to the major tertiary care services available in Halifax.

Payment to Hospitals

The Department of Health establishes budget targets, seeks advice from hospitals, and establishes approved budgets accordingly. Approved estimates form the basis upon which payments are made by the Plan to hospitals each year. In 1996-97 there were a total of 3375 (3.5 per 1000 population) hospital beds in Nova Scotia. Department of Health direct expenditures for general and psychiatric hospital services operating costs were $705.2 million. Payments to out-of-province hospitals for insured services provided to Nova Scotia residents totalled $11.4 million. Total separations from all hospitals were 120,091. Patient days in all hospitals totalled 874,444.

System of Payment for Medical Care

Payments to physicians are made on a fee-for-service basis in the vast majority of cases. Some insured services are rendered by salaried and contract physicians.

Reasonable Compensation

The *Health Services and Insurance Act* empowers the Department to negotiate compensation for insured medical and dental services with the Medical Society of Nova Scotia and the Nova Scotia Dental Association, and to participate in any process of final offer of arbitration for issues of compensation not resolved by negotiation.

During 1996-97 payments to Nova Scotia physicians totalled $267,647,910. The Department paid an additional $3,912,223 for physician services provided outside the province.

Extended Health Care Services (EHCS)

In April 1993 the responsibility for long-term care facilities (nursing homes, homes for the aged) was transferred from the Department of Community Services to the Department of Health. Effective April 1, 1995 the Department of Health became responsible for 100 percent of the cost of providing financial assistance to residents requiring it in nursing homes and homes for the aged. (Prior to April 1, 1995, the Department of Health had been responsible for 66.67 percent of this cost with municipal units retaining responsibility for the balance.)

On June 1, 1995 Home Care Nova Scotia was implemented across the province in two categories—Chronic Home Care and Hospital Replacement Home Care. Since the program's launch, the number of Nova Scotians who have benefitted from home care services has increased from 7000 to approximately 18,000.

New Brunswick

Public Administration

Hospital Services and Medical Care Plans

Both plans are administered by the Department of Health and Community Services on a non-profit basis and are subject to audits of their accounts and financial transactions by the provincial Auditor General.

Comprehensiveness

Hospital Services Plan

The in-patient services to which eligible persons are entitled correspond to those cited in the *Canada Health Act*, including accommodation and meals at standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy and physiotherapy services, where available. The out-patient services include laboratory, diagnostic and radiology procedures, where available; radiotherapy; physiotherapy; and the hospital component of other out-patient services.

Uninsured services include patent medicines; take-home drugs; third-party requests for diagnostic services; visits for the administration of drugs, vaccines, sera or biological products; televisions; telephones; preferred accommodation at patient's request; and any service not included in the provincial schedule of insured physicians' services.

Services are not insured if provided to those entitled under other statutes.

Services provided under the New Brunswick Extra-Mural Hospital Program are insured services. Also called the "hospital at home," the Extra-Mural Hospital is an active treatment program of professional acute and palliative health care in a person's place of residence. Patients are admitted only on referral by their physicians; physicians arrange admission, prescribe treatment and order discharge just as in conventional hospitals. An expansion during 1987-88 increased the total number of Extra-Mural Hospital units to 14. It was further expanded to provide province-wide coverage in 1992-93. Effective April 1, 1990 the Extra-Mural Hospital expanded its range of services to include long-term care services. This range of services was defined as Phase II of its mandate and was previously included as a public health service.

Medical Care Plan

Insured health services are defined as all medically required services rendered by a medical practitioner and certain medically required services rendered by qualified dental practitioners in an approved hospital.

Services not covered by the Plan include elective plastic surgery or other services for cosmetic purposes; medicines, drugs, materials, surgical supplies or prosthetic devices; advice or prescription renewal by telephone, except as provided in the schedule of fees; examinations of medical records or certificates at the request of a third party; immunizations, examinations or certificates for purposes of travel, employment, emigration, insurance or at the request of a third party; other services required by hospital regulations or medical by-laws; dental services provided by a medical practitioner; distance or travelling time, except as provided in the schedule of fees; testimony in court or before any other tribunal; services provided by medical practitioners to members of their immediate families; psychoanalysis; electrocardiograms where not performed by specialists in internal medicine or paediatrics; laboratory procedures not included as part of an examination or consultation fee; the fitting and supplying of eyeglasses or contact lenses; transsexual surgery; *in vitro* fertilization; acupuncture; and complete medical examinations where performed for the purposes of periodic checkups and not for medically necessary purposes.

Prescription Drug Program

The Prescription Drug Program provides prescription drug benefits to eligible residents of New Brunswick. The program consists of several individual drug plans, each designed to meet the needs of beneficiary groups.

Beneficiary groups include:

- residents of the province who are 65 years of age and older, registered with Medicare and, in receipt of Old Age Security/ Guaranteed Income Supplement (GIS), or who qualify for benefits based on annual income;
- residents in a registered nursing home;
- clients holding health cards issued by either the Department of Human Resources Development – NB or the Department of Health and Community Services;
- children in care of the Minister of Health and Community Services;
- cystic fibrosis cases registered with the Prescription Drug Program;
- organ transplant recipients registered with the Prescription Drug Program;
- individuals who are registered as receiving growth hormone; and
- persons who test HIV positive and are registered with the Prescription Drug Program.

EMERGENCY MEDICAL SERVICES

The Department of Health and Community Services administers the Ambulance Services Program, which ensures that ambulance service is available in the province through contracted public and private sector ambulance operators. Some subsidization is provided to operators to offset operating costs, and for purchases of vehicles and equipment. Funding is provided to a private sector training agent to administer and deliver an Emergency Medical Technology Level One program, which is the current personnel standard. A provincial air medical transport program is in place for critically ill or injured patients and a repatriation program arranges and funds transfers back to New Brunswick for eligible patients who have been hospitalized outside the province. Financial assistance is also provided for social assistance recipients and for eligible patients being transported between health care facilities by air or land.

Universality

HOSPITAL SERVICES AND MEDICAL CARE PLANS

All insured persons in the province are entitled to coverage. Not entitled are regular members of the Canadian Forces; members of the Royal Canadian Mounted Police; persons serving a prison term in a federal penitentiary, and people from another province or territory who are in New Brunswick for educational purposes, and who are eligible for coverage under their provincial or territorial plans.

In order to be entitled to insured health services, beneficiaries and their dependants must register. Upon registration, eligible persons are issued a New Brunswick Medicare card bearing the resident's name, date of birth, Medicare number and expiry date. This card must be produced when requesting services from a medical practitioner or a hospital. No premiums are levied. Effective September 1, 1992, the Medicare card included an expiry date.

Portability

HOSPITAL SERVICES AND MEDICAL CARE PLANS

Minimum Residence

A person is eligible to become a beneficiary under the health plan on the first day of the third month following the month of arrival in the province, when entering from another province or territory. The following groups may be eligible for first-day coverage when full-time residence in New Brunswick is established: discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and penitentiary inmates released in New Brunswick. When entering from outside the country a person may be eligible to become a beneficiary under the health plan on the first day of the third month following the month of arrival in the province and establishing permanent residence. This applies to non-Canadian spouses of Canadian residents assuming residence in Canada for the first time; landed immigrants; repatriated Canadians;

returning Canadians; returning landed immigrants; and Canadian citizens establishing residence in Canada for the first time. Coverage is provided to people from outside Canada who are in the province on work permits for periods of 12 months or longer.

Effective January 1, 1993, New Brunswick increased its minimum residence requirement to 183 days, in order to bring it in line with other jurisdictions.

An eligible person may be temporarily absent from the province for the purpose of vacation, visits or business arrangements; however, this absence must not exceed 182 days in a 12-month period, unless approved by the Director of Medicare.

Students may be temporarily absent on an annual basis when in full-time attendance at a university or another institution, provided they do not establish residence elsewhere. Students must inform the Medicare office annually.

Payment Arrangements In Canada

Hospital in-patient services will be paid at the rate approved by the relevant province's or territory's hospital insurance plan. Out-patient services are paid at the standard out-patient rate established by the Co-ordinating Committee on Reciprocal Billing. Payment may be made to the person directly, to the facility involved in the provision of the services, or through reciprocal hospital billing.

With the exception of Quebec, insured medical services incurred in all other provinces or territories are paid through a reciprocal billing arrangement at host province or territory rates. Selected high-cost procedures are paid as approved by the Co-ordinating Committee on Reciprocal Billing.

Payment Arrangements Outside Canada

All entitled out-of-country hospital services are covered in Canadian funds, regardless of the circumstances.

Hospital in-patient services available in the province are paid at the New Brunswick rate.

In-patient services not available in the province are paid at the average ward rate of three major Canadian hospitals.

All entitled out-of-country medical services are covered in Canadian funds, regardless of the circumstances.

Medical services not available in New Brunswick are paid at Ontario or Quebec rates (exceptions: pathology, radiology or diagnostic ultrasound services are paid at 70 percent).

Prior approval is required for in-patient treatment of substance abuse in an out-of-Canada facility and for in-patient treatment in a psychiatric facility within Canada.

Permanent Moves Out of 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 arrival in the new province or territory. Coverage ceases on the date of departure from Canada for residents moving permanently out of the country.

Accessibility

HOSPITAL SERVICES AND MEDICAL CARE PLANS

Reasonable Access

Possession of a New Brunswick hospital-medicare card entitles eligible people to insured services.

Preliminary hospital statistics for 1996-97 are 878,263 patient days, excluding newborns; 121,725 separations; and 777,410 emergency visits. There were 1,462,990 patient days; 12,256 admissions; and 10,866 separations from the Extra-Mural Hospital.

Medical care statistics for 1996-97: 5.1 million services were provided on a fee-for-service basis by in-province general practitioners and specialists.

Payment to Hospitals

New Brunswick hospitals receive an annual global budget to provide approved services. Payments are made to the hospitals on a bi-weekly basis. Total expenditures for insured, in-province hospital services amounted to an estimated $596.2 million in 1996-97. An estimated $27.1 million was paid to out-of-province hospitals for services rendered to New Brunswick residents.

New Brunswick hospitals received an estimated $23 million from other provinces and the territories for services provided to out-of-province residents. System of Payment for Medical Care Medical practitioners must submit a claim containing the required information regarding the patient and the services provided. A medical practitioner wishing to practise under the *Medical Services Payment Act* must obtain privileges from the Regional Hospital Corporation prior to being issued a billing number by the Minister.

Reasonable Compensation

Compensation for medical practitioners is based on the schedule of fees of the New Brunswick Medical Society. Fees for those services not included in this schedule are determined by the Director of the Medical Plan in consultation with the Society. During 1996-97, payments made on a fee-for-service basis to in-province physicians totalled $171.1 million. Out-of-province physician payments totalled $7.4 million.

Extended Health Care Services (EHCS)

Nursing home care is provided through the Nursing Home Services Program as a non-insured service under the authority of the Institutional Services Division of the Department of Health and Community Services. Adult residential care services and facilities are available through a variety of agencies and funding sources. The Family and Community Social Services Division of the Department is responsible for the Special Care Home and Community Residence programs, as well as for the Community-Based Services for Seniors and the Community Services for Disabled Adults programs.

