Minister of Health Ministre de la Santé

The Honourable/L'honorable Tony Clement

Ottawa, Canada K1A 0K9

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

May it please Your Excellency:

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

Tony Clement

Canada

Acknowledgements

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

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Prince Edward Island Department of Health

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New Brunswick Department of Health and Wellness

Quebec Department of Health and Social Services

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

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Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

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Introduction

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

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

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

The approach taken for gathering information on provincial and territorial health care plans for the annual report continues to follow that set out in the letter sent in June 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, federal Minister of Health and Welfare, confirming the government's position with respect to the interpretation and implementation of the CHA. The approach outlined by Minister Epp established the foundation on which the CHA has been subsequently interpreted and applied. It is based on collaboration and interaction where the provinces, territories and the federal government work together to supply the information needed by the Minister for the CHAAR.

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

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

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

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

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

Chapter 1 – Canada Health Act Overview

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

What is the Canada Health Act?

The CHA is Canada's federal legislation for publicly funded health care insurance. The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

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

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

Key Definitions under the Canada Health Act

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

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

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

Insured hospital services are defined under the CHA and include medically necessary in- and out-patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required; nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

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

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

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

Requirements of the Canada Health Act

The CHA contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash entitlement under the CHT. They are:

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

The Criteria

1. **Public Administration (section 8)**

   The public administration criterion, set out in section 8 of the CHA, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

2. **Comprehensiveness (section 9)**

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

3. **Universality (section 10)**

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

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

4. **Portability (section 11)**

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

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

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

   If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid

at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

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

5. **Accessibility (section 12)**

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

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

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

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

The Conditions

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

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

Extra-billing and User Charges

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

Extra-billing (section 18)

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

User Charges (section 19)

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

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

Other Elements of the Act

Regulations (section 22)

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

- defining the services included in the CHA definition of "extended health care services";
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require, and the times at which and the manner in which that information may be provided; and
- prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

To date, the only regulations in force under the Act are the *Extra-billing and User Charges Information Regulations*. These regulations require the provinces and territories to provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied. They must also provide financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (A copy of these regulations is provided in Annex A.)

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the CHA, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT. In plain terms, when it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal cash contribution to that province or territory will be reduced by that same amount.

Discretionary Penalty Provisions

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

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

Excluded Services and Persons

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

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

These exclusions are discussed below.

Non-insured Health Services

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

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

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

Excluded Persons

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

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

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

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

Policy Interpretation Letters

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

Epp Letter

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

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

Marleau Letter – Federal Policy on Private Clinics

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

At the Federal-Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax, all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial

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

Dispute Avoidance and Resolution Process

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

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

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

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

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

Chapter 2 – Administration and Compliance

Administration

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

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

The Canada Health Act Division

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

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

Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)

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

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

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

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

Compliance

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

Health Canada's approach to resolving possible CHA compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to administering and interpreting the CHA have been addressed and resolved without resorting to deductions.

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

The Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Sources for this information include: provincial and territorial government officials and publications; media reports; and correspondence received from the public and other non-government organizations. Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate action. Verifying the facts with provincial and territorial health officials may reveal issues that are not directly related to the CHA, while others may pertain to the CHA but are a result of misunderstanding or miscommunication, and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff, then discuss the issue and its possible resolution with provincial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, is it brought to the attention of the federal Minister of Health.

Compliance Issues

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

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

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

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

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

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

Since 2002, two specialist referral clinics in British Columbia have been offering expedited consultations with physician specialists for a fee for individuals who choose to bypass their family physicians to seek specialized treatment. Under the CHA, charges over and above the rate paid by a provincial health insurance plan to insured persons for medically necessary hospital and physician services constitute extra-billing. In December 2004, Health Canada officials restated this position to British Columbia. Further bilateral consultations are required on this issue.

Patient charges for insured health services in private surgical clinics

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

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

Patient charges for medical/surgical supplies

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

Canada Health Transfer Deductions in 2004-2005

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

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

The *Canada Health Act*, which came into force April 1, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the CHA provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244.732 million in deductions were refunded to New Brunswick ($6.886 million), Quebec ($14.032 million), Ontario ($106.656 million), Manitoba ($1.270 million), Saskatchewan ($2.107 million), Alberta ($29.032 million) and British Columbia ($84.749 million).

Following the CHA's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the CHA did not reoccur until fiscal year 1994-1995. As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the CHA. Including deduction adjustments for prior years, dating back to fiscal year 1992-1993, deductions began in May 1994 until extra-billing by physicians was banned when changes to British Columbia's *Medicare Protection Act* came into effect in September 1995. In total, $2.025 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992-1993 and 1995-1996. These deductions and all subsequent deductions are non-refundable.

In January 1995, the federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her

communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the CHA. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

From November 1995 to June 1996, total deductions of $3.585 million were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan.

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

From November 1995 to December 1998, deductions from Manitoba's CHST cash contribution amounted to $2,055,000, ending with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001-2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of $50,033 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured services in fiscal years 1997-1998 and 1998-1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to $2,355,201.

With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Before it closed, a total deduction of $372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.

In January 2003, British Columbia provided a financial statement in accordance with the CHA Extra-Billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000-2001, totalling $4,610. Accordingly, a deduction of $4,610 was made to the March 2003 CHST cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001-2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001-2002.

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

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

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

(in dollars $)

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

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

Evolution of Federal Health Care Transfers

Grants to help establish programs

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

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

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

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

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

Established Programs Financing (EPF)

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

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

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

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

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

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

Canada Health and Social Transfer (CHST)

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

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

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

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

In 2000 and 2003, First Ministers met to discuss health care, focusing on reform, reporting and funding requirements. In 2000, the federal government announced $23.4 billion in new spending over five years on health care renewal and early childhood development. Between 2001-2002 and 2005-2006, the government announced an additional $21.1 billion dollars for increases to the CHST cash contributions, as well as an additional $1.8 billion for targeted programs (medical equipment and primary health care reform), and $500 million for Canada Health Infoway.

In 2003, the government committed $36.8 billion over five years to support priority areas of reform (primary care, home care and catastrophic drugs) through increased CHST transfers ($14 billion) and new, targeted transfers ($16 billion for the Health Reform Transfer; $1.5 billion for medical equipment), as well as support for federal direct spending on health ($5