Home health care available through the Extra-Mural Hospital includes acute care services (medical/ surgical), palliative care, and long-term care.

Quebec

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The hospital insurance plan, the *régime d'assurance-hospitalisation du Québec*, is administered by the Ministry of Health and Social Services, the *ministère de la Santé et des Services sociaux*.

The health insurance plan, the *régime d'assurance-maladie du Québec*, is administered by the *Régie de l'assurance-maladie du Québec*, a public authority appointed by the provincial government and responsible to the Minister of Health and Social Services. Both plans are operated on a non-profit basis, and all accounts and transactions are audited by the Auditor General of the province.

Comprehensiveness

HOSPITAL INSURANCE PLAN

The network of establishments under the Ministry of Health and Social Services includes hospital centres, certain residential and extended-care facilities (formerly extended-care hospital centres)* and local community services centres.

The treatment of physical and mental illness is provided by the hospital centres, and by some of the residential and extended-care facilities.

Insured in-patient services are provided in the hospital centres, whereas out-patient services are available mainly in residential institutions and local community services centres.

Insured in-patient services include standard ward accommodation and meals; necessary nursing services; provision of routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; provision of medications, prosthetic and orthotic appliances that can be integrated to the human body, and of biological products and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital centre staff.

Out-patient services cover clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery care (day surgery); radiotherapy; diagnostic services; physiotherapy; ergotherapy; inhalation, audiology and speech therapies; orthoptics; and other services or examinations required under Quebec legislation.

Other services covered by insurance are mechanical, hormonal or chemical contraception; surgical sterilization (tubal ligation or vasectomy); and reanastomosis of the fallopian tubes or vas deferens.

The Ministry of Health and Social Services administers an ambulance transportation program free of charge to persons aged 65 and over.

Uninsured hospital services include cosmetic surgery; *in vitro* fertilization; private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services covered by the *Loi sur les accidents de travail et les maladies professionnelles* or other federal or provincial legislation.

* Since October 1, 1992, extended-care hospitals and residential facilities have been included in a single institutional category (the CHSLD — *centres d'hébergement et de soins de longue durée*), although no change has been made to their specific missions.

Medical Care Plan

The services insured by the medical care plan, the *régime de soins médicaux*, include medical and surgical services provided by physicians, as well as oral surgery performed in hospital centres or in a university facility determined by regulation by dental surgeons and specialists in oral and maxillo-facial surgery.

The following services are not considered insured: any examination or service not related to a process of cure or prevention of illness; psychoanalysis in every form, unless such service is rendered in an institution authorized by the Ministry of Health and Social Services; any service provided for purely aesthetic purposes; any consultation by telecommunication or by correspondence; any service rendered by a professional to the person's spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the person 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 injections given to a group or for certain purposes; any service rendered by a professional based on an agreement or a contract with an employer, an association or an organization; any adjustment of eyeglasses or contact lenses; any surgical removal of a tooth or tooth fragment carried out by a physician, except in certain cases where the service is provided in a hospital centre; all acupuncture procedures; the injection of sclerosing substances and the examination made at that time; thermography, mammography for detection purposes, tomodensitometry, magnetic resonance imaging, the use of radionuclides *in vivo* in a human, and ultrasonography, unless all these services are rendered in a hospital centre; any radiological or anaesthetic service provided by a physician if it is required with a view to dispensing an uninsured service, with the exception of a dental service provided in a hospital centre; and any surgical service provided for the purposes of transsexualism unless such a service is provided upon the recommendation of a physician specialized in psychiatry and carried out in a hospital centre recognized to this end; and any services not associated with a pathology and that are rendered by a physician to a patient between the ages of 18 and 65 years, unless that individual is the holder of a claim card for colour-blindness or a refraction problem, for the purpose of obtaining or renewing a prescription for eyeglasses or contact lenses.

In addition to the basic insured services, the *Régie* also covers, with some limitations regarding certain residents of Quebec as defined by the *Loi sur l'assurance-maladie* and Income Security recipients, optometric services; dental care for children and Income Security recipients and acrylic dental prostheses for children and Income Security recipients; prostheses, orthopaedic appliances, locomotion and postural aids or other equipment for persons with physical disabilities; external breast prostheses; ocular prostheses; supplementary hearing aids and visual aids for people with visual or auditory handicaps; permanent ostomy appliances. Moreover, since January 1, 1997, in terms of drug insurance, the *Régie* covers over and above its regular clientele (Income Security recipients and seniors 65 years and older), individuals who do not otherwise have access to a private drug insurance plan. The new drug insurance plan covers nearly three million people.

Universality

Hospital Insurance and Medical Care Plans

Registration with the hospital insurance plan is not required. Registration with the *Régie de l'assurance-maladie* or proof of residence is sufficient to establish eligibility. All residents or deemed residents of Quebec must be registered with the *Régie de l'assurance-maladie* to be eligible for the health insurance programs. Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police, and inmates of federal penitentiaries are not covered by the plan. No premium payment exists.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

Insured persons moving to Quebec from other provinces or territories in Canada are entitled to coverage under the Quebec health insurance plan when benefits under the province or territory of origin cease, provided they register with the *Régie de l'assurance-maladie*.

If outside Quebec for 183 days or more, students, full-time unpaid trainees, Quebec government civil servants, employees of non-profit organizations with head offices in Canada and employed abroad in assistance or co-operation programs recognized by the Minister of Health and Social Services, and the spouse and dependants of all such persons maintain their resident status, provided the *Régie* is notified of their absence.

This is also the case for persons living in another province for the purpose of seeking employment, holding temporary employment or working on contract, provided their families remain in Quebec or they retain a residence there. Their resident status can be maintained for no more than two consecutive years.

Persons employed or working on contract outside Quebec for a company headquartered in Quebec, or employed by the federal government and posted outside Quebec, also retain their resident status, provided their families remain in Quebec or they retain a residence there, and provided they return to Quebec at least once every 12 months.

Resident status is also maintained by those persons who remain outside the province for 183 days or more, but less than 12 months within a calendar year, provided such an absence occurs only once every seven years and is reported to the *Régie*.

First-day coverage is provided to certain categories of residents, notably permanent residents under the *Immigration Act*, repatriated Canadians, returning Canadians, members of the Canadian Forces and Royal Canadian Mounted Police who have not acquired their resident status, and inmates of federal penitentiaries, upon release or discharge. Immediate coverage is also provided to persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for three months or more, or who are living in Quebec under an official bursary or internship program of the Ministry of Education or the Ministry of Post Secondary Education and Science.

Payment Arrangements In Canada

Hospital costs incurred in other provinces or territories are paid through reciprocal billing, an interprovincial agreement established between the provinces and territories. In-patient costs are paid at standard ward rates approved by the host province or territory and out-patient costs or high cost procedures are paid at approved standard interprovincial/territorial rates. However, since November 1, 1995 Quebec only reimburses the average rate of Outaouais specialized centres to Ottawa hospitals when an Outaouais resident is hospitalized for non-urgent care or services available in the Outaouais.

The costs of medical services incurred in other provinces or territories are reimbursed at the amount actually paid, or the rate that would be paid by the *Régie* for the same services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for emergency care and when specialized services are not offered in the Outaouais region. This agreement became effective November 1, 1989. A similar agreement was signed in December 1991 for the Abitibi-Témiscamingue/ North Bay area.

Payment Arrangements Outside Canada

As of September 1, 1996, hospital services provided outside Canada in cases of emergency or sudden illness are reimbursed by the *Régie*, usually in Canadian funds, to a maximum of $100 Canadian per diem if the patient was hospitalized (including day surgery), or $50 per out-patient visit. However, hemodialysis treatments are covered to a maximum of $220.00 per treatment. In such cases, the *Régie* reimburses the associated professional services. Services must be dispensed in a recognized establishment accredited as a hospital or hospital centre by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Students, trainees, Quebec officials posted abroad, missionaries and employees of non-profit organizations working under programs of international aid or co-operation recognized by the Ministry of Health and Social Services, must contact the *Régie* in order to ascertain their eligibility. If the *Régie* recognizes them as having special status, they receive 100 percent reimbursement in hospital insurance benefits in case of emergency or sudden illness, and 75 percent reimbursement in other cases, when the services are dispensed in the area of their posting.

Costs for medical services are reimbursed at the rate that would have been paid by the *Régie* to accredited Quebec health professionals (physicians, dentists, oral surgeons, optometrists and pharmacists), up to the amount of the expenses actually incurred. All services insured in the province are covered abroad, usually in Canadian funds, at the Quebec rate.

Beneficiaries requiring medical services in hospital abroad for services unavailable in Quebec or elsewhere in Canada are reimbursed 100 percent with prior consent for medical and hospital services meeting certain conditions. Consent is not given if the hospital service is available in Quebec or elsewhere in Canada.

Permanent Moves Out of the Province

Insured residents moving permanently to other parts of Canada are covered for up to three months after leaving the province.

Coverage is immediately discontinued as of the first day that insured residents move permanently to another country.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

Everyone has the right to receive adequate health care services without any kind of impediment.

There is no extra-billing by physicians in the Province of Quebec. 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 in accordance with the provincial fee schedule; and non-participating professionals who practise outside the plan entirely, so that neither they, nor their patients, receive reimbursement from the *Régie*.

As of March 31, 1997, Quebec counted 120 institutions operating as hospital centres for a clientele suffering from serious diseases with 27,222 beds allotted to these institutions. Moreover, from April 1, 1995 to March 31, 1996, hospital institutions treated more than 850,000 in-patients and did more than 286,000 day surgeries. These hospitalizations represented a total number of more than 8,114,637 patient days.

Payment to Hospitals

The financing of a hospital centre by the Ministry of Health and Social Services is carried out through a system of payments in respect of the cost of insured services provided.

The payments transferred in 1996-1997 to institutions operating as hospital centres for insured health services for Quebec residents have amounted to $5.33 billion and payments transferred to hospital centres outside of Quebec amounted to approximately $76.713 million.

System of Payment for Medical Care

Physicians are paid in accordance with a negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient in accordance with the fee schedule after the patient has collected from the *Régie*. Non-participating physicians are paid directly by the patients according to the amount charged.

Reasonable Compensation

Provision is made in law for reasonable compensation for all insured health services rendered by health care professionals. The Minister may enter into an agreement with the organizations representing any class of professionals in the health care field, prescribing a different remuneration for medical services where the number of professionals is insufficient. The Minister may also provide a different remuneration for physicians during the first years of practice or specialty according to the territory of practice and the nature of activities. These provisions are preceded by consultation with organizations representing health care professionals.

In 1996-1997, the *Régie* had paid approximately $2.162 billion to doctors in the province and the amount evaluated for medical services outside of the province had reached $9.1 million.

EXTENDED HEALTH CARE SERVICES (EHCS)

Nursing home intermediate care, adult residential care and home care services are available with admission co-ordinated through a regional admission system and based on a single assessment tool. Local community services centres, (*centres locaux de services communautaires*) receive individuals, evaluate their care requirements and either arrange for the provision of such services as day centre programs or home care, or refer them to the appropriate agency.

Some home care services are offered by the provincial Ministry of Health and Social Services, including nursing care and assistance, homemaker services and medical surveillance.

Residential facilities and long-term care units in short-term care hospitals focus on the maintenance of autonomy and functional capacities of their clients by providing a variety of programs and services, including health care services.

Ontario

Public Administration

The insured health program in Ontario is established under the *Health Insurance Act* to provide insurance in respect of the cost of services in hospitals and health facilities, by physicians and by other health care practitioners. The health program is administered on a non-profit basis by the Ministry of Health. The accounts and transactions are audited by the Provincial Auditor and are published in the Public Accounts of Ontario.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured in-patient hospital services are accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologicals and related preparations; use of operating rooms, obstetrical delivery room and anaesthetic facilities.

Insured out-patient services include out-patient day surgery; rehabilitation therapy; 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 home renal dialysis and home hyperalimentation equipment, supplies and medication; provision of equipment, supplies and medication to haemophiliac patients for use at home; and currently the provision of specific drugs for patients to take home, including Cyclosporin to transplant patients, AZT to AIDS patients, biosynthetic human growth hormone, rabies vaccines, and drugs for treatment of cystic fibrosis and thalassemia. The mechanism for coverage of these drugs for patients to take home is under review.

Uninsured hospital services include additional charges for preferred accommodation unless prescribed by a physician; telephones; televisions; charges for private-duty nursing; cosmetic surgery under most circumstances; provisions of medications for patients to take home from hospital, with certain exceptions; and in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

In addition to the insured hospital benefits, Ontario provides mental health services, including the operation of provincial psychiatric hospitals; the residential component of the Homes for Special Care Program; ambulance services (air and land) with a patient co-payment component; dental treatments for patients with cleft lip/palate registered at a designated clinic; and funding for a Breast Screening Program.

MEDICAL CARE PLAN

Insured medical services include all medically necessary services provided by physicians. Insured physician services in facilities, physicians' offices or in a patient's home include diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anaesthesia; radiology and laboratory services in approved facilities; and immunizations, injections and tests. Insured hospital surgical-dental services include repair of traumatic injuries; surgical incisions; excision of tumors and cysts; treatment of fractures; homeografts; implants; and alloplastic reconstructions and other specified dental procedures where it is medically necessary that they be rendered in hospital.

In addition to the basic insured health services, the Ministry of Health also provides oculo-visual assessments by optometrists; a drug benefit program for persons who are legally entitled to remain in Canada and reside in Ontario, and who belong to one of the following groups:

- people 65 years of age and older
- residents of long-term care facilities
- residents of Homes for Special Care

- people receiving professional services under the Home Care Program
- Trillium Drug Program recipients
- people receiving social assistance (General Welfare or Family Benefits)

Effective July 15, 1996, all recipients pay a portion per prescription toward the dispensing fee.

The Ministry also provides a Trillium Drug Program for those people who spend a large part of their income on prescription drugs; an assistive devices program that provides such items as home oxygen, artificial limbs, hearing aids, wheelchairs, respiratory equipment and supplies, and an annual grant for needles and syringes for insulin-dependent senior diabetics; a northern health travel grant program; and, with some limitations, the services of chiropractors, osteopaths and podiatrists, and physiotherapy in approved facilities.

Uninsured services include travelling to visit an insured person outside the area of the practice; toll charges for long-distance telephone calls; preparing or providing a drug, antigen, antiserum or other substance; advice given by telephone at the request of the insured person or the person's representative; an interview or case conference; preparation and transfer of records at the insured person's request; a service that is received wholly or partly for the production or completion of a document or the transmission of information in specified circumstances; the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances; provision of a prescription when no concomitant insured service is rendered; cosmetic surgery; acupuncture procedures; psychological testing; group screening programs; and research and survey programs. This is not an exhaustive list and is subject to exceptions. Refer to section 24 of Reg. 552 under the *Ontario Health Insurance Act* and to the Schedule of Benefits for physicians.

Universality

With certain exceptions, all residents of Ontario are eligible for coverage, subject to a three-month waiting period. Regulations under the *Ontario Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are subject to the three-month waiting period (refer to section 11 of the *Ontario Health Insurance Act* and O. Regs. 490 and 491/94).

Every resident of Ontario is required to register. All insured hospital, medical and dental services to which federal contributions are related are available to Ontario residents on uniform terms and conditions.

Portability

Minimum Residence

Subject to certain exceptions, new or returning residents who apply to become insured persons are subject to a three-month waiting period before they are eligible for or entitled to insured health services (refer to O. Reg. 491/94).

Each resident must make a permanent and principal home in Ontario for a minimum of 183 days in any 12-month period.

In accordance with the Interprovincial Agreement on Eligibility and Portability, it is possible for residents to maintain continuous coverage while temporarily working or studying in another Canadian province. To avoid a lapse in coverage, the person should notify the Ministry of Health about an intended absence.

An insured person can also maintain continuous coverage while temporarily out of the country for reasons such as work or study. However, the individual must notify the Ministry prior to leaving and receive confirmation of eligibility. Restrictions apply to the nature and duration of out-of-country absences.

Payment Arrangements In Canada

Ontario participates in reciprocal agreements with all other provinces and territories for insured hospital in- and out-patient services. Payment is at the in-patient rate of the Plan in the province or territory where hospitalization occurs. Ontario pays the standard out-patient charges authorized by the Advisory Committee on Institutional and Medical Services.

Ontario also participates in reciprocal billing arrangements with all other provinces and the territories, except Quebec, (which has not signed a reciprocal agreement with any other province or territory) for insured physician services.

Payment Arrangements Outside Canada

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

- a maximum $400 Canadian for in-patient services,
- a maximum $50 Canadian for out-patient services, and
- a maximum $210 Canadian per dialysis treatment.

Medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) as well as laboratory tests required on an emergency basis, are reimbursed at the rates listed in the Ontario Ministry of Health's Schedule of Benefits or the amount billed, whichever is less.

Where medically accepted treatment is not available in Ontario, or in those instances where the patient is threatened in terms of life or irreversible damage, the patient's Ontario physician may request approval prior to departure for full Ministry funding of out-of-country health services.

Permanent Moves Out of the Province

Ontario residents who leave permanently and immediately establish residence in another province or territory of Canada are entitled to benefits for three months from the date they cease to be residents.

Accessibility

Reasonable Access

All insured persons are entitled to all insured hospital and medical services to which federal contributions relate. No resident will be refused insured services because of financial difficulties. Public hospitals in Ontario are required to accept persons admitted to hospital by physicians. A user charge for room and board in respect of chronic hospital care applies after 60 days and is permissible by virtue of subsection 19 (2) of the *Canada Health Act*. Income exemption provisions ensure access to those in financial need.

In 1996-97 there were 211 public hospitals in the province, staffed and in operation, which included chronic, general and special rehabilitation units. More than 6,360,845 acute patient days and 2,721,178 chronic patient days were delivered by public hospitals during the fiscal year.

Reasonable access to physician services is ensured by an adequate supply of physicians. An Underserviced Area Program is aimed at providing residents of rural and remote areas of the province with improved access to general physician services. Two programs enhance access to health services for residents of Northern Ontario: the Northern Medical Specialist Incentive Program provides financial assistance to specialists locating their practices in Northern Ontario, and the Northern Health Travel Grant financially assists patients who must travel a minimum of 100 kilometres one way in Northern Ontario or Manitoba, or a minimum of 200 kilometres one way in the rest of Ontario to receive hospital and medical specialist services.

Financial barriers limiting access to the insured services of physicians, dentists and optometrists have been removed with the passage of the *Health Care Accessibility Act*. Physicians and optometrists who bill their patients directly, and dentists, may not charge or accept payment for more than the amount payable under the Plan for rendering an insured service to an insured person.

Payment to Hospitals

Public general hospitals are paid on a budget basis including all reasonable costs for insured services. The Ontario budget system is a prospective

reimbursement system incorporating annual increases to reflect the effects of inflation, workload increases, introduction of approved new programs, and cost increases in respect of growth in volume of specific designated life-support programs. Payments are made to hospitals on a semi-monthly basis.

In 1996-97 Ontario paid hospitals an estimated $7.4 billion for insured services provided to Ontario residents; payments to out-of-province hospitals (the reciprocal hospital billing system) totalled $47.9 million; and payments to out-of-country hospitals totalled $39.7 million.

System of Payment for Medical Care

Insured services provided by physicians and dentists in the province are paid primarily on a fee-for-service basis, according to the Schedules of Benefits within Regulation 552 of the *Health Insurance Act.* Physicians elect to opt in and bill the Plan for all services, or opt out and bill the patient for all services. Non-participating physicians in Ontario have the option to bill the Plan directly for certain specified groups of patients and through an associated medical group for services rendered in public hospitals, nursing homes and other institutions. The percentage of opted-out physicians has fallen to approximately one percent since the passage of the *Health Care Accessibility Act*.

Under the *Independent Health Facilities Act*, Ontario licenses and funds independent health facilities (IHFs) for the costs of providing insured physician services to the public where these costs are not already included in the fees paid under Regulation 552 of the *Health Insurance Act*. There are two types of IHFs. Diagnostic IHFs are funded on a fee-for-service basis to provide most imaging and pulmonary function tests. Ambulatory care IHFs provide surgical and therapeutic procedures such as cataract and retinal laser surgery, abortion, chronic care haemodialysis, plastic surgery, laser dermatologic surgery, and gynaecologic surgery. Currently, there are 950 diagnostic IHFs and 22 ambulatory care IHFs that are licensed and funded in Ontario. The *Independent Health Facilities Act* also makes it illegal to charge facility costs to patients in connection with the provision of an insured physician service.

Reasonable Compensation

The Government of Ontario negotiates with the Ontario Medical Association (OMA) to determine funding amounts for physician services. A "Schedule of Benefits Working Group," composed of Ministry of Health and OMA representatives, reviews items in the Plan's Schedule of Benefits.

Representatives of government and the Ontario Dental Association negotiate agreements on adjustments to the Plan's Schedule of Benefits that cover insured dental services provided in hospital.

During 1996-97, medical payments totalled $4,311,879,843. This amount covers payments for physician and laboratory services. For physician services provided out-of-province (the reciprocal medical billing system, excluding Quebec), the Plan paid $11,975,602 for fiscal year 1996-97.

Extended Health Care Services (EHCS)

Extended health care is provided by nursing homes funded by the Ministry of Health, as well as by homes for the aged and charitable institutions supported through the Ministry of Community and Social Services. Both acute and chronic home care services are also provided, including supplemental features such as home renal dialysis and hyperalimentation.

Ontario is undertaking a significant and comprehensive reform in the delivery, funding and administration of long-term care services that will emphasize community-based and in-home services as alternatives to traditional residential care.

Manitoba

Public Administration

The insured health program in Manitoba is administered by the Ministry of Health through the Manitoba Health Services Insurance Fund, established under the *Health Services Insurance Act*, to provide insurance in respect of the cost of hospital services, medical services and other health services.

The Ministry is required to submit an annual report of the Fund to the Minister of Health, including an audited balance sheet and audited statement of operating revenues and expenditures. The accounts and transactions are audited by the provincial auditor's office.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured hospital services are 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. Most out-patient services are insured, including dialysis in an approved facility. In some cases, the hospital may charge for take-home supplies of drugs and dressings.

Uninsured hospital services include additional charges for preferred accommodation; charges for private nurses; and personal services such as television, radio, and telephone.

Services are not insured if provided to insured persons under other statutes.

MEDICAL CARE PLAN

Insured physician services in facilities, physicians' offices or patients' homes include diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anaesthesia; x-rays and laboratory services in facilities approved by Manitoba Health; and immunizations, injections and tests. Insured dental services when provided by a licensed oral and maxillo-facial surgeon or a licensed dentist in a hospital, where a hospital is required for the proper performance of the procedures include surgical removal of impacted teeth; repair of traumatic injuries to soft tissue in and around the mouth; and, in cases of emergency or at the special request of a medical practitioner, performing or assisting a medical practitioner in the closed reduction of fractures of mandible or maxilla.

Uninsured medical services include examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties; group immunization or other group services except where authorized by Manitoba Health; services provided by a medical practitioner, dentist, chiropractor or optometrist to himself or herself or any dependants; preparation of records, reports, certificates, communications and testimony in court; mileage or travelling time; advice by telephone; services provided by psychologists, chiropodists, naturopaths, podiatrists and other practitioners not provided for in legislation; *in vitro* fertilization; tattoo removal; contact lens fitting; reversal of sterilization procedures; and psychoanalysis.

In addition to the basic insured health services, Manitoba Health also provides, with limitations, a Pharmacare drug program; eyeglasses for seniors; contact lenses for seniors and children with congenital eye defects; prosthetic and orthotic devices and services; telecommunication devices for the profoundly deaf or speech impaired; artificial eyes; breast prostheses and surgical brassieres; dental coverage for patients with cleft lip/palate or significant congenital or hereditary dysplasia; hearing aids and orthopaedic shoes for children; an emergency air ambulance program; northern patient transportation for medical treatment; an out-of-province transportation subsidy for patients referred for medical treatment not available in the province; and, with some limitations, the services of

chiropractors and optometrists. It also administers the Land Ambulance Services Program, which provides grants that may be applied toward the purchase of ambulance vehicles and equipment or to subsidize operating costs.

Universality

All residents, with the exception of members of the Canadian Forces, members of the Royal Canadian Mounted Police, and inmates of federal penitentiaries, who are legally entitled to be in Canada and who make their homes in Manitoba and are physically present in the province at least six months a year, are eligible for coverage subject to certain waiting periods (see Portability section). Every resident of Manitoba is required to register him/herself and dependants. All insured hospital, medical and in-hospital dental services to which federal contributions are related are available to Manitoba residents on uniform terms and conditions. No premiums are levied.

Portability

Minimum Residence

Benefits are available on the first day of the third month following the month of arrival in Manitoba for persons from another province or territory. Returning Canadians and landed immigrants arriving from outside Canada are insured on the date of arrival in Manitoba. Persons from outside Canada who are in the province with work authorizations for more than one year are eligible for coverage, provided they are physically present in Manitoba for the duration of the employment authorization. First-day coverage is also provided to discharged members of the Canadian Forces and Royal Canadian Mounted Police, and to discharged inmates of federal penitentiaries.

Persons temporarily absent from the province may continue as insured persons for up to 12 months. Students who intend to return to reside in Manitoba upon completion of studies are covered for the duration of their studies provided they are attending an accredited institution on a full-time basis. A person must be physically present in the province for at least six months a year to qualify as a resident.

Payment Arrangements In Canada

Manitoba has a reciprocal billing arrangement with all other provinces and territories for insured in- and out-patient hospital services. Payment is at the in-patient rate of the Plan in the province or territory where hospitalization occurs. Manitoba pays out-patient charges at the approved standard interprovincial or interterritorial rates.

Payment for professional (medical) benefits are in accordance with the reciprocal billing agreement between provinces, except Quebec. Claims for medical services received in Quebec are submitted by the patient or physician to the Manitoba Insured Benefits Branch for payment at host province rates.

Payment Arrangements Outside Canada

Hospital services received outside Canada due to an accident or sudden illness are paid as follows:

- in-patient—the lesser of the actual hospital charges for the insured services provided and the per diem rate established by regulation, according to hospital bed size; and
- out-patient—the lesser of the actual hospital charges for the insured services provided and the flat rate per visit established by regulation.

When hospital services are recommended by an appropriate Manitoba specialist and approved by the Minister, but are not available or cannot be adequately provided in Manitoba or elsewhere in Canada, the Plan pays the following fees:

- in-patient — the greater of 75 percent of the actual hospital charges for the insured services

provided and a per diem rate established by regulation, according to hospital bed size; and

- out-patient — the greater of 75 percent of the actual hospital charges for insured services provided and a flat rate per visit established by regulation.

Payment for hospital services is made in U.S. funds. For physician services received outside of Canada in an emergency or upon referral by an appropriate specialist and approved by the Minister, payment is made according to the current *Manitoba Physicians' Manual* in Canadian funds.

Permanent Moves Out of the Province

Manitoba residents moving permanently to other parts of Canada are entitled to benefits up to the last day of the second month following the month of arrival in their new place of residence. Reciprocal agreements exist with all the provinces and territories to ensure there is no gap in continuity of coverage for necessary hospital and physician services.

Manitoba residents moving to another country are entitled to insured benefits up to the last day of the second month following the date of departure from Manitoba.

Accessibility

Reasonable Access

All insured persons are entitled to all insured hospital and medical services to which federal contributions relate.

As of March 31, 1997 Manitoba had a total of 4170 acute care set-up beds and 922 other set-up beds (psychiatric extended treatment, palliative, chronic, long-term assessment/rehabilitation and panelled) to serve a population of 1,144,643; or 3.6 acute and 0.8 other set-up beds per 1000 population.

Fifty-six percent of the population live in Winnipeg, which has 2311 acute care set-up beds and 691 other set-up beds. There are two teaching hospitals and five community hospitals in the city. These facilities range in size from 136 to 800 set-up beds. In addition, there are two hospitals that provide long-term care and one adolescent psychiatric facility.

Manitoba's rural population is served by Brandon General Hospital and 68 community and district hospitals, (for a total of 69 community and district hospitals) ranging in size from 4 to 279 set-up beds, plus two federal hospitals and 18 federal nursing stations. In addition, rural Manitoba residents have access to Winnipeg acute care set-up beds.

While the number of physicians in Manitoba is comparable with other provinces, the distribution of physicians within the province is a concern. A Physician Resource Committee with broad representation was established to develop a comprehensive physician resource plan for Manitoba. This plan has been developed and a working group is being established to review the feasibility of the Committee's recommendations and to develop an action plan for implementation.

Payment to Hospitals

Public general hospitals in the province are paid on a budget basis including all reasonable costs for insured services.

Total Manitoba Health expenditures for hospital services during fiscal year 1996-97 amounted to $929,989,562. This includes payments to federal hospitals in the amount of $2,074,550; $17,553,184 to Red Cross Blood Transfusion Services; $17,789,095 to hospitals outside the province; $871,143,158 to public general hospitals; and $21,429,575 to community health centres and clinics.

System of Payment for Medical Care

The majority of physicians in the province are paid according to a fee schedule negotiated with the Manitoba Medical Association. Roughly 20 percent of total physician remuneration is paid by arrangements other than fee-for-service, such as salary, sessional or block arrangements.

Physicians may elect to opt out of the medical insurance plan and bill their patients directly. Extra-billing beyond the rates paid by government is prohibited.

The Manitoba Medical Association and Manitoba Health have been working co-operatively toward the development of a resource-based relative value schedule of benefits for paying for medical services.

The total Manitoba Health expenditures for medical services during fiscal year 1996-97 amounted to $337,261,050. This includes payments for other health services in the amount of $3,414,637 for optometric services, $9,624,089 for chiropractic services and $4,500,342 for prosthetic and orthotic devices.

Reasonable Compensation

A five-year agreement between the Manitoba government and the Manitoba Medical Association is in place for the period April 1, 1993 to March 31, 1998. The agreement establishes annual limits for the total cost of physician services in Manitoba paid on a fee-for-service basis. The Manitoba Medical Services Council is responsible for developing a plan to ensure that the available amount is not exceeded in the last three years of the agreement.

Extended Health Care Services (EHCS)

Manitoba Home Care is a province-wide program that provides a range of health and support services to individuals who require assistance to remain at home. Services provided are based on a professional assessment of individual needs and takes into consideration existing community resources and supports. Home Care services can include home oxygen therapy, intravenous antibiotic therapy and in home dialysis. The Program is also responsible for the assessment and placement for long-term institutional care.

Most services are delivered by direct service workers employed through the regional offices of Manitoba Health. Some services are delivered by contracted agencies such as the Victorian Order of Nurses and Community Therapy Services. Service delivery options also include funding for clients to be "self managers" and funding for group shared-care arrangements. Grant funding is provided to a small number of organizations such as Meals on Wheels, the Independent Living Resource Centre and the Alzheimer Society of Manitoba.

The Home Care Equipment and Supply Program provides supplies and medical equipment services in support of a number of government programs, including Home Care, the Manitoba Wheelchair Services Program, and the Manitoba Ostomy Program.

Personal care homes are funded and licensed through Manitoba Health. The Manitoba Health Services Insurance Plan provides insured coverage for eligible persons residing in personal care homes. Residents of personal care homes pay a daily residential charge.

Saskatchewan

Public Administration

HOSPITAL INSURANCE PLAN

Hospital services are funded by the Government of Saskatchewan and are administered on a non-profit basis by 30 district health boards established under *The Health District Act* to plan and manage the provision of health services district boundaries. Hospital services in northern Saskatchewan are administered by Saskatchewan Health until health boards can be established. District health boards are accountable to the provincial government and to the district residents they serve.

MEDICAL CARE PLAN

Prior to January 1, 1988 the Medical Care Insurance Plan was administered on a non-profit basis by the Saskatchewan Medical Care Insurance Commission. The Commission was responsible to the provincial government through the Saskatchewan Minister of Health.

Since January 1, 1988 the Saskatchewan Minister of Health has been directly responsible for the administration of the Medical Care Insurance Plan. The administrative activities of the Plan have been integrated into the Medical Services and Health Registration Branch of Saskatchewan Health.

Comprehensiveness

HOSPITAL INSURANCE PLAN

A comprehensive range of insured services is provided by hospitals, including public ward accommodation; necessary nursing services; operating room and case room facilities; surgical dressings and casts, as well as other required surgical materials and appliances; x-ray, laboratory and other diagnostic procedures; radiotherapy; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all other services rendered by individuals who receive any remuneration from the hospital; and all drugs, biologicals and related preparations administered in hospital and approved by the Minister.

Uninsured services, either in or out of the province include extended care within the province; private and semi-private accommodation when chosen by the patient; services provided by persons not employed by the hospital; custodial care, whether provided in hospital or at home, and care and treatment in institutions primarily concerned with mental or nervous disorders; cosmetic surgery, with certain exceptions; reversal of sterilization; electrolysis; penile prostheses; out-of-province cataract surgery and MRIs unless prior and written approval has been obtained from Saskatchewan Health; certain drugs, biologicals and related preparations; transportation costs (ambulance services), except between hospitals within the same Saskatchewan city; services provided outside Canada for the treatment of cancer involving the use of cancer treatment drugs or procedures not approved in Canada; and take-home drugs and appliances.

In addition to insured hospital services, the branches also directly fund a variety of other agencies, programs and activities, including the Saskatchewan Cancer Foundation; the Canadian Red Cross Society; community clinics; physical therapy facilities; the College of Medicine, University of Saskatchewan, and other health organizations.

Prescription drugs required outside of hospitals are eligible for cost-shared benefits through the Saskatchewan Prescription Drug Services Branch.

Supplementary benefits include patient charges for emergency medical transportation (road ambulance and Saskatchewan Government air ambulance service).

MEDICAL CARE PLAN

A comprehensive range of insured services is provided by medical practitioners and dentists.

Uninsured services under medical care insurance include services covered by the *Workers' Compensation Act* or by other federal or provincial legislation; travelling; advice to patients by telephone; surgery for cosmetic purposes, with exceptions; sterilization reversals; medical reports or certificates; eyeglasses; group immunizations; services provided by a person to the self or any dependants; acupuncture; *in vitro* fertilization; and any mental or physical examination for the purpose of employment, insurance, judicial proceedings, etc.

In addition to the basic insured health services, the province also provides, with limitations, a prescription drug plan; a children's dental educational program; a hearing aid plan; the Saskatchewan Aids to Independent Living (SAIL) Program, which provides medical equipment and appliances to disabled persons; limited coverage for services provided by chiropractors and optometrists; and coverage for services provided by chiropodists.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

All insured persons, as prescribed by the *Saskatchewan Hospitalization Act and Regulations*, are entitled to services covered by Saskatchewan Health. A person must be a resident of the province, that is, someone legally entitled to remain in Canada, who makes his/her home and is ordinarily present in the province, or any other person declared by the Lieutenant Governor in Council to be a resident, in order to become a beneficiary eligible for insured medical services. Eligibility for benefits for residents is solely dependent upon registration. No premiums are levied.

The following are ineligible: students from another province or territory entitled to or eligible for benefits in their home province or territory; members of the Royal Canadian Mounted Police; members of the regular Canadian Forces; and persons serving a term of imprisonment in a federal penitentiary.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence (General Policies)

Unmarried persons are entitled to insured services on and from the first day of the third month following the first day of residence in Saskatchewan. Married persons are entitled to insured services on and from the first day of the third month following establishment of residence by the last-arriving spouse.

Persons entitled to first-day coverage for insured health services include discharged members of the Canadian Forces and Royal Canadian Mounted Police; parolees and penitentiary inmates upon discharge; prisoners in a provincial jail; landed immigrants; in-patients of a mental hospital or facility; and persons nominated under the *Saskatchewan Assistance Act*. First-day coverage is available to persons from outside Canada who are in the province under a student or employment authorization issued by Citizenship and Immigration Canada.

A resident continues to be eligible for benefits during periods of temporary absence, provided that person is physically present in Saskatchewan for at least six months that a year; or the person is in full-time attendance at an accredited educational institution outside the province and is intending to return to maintain residence in Saskatchewan within 60 days of completion of studies; or the person is employed outside Canada under a contractual agreement for a period not exceeding 24 months and intends to continue residing in the province upon completion of the contract; or the person is ordinarily physically present in Saskatchewan but is temporarily absent from the province for not more than 12 consecutive months for the purpose of a vacation, visit, business engagement or employment.

Payment Arrangements In Canada

Saskatchewan Health pays for insured hospital services at the host province or territory rates. A common claim form is used by the out-of-province/ territory hospital to bill its provincial/territorial hospital insurance plan, which in turn bills the Saskatchewan Medical Care Insurance Branch.

The Medical Services Plan pays for insured medical services provided in other provinces and territories, except Quebec, according to a reciprocal billing arrangement. Out-of-province physicians bill their own health plans for services provided to Saskatchewan residents. These costs are periodically charged back to the Branch.

Payment Arrangements Outside Canada

Insured emergency in-patient services provided in approved hospitals are paid up to a maximum rate of $100 Canadian per day.

Emergency out-patient services provided by approved hospitals outside of Canada are paid up to a maximum rate of $50 Canadian per visit.

Emergency physician services covered in the province that are provided outside Canada are normally paid in Canadian funds at rates approved in Saskatchewan. Elective hospital and physician services are covered only if the treatment has received prior written approval of Saskatchewan Health.

No prior consent is required to obtain coverage for emergency physician services at Saskatchewan rates. However, where approval is obtained from the Medical Services Plan prior to treatment outside the country, for a service not available in Saskatchewan or another province in Canada, physicians may be paid a fair and reasonable fee (including exchange) charged in the place the service is obtained.

Prior approval is required for residents receiving cancer treatments, drugs or procedures outside Canada.

Permanent Moves Out of the Province

Residents moving permanently out of the province or outside Canada are eligible for coverage for the remainder of the month in which they take up new residence outside Saskatchewan, plus the following two months.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

Saskatchewan states that reasonable access to hospital and medical services is available for Saskatchewan residents.

As of March 31, 1997, there were 75 acute care hospitals in the province. Utilization data indicate that these hospitals operated about 4055 beds during 1996-97 (based on the Average Daily Census for all beds in acute care hospitals adjusted to reflect an assumption of 80 percent occupancy). In addition, 71 health centres, including six northern centres, provide emergency out-patient services. There is also one rehabilitation hospital. No user charges exist for hospital services. There are 1160 active physicians in the province. Effective August 1985, extra-billing by physicians, dentists, chiropractors and optometrists was banned. Under a new co-payment system introduced in 1992, chiropractors are now able to charge most patients an additional amount beyond the amount paid by the Plan.

Payment to Health Districts and Hospitals

Legislation authorizes the Minister of Health to make payments to health districts and hospitals. Semi-monthly payments are made on the basis of the estimated reasonable cost of providing insured services by each health district or hospital in the fiscal year.

As of March 31, 1996, 30 health districts were established under *The Health Districts Act*. Health districts receive funding for all hospitals within their boundaries, as well as for special care homes, ambulances and home care services, alcohol and drug services, community health services, and mental health services and accommodation. There are four hospitals in northern Saskatchewan where health districts have not been formed. Total funding to health districts and the four northern hospitals was $1,080.6 million in 1996-97 ($1,031 million operating and $49.6 million capital). An additional $13.7 million was spent on other northern health services. Saskatchewan hospitals and health districts received $9.0 million for in-patient and $2.5 million for out-patient care provided to residents of other provinces or territories under reciprocal agreements. During 1996-97, payments for insured hospital services provided to out-of-province Saskatchewan residents amounted to $25.79 million in Canada, and $3.1 million out of Canada, totalling $28.89 million.

System of Payment for Medical Care

Insured physician and dental services are paid on a fee-for-service basis in accordance with the Medical Services Plan payment schedule and assessment rules.

Reasonable Compensation

Legislative provisions include a method for determining reasonable compensation for physicians. Under these procedures, a Medical Compensation Review Committee is established, with members appointed by the Minister of Health and the Saskatchewan Medical Association. This committee attempts to reach an agreement on the amount of money to be made available during the term of the agreement and for adjustments in the general rates of payment for insured medical services contained in the medical care payment schedule. The legislation also includes provision for a Medical Compensation Review Board, an arbitration panel that acts in the event that the Committee is unable to reach an agreement.

During 1996-97, payments to physicians in the province totalled $242 million. Payments for insured physician services provided to Saskatchewan residents out of province amounted to $9.287 million in Canada; and $519,000 out of Canada, totalling $9.806 million.

Extended Health Care Services (EHCS)

The Province provides funding to district health boards for a variety of home care programs and other community based support services, and for special care homes.

Home care programs delivered by district health boards provide assessment and care co-ordination, meals, nursing, homemaking (including personal care and respite), home maintenance, a variety of volunteer services and, occasionally, therapies. Community support programs include adult day programs and institutional respite.

Special care homes provide residential care for adults who do not require acute care but do require a greater degree of care or supervision than they could receive in their own homes.

Personal care homes are private businesses that provide residential care to individuals over the age of 18. These facilities are licensed and monitored on an annual basis under *The Personal Care Homes Act*. The *Act* was passed in August 1989 and proclaimed on October 1, 1991.

The Province funds health districts to provide community health, mental and addiction service programs in institutional, home and community settings. Other programs delivered by health districts include community therapy and chiropody services.

Alberta

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Hospitalization Benefits Plan and the Health Care Insurance Plan are administered and operated on a non-profit basis. The Minister of Health is responsible for the Plans, and the accounts are audited annually by the Auditor General.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured hospital services under the Hospitalization Benefits Plan include accommodation and meals at the standard or public ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in a hospital, except when not considered medically necessary; routine surgical supplies; use of operating room, case room and anaesthetic facilities and necessary equipment and supplies, where available; use of radiotherapy, occupational therapy, speech therapy, respiratory therapy, psychiatric therapy and physical therapy facilities, where available, for in- and out-patients; services rendered by persons receiving remuneration from a hospital; semi-private or private accommodation when medically necessary; private nursing care when ordered by the attending physician and approved in accordance with hospital by-laws; pacemakers, steel plates, pins, joint prostheses, valve implants and any other goods approved by the Minister; transportation in Alberta, whether by ambulance or other commercial vehicle, to transport in- and out-patients between hospitals; out-patient goods and services including goods used in a medical procedure; and provision of designated drugs through clinics located in Edmonton and Calgary for persons with cancer, cystic fibrosis, HIV/ AIDS or growth hormone deficiency, or those requiring organ transplants.

Uninsured hospital services include preferred accommodation at the patient's request; televisions; telephones; take-home drugs, appliances and biologicals; private nursing services; artificial limbs and other external prosthetic appliances; and examination for the use of third parties.

The Department of Health administers the Cleft Lip/ Palate (Dental Indemnity) Program and provides funds for the Early Detection of Breast Cancer Program.

MEDICAL CARE PLAN

Insured health services under the Health Care Insurance Plan include all services provided by physicians that are medically required and listed in the Medical Benefits Regulations, and those services provided by a dental surgeon in the field of oral surgery as specified in the regulations.

Services not insured under the Plan include medico-legal services; medical reports or certificates; advice by telephone; examinations required by a third party for drivers' licences (except as required by law for seniors just prior to their 75th birthday, and as required thereafter), employment, schools, summer camps, insurance and similar purposes; services that a resident is eligible to receive under a statute of any other province or territory, under any statute relating to Workers' Compensation or under any statute of the Parliament of Canada; services not provided by or under the supervision of a practitioner; any service determined "not medically required" by a physician, or classed as experimental; drugs, plaster and special bandages; patient or practitioner transportation costs; lab and x-ray services performed in a facility not approved by the Minister; substance abuse, eating disorder or similar addictive behaviour treatment provided outside Alberta without prior approval of the Minister; routine

dental care, dentures, eyeglasses, hearing aids, medical and surgical appliances and supplies; services provided by a clinical psychologist, and physiotherapy.

In addition to the insured medical and dental services, the Alberta Health Care Insurance Plan provides some benefits in respect of additional services under the Basic Health Services Program, including chiropractic, oral surgery, optometric (for children under 19 and individuals over 65) and podiatric services. The Plan also provides out-of-province hospitalization and medical benefits for Alberta residents and Extended Health Benefits and Non-Group Blue Cross Benefits for eligible residents.

Non-Group Blue Cross coverage is available to all registered residents on an optional basis subject to the payment of premiums, and provides additional benefits for approved prescription drugs, accidental dental care, ambulance services, registered clinical psychological services, home nursing care, appliances and hospital care.

The Extended Benefits Program provides additional benefits for eyeglasses, and dental goods and services to residents aged 65 and older, their spouses and dependants, and eligible widows and widowers aged 55 to 64 and their dependants. Persons eligible for the Extended Benefits Program receive premium-free Blue Cross coverage.

The Alberta Aids to Daily Living Program, in co-operation with authorizers and vendors, assists individuals who have a chronic disability or illness, and individuals who are terminally ill, to secure certain basic medical supplies and equipment necessary for more independent functioning at home or in a home-like setting. Examples of supply and equipment support include medical and surgical supplies respiratory therapy benefits; walking aids; hearing aids; wheelchairs and accessories. There are quantity limits and price maximums for some of the benefits.

The Air Ambulance Program covers emergency air ambulance costs to transport residents within Alberta to receive the required level of service, when ordered by a physician. All air ambulance transfers are funded by the provincial government. Ground ambulance services are available in 141 locations throughout the province.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

All residents of Alberta, with the exception of members of the Canadian Forces, members of the Royal Canadian Mounted Police, and inmates of federal penitentiaries, are entitled to coverage under the Hospitalization Benefits Plan, provided they are registered with the Minister. Should the Minister discover a resident who is not registered, the Minister may register that resident and dependants. Registration entitles the resident to coverage for insured hospital and health services.

Although Alberta has a premium system, no resident is denied coverage due to an inability to pay premiums. The Alberta Health Care Insurance Plan offers a premium subsidy and premium waiver program for residents with financial hardships. Recipients of certain social allowances, inmates of Alberta correctional institutions, and mental health patients and their dependants receive premium-free coverage.

Seniors are required to pay premiums at the same rate as non-seniors. Lower and middle-income seniors receive premium subsidies through the Alberta Seniors Benefit Program.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

The minimum residence period for coverage under the Alberta Hospitalization and Medical Benefits Plans does not exceed three months.

First-day coverage is provided to people arriving from outside Canada and people discharged in Alberta from the Royal Canadian Mounted Police and the Canadian Forces, inmates released from federal penitentiaries, and specified persons from outside Canada who have established residence in Alberta.

A resident who is temporarily absent from the province for vacation, visit or business engagement reasons continues to be eligible for benefits, provided the absence does not exceed 12 consecutive months. A resident on educational leave from employment is eligible for benefits for the period of temporary absence up to a maximum of 24 consecutive months. A resident who works on behalf of a religious organization approved as a registered charity, such as a missionary worker, is eligible for benefits for the period of temporary absence up to a maximum of 48 consecutive months.

Coverage is maintained for the duration of the temporary absence from the province for students enrolled in full-time study at an accredited educational institution.

A resident must live in Alberta for the major portion of each year in order to maintain coverage. Premiums must continue to be paid during a temporary absence (premium assistance programs apply as for in-province coverage).

Regardless of the reason for temporary absence, residents are required to notify Alberta Health Care as soon as it appears likely that treatment for a single accident or illness will continue for more than three months.

Payment Arrangements In Canada

Payment for insured hospital and medical services provided to eligible Albertans elsewhere in Canada is at the rate approved by the hospital insurance plan of the province or territory in which the goods or services are provided, unless the Minister has entered into an agreement with the government of a province or territory to apportion the costs in a different manner.

Payments for insured medical services provided to eligible Albertans elsewhere in Canada are at the host provincial/territorial rates, except for Quebec. For Alberta residents who obtain physician services in Quebec, payments are made according to the Alberta rates.

Payment Arrangements Outside Canada

Hospitalization benefits are only payable when services are provided in active treatment general hospitals that provide standard services such as I.C.U. or emergency ward or auxiliary hospitals that provide standard acute care services to long-term or chronically ill patients. If services are not insured in the province, they are not insured when provided out of the country.

The maximum amount payable for out-of-country in-patient hospital services is $100 per day, (not including day of discharge). The maximum out-patient per visit rate is $50. Some specialists' out-patient services, such as CAT scans, are paid at higher rates.

Benefits for out-of-country practitioner services are payable according to the fee charged or the Alberta rate, whichever is the lesser.

Prior approval is required for the treatment of alcohol and substance abuse, eating disorders and similar addictive/behavioural disorders, whether the treatment is out-of-province or out-of-country.

Full coverage of treatment costs outside Canada may be provided under the following two programs:

- the Out-of-Country Health Services Program, which may apply where the required service is not available in Canada; and

- the Emergency Financial Assistance Program, which may apply where the treatment expense could not have been guarded against.

Permanent Moves Out of the Province

A resident leaving Alberta for the purpose of establishing permanent residence in another province or territory is entitled to continued coverage for the period beginning the day of leaving Alberta and ending on the last day of the second month following the month of arrival in the new province or territory, unless the period is extended by the Minister in special circumstances.

A resident establishing permanent residence outside Canada is entitled to continued coverage under the Plan, if the Minister is notified, for the period beginning the day of leaving Alberta and ending one, two or three months, as prescribed by the Minister, from that date, unless the period is extended by the Minister due to special circumstances.

A resident establishing permanent residence outside Canada is not entitled to continued coverage until all arrears of premiums have been paid as well as premiums applicable to the period of continuing coverage.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

In 1996-97 Albertans had access to acute care hospital services through 110 facilities and to long-term care services through 166 facilities throughout the province. Acute care hospitals operated 6787 beds, and long-term care operated 13,521 beds. Per diem accommodation rates for long-term residents effective April 1994 are $24.75 (standard), $26.25 (semi-private) and $28.60 (private). The charge is compatible with the exclusions provided for under subsection 19(2) of the *Canada Health Act.* In Alberta's restructured health system, Albertans also have to access insured diagnostic and treatment services through private clinics under contract to the Regional Health Authorities and community health centres. New models of continuing care are being evaluated across the province.

Payment to Hospitals

Hospitals are funded by the Regional Health Authorities (RHAs), mainly through global budgets.

Expenditures for out-of-province hospital and medical care were $28 million in 1995-96.*

System of Payment for Medical Care

Most physicians are paid on a fee-for-service basis. Medical practitioners are encouraged to bill the Plan, but are also allowed to bill the patient. Extra-billing for medical practitioners was terminated in Alberta on October 1, 1986.

Reasonable Compensation

In 1986 Alberta Health and the Alberta Medical Association reached an agreement that provided for negotiation of fees, and if necessary, a reference of fee disputes to arbitration. In 1991 this agreement was expanded to include a negotiated cap on the total medical care budget. Both agreements were ratified by majority vote of the members of the Alberta Medical Association.

Preliminary actuals in 1996-97 indicate that medical services expenses were $763,047 million including $736,700 million under an agreement between Alberta Health and the Alberta Medical Association for physician services. The remaining $26,347 million comprises out-of-province and out-of-country medical hospital payments for Albertans, physician salary programs not covered by the agreement with the Alberta Medical Association, clinical practice guidelines funding, supplementary medical and hospital funding and funds allocated to physicians from government reinvestment in the Regional Health Authorities.

* Latest year for which figures are available.

Extended Health Care Services (EHCS)

Alberta Continuing Care Centres provide room and board and a range of care services, from personal care with nursing supervision to skilled medical and therapeutic services. In most instances, both auxiliary hospitals and nursing homes are now referred to as Continuing Care Centres and they meet the needs of residents with similar care requirements. Funding for Continuing Care Centres has been transferred from Alberta Health to the 17 Regional Health Authorities (RHAs). RHAs either operate Continuing Care Centres or sign contracts with voluntary or private operators to deliver these services.

The Home Care Program is also delivered through the authorities and provides a variety of professional health and support services to assist individuals of all ages to return or remain at home. All Home Care Programs provide assessment, case co-ordination, and nursing and support services such as personal care and home support. Other services may include occupational, physical and respiratory therapy, speech-language pathology, social work and nutrition services.

Admission to the continuing-care system, which includes Home Care, Continuing Care Centres and Adult Day Programs, is based on a functional assessment of the individual's need, using the Alberta Assessment and Placement Instrument. The Single Point of Entry (SPE) process was developed to provide a single point of access to individuals seeking facility- or community-based long-term care. Its purpose is to ensure that all possible community options are explored before facility-based care is considered. Home Care staff conduct assessments, identify needs in co-operation with clients and their families, and recommend health and support services that best suit these needs.

Alberta Health also administers the Alberta Aids to Daily Living (AADL) Program. The purpose of AADL is to enhance the independence of clients living at home who have a chronic or terminal illness or disability, by assisting them with the provision of Program-approved medical equipment and supplies. Clients are assessed for eligibility by Regional Health Authority professionals working in community care, continuing care or acute care settings.

Mental health services delivered by the Provincial Mental Health Board include community clinics, two mental health hospitals, two care centres, and non-profit community agencies. Services provided by the clinics include assessment and treatment of individuals and families, and consultation to physicians, health facilities, health units, schools and community agencies. Two mental health hospitals provide assessment, treatment and rehabilitation for adults with mental illness, including mentally ill offenders, and for adults with brain injuries. Two residential care centres provide long-term rehabilitation programs for people with severe mental illness. More than 70 community agencies are funded to provide residential programs such as assessment units, assisted apartment living and group homes, and non-residential programs such as drop-in centres, counselling services, suicide prevention programs and family violence interventions.

Other services provided by Regional Health Authorities include specialized psychiatric services located in 17 hospitals throughout the province. Family physicians, Home Care Programs and Continuing Care Centres also provide services to people with mental illness.

British Columbia

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Hospital Insurance Plan is administered and operated on a non-profit basis by the Acute and Continuing Care Program of the Ministry of Health. The Program is responsible to the provincial government for the administration and operation of the Plan.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission, a public authority designated by statute. The Commission is responsible to the provincial government for the administration and operation of the Plan.

The Acute and Continuing Care Program and the Medical Services Commission are subject to audit of their accounts and financial transactions by the Auditor General of British Columbia.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured in-patient services provided by hospitals are accommodation and meals at the standard or public ward level; necessary nursing services; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister; clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the *Hospital Insurance Act*; routine surgical supplies; use of operating room and case room facilities; anaesthetic equipment and supplies; use of radiotherapy and physiotherapy facilities, where available; and other services approved by the Minister that are rendered by persons who receive remuneration from the hospital. Qualified persons not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Hospital out-patient benefits include out-patient renal dialysis treatments in designated hospitals or other approved facilities; diabetic day-care services in designated hospitals; out-patient dietetic counselling services at hospitals with qualified staff dieticians; psychiatric out-patient and day-care services; physiotherapy and rehabilitation out-patient day care services; cancer therapy and cytology services.

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures excluded under the *Hospital Insurance Act* are diagnostic out-patient services not associated with emergency services; the services of medical personnel not employed by the hospital; treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible; transportation to and from hospital; *in vitro* fertilization; cosmetic services solely for the alteration of appearance; and reversal of sterilization procedures. Uninsured hospital services also include preferred accommodation at the patient's request, televisions, telephones, and private nursing services.

MEDICAL CARE PLAN

The Medical Services Plan provides for all medically required services of medical practitioners and specified dental/oral surgery when it is necessary for it to be performed in hospital by a dental/oral surgeon. The broad category of services covered is consultations; complete examinations; home visits; major and minor surgery; obstetric services; surgical assistance; anaesthesia; diagnostic/therapeutic procedures; special and miscellaneous services; other office procedures; and other hospital procedures performed by a physician or dentist.

Services not insured are those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any third-party request for a medical examination or certificate; oral surgery rendered in a dentist's office; acupuncture; group immunizations; telephone advice; reversal of sterilization procedures; *in vitro* fertilization; medico-legal services; cosmetic services; and preventive medical counselling, for example, smoking withdrawal programs.

In addition to the basic insured health services, the province also provides screening mammography services; hearing devices at competitive prices; oral surgery and orthodontic treatments for patients aged 20 years or younger with cleft lip/palate or severe congenital facial abnormalities; and, with some limitations, the services of chiropractors, naturopaths, optometrists, physical therapists, massage therapy practitioners and podiatrists.

The Pharmacare program provides full or partial assistance with the cost of designated prescription drugs; ostomy and mastectomy supplies; prosthetic devices and orthotic bracing for children 19 years of age and under; needles and syringes for insulin-dependent diabetics; and blood-glucose testing strips for diabetics with a Certificate of Training from a recognized training centre.

Ambulance services are provided within the province by the British Columbia Ministry of Health through the Emergency Health Services Commission, with a nominal charge to the patient.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

All residents, excluding members of the Canadian Forces and the Royal Canadian Mounted Police and inmates of federal penitentiaries, are entitled to hospital and medical care insurance coverage.

There are no premiums for the Hospital Insurance Plan. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The accommodation rate, representing the cost of accommodation and meals, is established once a year. At the end of 1996-97, the maximum non-subsidized rate was $38 a day. Residents of limited means are eligible for assistance. There are five levels, ranging from 20 to 100 percent of the difference between the $38 rate and $24.50, being 85 percent of the Old Age Security and Guaranteed Income Supplement. In certain circumstances there is a provision to waive a portion of the $24.50 fee. Accommodation rates of less than $38 per day are reviewed quarterly and patients are advised one month before any changes.

Enrolment in the Medical Services Plan is not mandatory, but payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to access to care for those who meet the basic enrolment eligibility criteria. Residents of limited means are eligible for premium assistance. There are five levels, ranging from 20 percent to 100 percent of the full premium. Several months of retroactive coverage may be possible for persons previously enrolled in the Plan who have allowed their premiums to lapse, if they make up the required premium payments.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

The minimum residence requirement for hospital insurance and medical care coverage is a waiting period ending at midnight on the last day of the second month following the month in which the individual becomes a permanent resident.

The Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside of British Columbia, they must wait the prescribed period. Coverage is provided to landed immigrants who have completed the minimum residence requirement on the first day of the third month following the month of arrival in the province. After the waiting period coverage is available to persons from outside Canada who are in the province on work permits or student visas,

provided the permits or visas are valid for at least six months.

Individuals who leave the province temporarily on extended vacations or for temporary employment are covered for up to 12 months, provided the required premiums are paid. Residents may take annual vacations of up to six months provided they are physically present in the province for six months each calendar year.

Persons attending school outside Canada may be entitled to coverage for up to five years while away from the province; those working for some overseas non-governmental organizations may be entitled to coverage for up to two years while away from the province. Continuous coverage will be maintained, and is subject to payment of the required premiums, unless the individual returns after the expiration of the coverage, in which case the person must wait the required three months.

Payment Arrangements In Canada

According to interprovincial/territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents on presentation of a valid Medical Services Plan card (CareCard). British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered.

For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the interprovincial/territorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled through the interprovincial/territorial reciprocal billing procedures.

Payment Arrangements Outside Canada

With prior authorization, coverage is provided for hospital service not available in Canada at the hospital's usual and customary rate. In other circumstances, with prior authorization, in-patient coverage is at the established standard ward rate. Renal dialysis day care is available at the interprovincial/territorial Canadian rate. In all other cases, including emergency or sudden illness during temporary absences from the province, in-patient hospital care is paid up to $75 Canadian per day for adults and children, and $41 Canadian per day for newborns.

Out-of-country medical services are covered for emergency or sudden illness during temporary absences from the province. These are paid up to the same fee payable for that service had it been performed in British Columbia. Cases pre-authorized because of extenuating circumstances, however, are paid at the rate applicable where the service is rendered. With prior authorization, payment for non-emergency medical services outside the country may be made at usual and customary rates, when the acceptable treatment is not available in the province.

The attending specialist must request prior consent from the Ministry of Health. Consent may be given based on the merit of each request, even though the service is available in the province or elsewhere in Canada.

Elective services are provided only with prior authorization by both the Medical Services Plan of British Columbia and the Acute and Continuing Care Program.

Permanent Moves Out of the Province

Persons moving permanently to another part of Canada or to another country are entitled to coverage to the end of the second month following the month of departure. On interprovincial/territorial moves, persons may be extended coverage, not to exceed three months, for a reasonable period of travel. This additional coverage is not available when a person moves out of the country.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

British Columbia declares that there is reasonable access to hospital and medical care services. On March 31, 1997 there were 87 acute/rehabilitation care hospital societies (8871 beds and 1018 bassinets); two rehabilitation hospital societies (193 beds); and one federal hospital (12 beds) used by residents and for which the provincial Plan pays a per diem rate when the beds are used. The number of beds and bassinets available totalled 10,094. In addition, there were 18 Diagnostic and Treatment Centres and six Red Cross Outposts.

Patients admitted to acute/rehabilitation care during the fiscal year totalled 378,206, with total patient day services of 2,823,915. Included in this total were 179,650 alternative level of care days.

The province also offers access to care services for extended care patients. In 1996-97, these care units and the associated beds were offered by 71 acute/ rehabilitation hospital societies (7201 beds), and 10 hospital societies specialized in extended care (1440 beds). The number of extended care beds available totalled 8641.

Patients/residents admitted to these units totalled 7574, with total patient day services of 3,004,150.

Payment to Hospitals

Regular bi-weekly payments to hospitals are made by the Ministry of Health, based on annual operating grants determined by the Ministry. Adjustments to the grant may be made during the fiscal year after an appropriate review.

The 1996-97 cost of hospital programs (contributions to hospitals) was estimated at $2.881 billion. Payments to out-of-province hospitals included in the foregoing amount totalled $46.0 million for insured services provided to British Columbia residents.

System of Payment for Medical Care

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on billings submitted. The patient is not normally involved in the payment system. Ninety-eight percent of the claims are submitted electronically through the Teleplan Program, while the remaining two percent are submitted on claim cards by low-volume physicians.

The Medical Services Commission also funds certain medical services through alternative payment arrangements. An Alternative Payments Branch provides funding to some 350 health care agencies that retain physicians to deliver approved programs. Approximately 1800 physicians (equating to 730 full-time equivalent positions) have voluntarily entered into alternative payment arrangements with these agencies, and receive part or all of their income through salaries, sessions or service agreements. A variety of alternative payment arrangements are currently being explored, including capitation funding for family practice.

Reasonable Compensation

Compensation for medical practitioners is based on a fee schedule established by the Medical Services Commission with the advice of the British Columbia Medical Association. Other health care practitioners offering insured services have individual fee schedules approved by the appropriate co-managed tripartite special committees.

The master agreement between the Medical Services Commission, the Government of British Columbia and the British Columbia Medical Association, signed in December 1993 will be in place until the year 2000. Key elements include a binding dispute resolution mechanism, and participation by the Association in the Commission. One component of the agreement is a working agreement, in place between 1992-93 and 1996-97, but now revised for April 1, 1996 to March 31, 1998. The revised working agreement caps payments to physicians in 1996-97 at 1995-96 levels (almost $1.4 billion). For 1997-98, there is an additional $31 million available. As of April 1, 1996, a reserve fund of $26 million may be used to offset over-runs if the

cap is exceeded. On April 1, 1997, an additional $4 million was added to the reserve fund.

During 1996-97, payments to physicians and supplementary benefit practitioners in the province totalled an estimated $1.750 billion. For physician services provided out-of-province, the Plan paid approximately $15.8 million, of which approximately $13.6 million was for reciprocal payments to other provinces or territories.

Extended Health Care Services (EHCS)

The Acute and Continuing Care Program of the Ministry of Health provides a comprehensive range of community based supportive care services to assist people whose ability to function independently is affected by long-term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, home nursing care, physical therapy, occupational therapy, dietician counselling, social worker services, and meals programs); residential care services (family care homes, group homes, personal and intermediate care homes, private hospitals, extended care units and special care units); and special support services (adult day centres, respite care, and assessment and treatment centres). Services are delivered at the community level through health units and health departments.

Residential care services provide care and supervision in a protective, supportive environment for adults who can no longer be looked after in their own homes.

Home nursing care services provide professional nursing care to people of all ages in their own homes. These services are available on a non-emergency basis and include assessment, teaching, and consultation, care co-ordination, and direct nursing care for clients requiring chronic, acute, palliative or rehabilitative services.

Home support services provide non-professional assistance with personal care and housekeeping, and adult day centres offer a centre-based program of health, social and recreational activities.

Yukon

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Yukon's Hospital Insurance Services Plan and Health Care Insurance Plan are administered by employees appointed pursuant to the *Public Service Act*. Both plans are non-profit and are subject to audit by the Yukon Office of the Internal Auditor and the Auditor General's office.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured in-patient hospital charges include accommodation and meals at the standard ward level; all necessary nursing services; all laboratory, x-ray and diagnostic procedures; all drugs, biologicals and appliances prescribed by a physician and administered in hospital; operating room, case room and anaesthetic facilities; routine surgical supplies; radiotherapy and physiotherapy services; and services rendered by persons who are paid by the hospital.

In-patient days of care provided by active treatment centres are fully insured. Preferred accommodation is also insured if medically necessary. Out-patient visits to approved active treatment centres, where the purpose of the visit cannot be accomplished outside of a hospital context, are fully insured at prevailing approved rates.

Insured out-patient services include laboratory, radiology and other diagnostic procedures, together with the necessary interpretations to assist in diagnosis and treatment of any injury, illness or disability; necessary nursing services; drugs, biologicals and related preparations when administered in hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; and services rendered by persons who are paid by the hospital.

Non-insured services include non-resident hospital stays (for example, medical boarding); drugs and biologicals required following discharge; preferred accommodation surcharges when not medically necessary; special services at the patient's request, such as television charges, and private nursing when not medically necessary.

MEDICAL CARE PLAN

Insured services are defined as medically required services rendered by a medical practitioner. 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, surgical correction of prognathism or micrognathia.

Non-insured services include medico-legal services, including examinations and reports relating thereto, and testimony in court or provision of evidence in legal proceedings; detention time; insured services rendered by a medical practitioner to the self or any dependants, except where the Director decides otherwise; issuing prescriptions; the dispensing by a medical practitioner of medicines, drugs or medical appliances; the fitting and supply of eyeglasses; routine dental care including dental x-rays; services rendered for third parties; cosmetic services unless specifically approved by the Plan's Medical Advisor; reversal of sterilization procedures; medical reports or certificates; group immunizations; telephone advice; acupuncture; services provided by podiatrists, osteopaths, naturopaths, orthodontists, chiropractors and physiotherapists; dental surgery performed outside of a hospital; and laboratory and x-ray procedures performed in facilities not approved by the Plan.

In addition to insured benefits covered under the Yukon Health Care Insurance Plan and administered by the Yukon Department of Health and Social Services, supplementary benefits are provided under Health Benefits Program legislation, including Pharmacare and Extended Health Care Benefits for seniors; and a Chronic Disease and Disability Program. For insured services not available in the community, there is also a Travel for Medical Treatment Program that covers elective as well as emergency health transportation both within Yukon

and to tertiary care centres in Alberta and British Columbia. The Program also offers subsidies for meals and accommodation for patients travelling to centres where they receive medical treatment. Audiology, psychology, speech therapy, and screening mammography services are part of community health services funded by the Department.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

All Yukon residents, with the exception of members of the Canadian Forces and the Royal Canadian Mounted Police and inmates of federal penitentiaries, are entitled to full coverage under the Plans. Services that are medically required are provided on uniform terms and conditions to all bona fide residents of Yukon. "Resident" is defined using the wording of the *Canada Health Act*.

The *Yukon Health Care Insurance Plan Act* requires registration of self and dependants upon establishing residence. Eligibility is not linked by statute or regulation to registration. No premiums are levied.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

All terms and conditions of the Agreement on Eligibility and Portability are fully complied with. Definitions have been rendered consistent in regulations, policies and procedures. An insured person is eligible for insured services after midnight on the last day of the second month following the month of arrival in Yukon.

First-day coverage is provided for returning Canadians, landed immigrants, and persons discharged from the Canadian Forces, the Royal Canadian Mounted Police, and those released from federal penitentiaries. Coverage is available to persons from outside Canada who are in Yukon on work permits for one year or more. Residents must maintain a permanent residence and ordinarily be present in Yukon.

Payment Arrangements In Canada

In-patient services are paid at the standard ward per diem rate set by the relevant authority. Out-patient services and insured medical care and elective services are paid in accordance with reciprocal billing arrangements.

Payment Arrangements Outside Canada

The Yukon Hospital Insurance Services Plan will pay for out-of-country hospital services up to the Yukon rate at the discretion of the Director of Health Care Insurance.

Out-of-country hospital services are covered, in Canadian funds, provided they are comparable to services provided in Yukon. There is no exclusion of services.

Out-of-country medical services are covered, in Canadian funds, provided they are comparable to services provided in Yukon. There is no exclusion of services.

The Yukon Health Care Insurance Plan will pay for out-of-country physician services at the Yukon rate.

The Plan does not require prior consent for out-of-territory services.

Permanent Moves Out of the Territory

Coverage upon permanent departure is normally three months. This may be extended for periods of up to 12 months if the individual is not directly relocating.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

There are no user fees or co-insurance charges under the Hospital Plan. Hospital beds are readily available. No waiting list for admission exists.

Yukon has one acute care facility located in Whitehorse; beds staffed and in operation as of March 1997 totalled 59. Construction by the Department of Health and Social Services of a new 77-bed facility in Whitehorse to replace the existing facility is scheduled for completion in the fall of 1997.

Access to specialists and tertiary hospital care is insured through a publicly funded visiting medical specialist program and a travel for medical treatment program.

There is no extra-billing in Yukon for any services provided under the Health Care Insurance Plan.

Payment to Hospitals

Approved Yukon hospitals operate on annual funding levels. Hospitals submit a budget annually to the Yukon Hospital Insurance Services Plan for review.

Payments to Yukon hospitals totalled $18,944,842 in 1996-97. Total payments to out-of-territory hospitals equalled $5,676,424 during the same period.

System of Payment for Medical Care

Payments to physicians are made on a fee-for-service basis in the vast majority of cases. Some insured services are rendered on a contract basis. Reciprocal billing of physician claims for services rendered to Canadian non-residents and Yukon residents receiving medical services in another province or territory was introduced April 1, 1988.

Reasonable Compensation

Fees are negotiated with fee-for-service practitioners, depending on the duration of the agreement in force, with standing committees representing the health plan and the profession. These committees meet regularly to make redistributions, clarify practices, resolve problems and adjudicate disputed billing practices.

During 1996-97 payments to physicians in the territory totalled $9,157,048. For physician services provided outside the territory, the Plan paid $1,323,902.

Extended Health Care Services (EHCS)

Nursing home intermediate care, adult residential care and extended care services are provided in designated beds in hospitals, the Thomson Centre, Macaulay Lodge and the Alexander MacDonald Home for Seniors. Services include medical supervision and nursing, physiotherapy, recreation, and social programs.

Northwest Territories

Public Administration

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Hospital Insurance Plan is administered by the Department of Health and Social Services, Government of the Northwest Territories. Each hospital is required to submit annual statements that have been audited by a public accounting firm. The Audit Bureau of the Government of the Northwest Territories is also required by the *Territorial Hospital Insurance Services Act* to perform periodic examinations of the operations of each hospital.

The Medical Care Plan is administered entirely by the Northwest Territories Department of Health and Social Services. The Auditor General of Canada is responsible for auditing the accounts of the Government of the Northwest Territories.

Comprehensiveness

HOSPITAL INSURANCE PLAN

Insured in-patient services include accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; psychiatric and psychological services provided under an approved program; services rendered by persons who are paid by the hospital; and services rendered by an approved detoxification centre.

Out-patient services include laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy and speech therapy services in an approved hospital; and psychiatric and psychology services provided under an approved hospital program.

Services considered by the territories or the health community at large to be experimental are not insured. Services for cosmetic surgery, preferred accommodation at the patient's request, drugs and biologicals dispensed after discharge from a hospital, telephones, televisions, private nursing services and ambulance charges, with the exception of inter-hospital transfer, are non-insured.

Under the Hospital Insurance Plan, coverage is provided for chronic and extended care. Medical and nursing care are insured services. Room and board is not an insured service. Patients must contribute to room and board based on Territorial Hospital Insurance Services (THIS) regulations.

MEDICAL CARE PLAN

The Medical Care Plan insures all medically required procedures provided by medical practitioners, including approved diagnostic and therapeutic services; necessary surgical services; complete obstetrical care; eye examinations; and visits to specialists, even when there is no referral by a family physician. Dental services required as a result of injury or disease of the jaw are limited to specific oral surgery procedures provided in an approved health facility.

Not insured are medico-legal services; telephone advice or prescriptions given over the telephone; surgery for cosmetic purposes; medical reports or certificates; examinations on request of third parties; optometry services; acupuncture; group immunizations; *in vitro* fertilization; reversal of sterilization procedures; mileage charges; services provided by a medical practitioner to family; dressings, drugs, vaccines, biologicals and related

preparations; eyeglasses and special appliances; plaster, surgical appliances or special bandages; treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners; physiotherapy and psychology services received from other than an insured out-patient facility; services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and routine annual check-ups where there is no definable diagnosis. Where the patient has attained 65 years of age or is under the age of 10 and there is no definable diagnosis, benefits shall be paid for a routine check-up once every two years.

In addition to the basic insured health services, the Northwest Territories also provides a Medical Travel Subsidy Program and an Extended Health Benefits Program to assist Métis and non-Native residents with costs associated with investigation, treatment and maintenance, and for rehabilitation of long-term debilitating conditions. The benefits include drugs, medical supplies, appliances and prosthetics, and some travel benefits.

Universality

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

The Northwest Territories Plans entitle all residents of the Northwest Territories, excluding members of the Canadian Forces and the Royal Canadian Mounted Police, and inmates of federal penitentiaries, to be registered. Residence requirements are in accordance with the interprovincial Agreement on Eligibility and Portability. There are no special provisions outside this agreement. No premiums are levied.

Portability

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Minimum Residence

The minimum residence period does not exceed three months, though the Plan reserves the right to determine whether an individual has indeed taken up residence or is itinerant.

First-day coverage is provided to landed immigrants, those released from federal penitentiaries, and individuals discharged from the Canadian Forces or the Royal Canadian Mounted Police. Coverage is available to persons from outside Canada who are in the Northwest Territories on work permits.

Individuals who are temporarily absent from the Northwest Territories are covered for up to 12 months, provided prior notice is given.

Payment Arrangements In Canada

All hospital and medical care services are covered at the rate assessed by the host province or territory. Patients are not required to receive prior approval. Patients are not billed directly for hospital services, but may be reimbursed directly for medical care services, if required. However, benefits permitted are those determined and approved by the Northwest Territories.

Payment Arrangements Outside Canada

The Northwest Territories Health Care Plan covers insured hospital services provided out of the country up to Northwest Territories rates, paid in Canadian funds to residents. If service is not available within the Northwest Territories, the Department of Health and Social Services uses the rates set by an appropriate location within Canada.

The Plan covers insured medical services provided out of the country up to Northwest Territories rates. If service is not available within the Northwest Territories, the Department of Health and Social Services uses the rates set by an appropriate location within Canada.

In exceptional circumstances, the Plan will cover the full cost of out-of-country insured services when the Department of Health and Social Services has given prior approval for a specific request. Such approvals are limited to situations where there is a medical referral and the service is not available in Canada.

Permanent Moves Out of the Northwest Territories

Residents who move permanently to another part of Canada are provided coverage for three months as per the Eligibility and Portability Agreement. Coverage expires on the date of departure for residents leaving the Northwest Territories to establish permanent residence outside Canada.

Accessibility

HOSPITAL INSURANCE AND MEDICAL CARE PLANS

Reasonable Access

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories. In 1996-97 there were six acute care hospitals in the Northwest Territories with a total of 261 beds and cribs, and 44 bassinets. Northwest Territories Health Centres provided 111 holding beds and 48 bassinets.

Payment to Hospitals

Northwest Territories hospitals are paid on a budget review basis. Hospital care outside the Northwest Territories is paid through interprovincial/territorial reciprocal billing agreements. Expenditures for insured hospital services amounted to $89,864,000 in 1996-97. Payments to hospitals outside the Northwest Territories totalled $19,242,000 for insured services provided to Northwest Territories residents.

System of Payment for Medical Care

Physicians can be employed on salary by health boards or hospitals, or in private practice on a fee-for-service basis.

Reasonable Compensation

The Government of the Northwest Territories and the Northwest Territories Medical Association negotiated an agreement, subsequently signed into law, as regulations of the *Medical Care Act*. These regulations cover the period starting August 15, 1995 through March 31, 1997, permitting an overall annual net decrease of four percent.

During 1996-97 payments to Northwest Territories physicians totalled approximately $16,968,000. The Plans paid approximately $3,553,000 for physician services provided outside the territories.

Extended Health Care Services (EHCS)

Nursing home-level care is supported by Territorial Hospital Insurance and provided in designated beds in facilities in Inuvik, Chesterfield Inlet, Iqaluit, Yellowknife, Hay River, Fort Smith, Fort Simpson and Baffin Regional Hospital. Where appropriate services are not available in the Northwest Territories, clients are accommodated in facilities in southern Canada.

There are co-ordinated home care programs in Yellowknife, Hay River, Fort Smith, Inuvik, Baker Lake and Iqaluit.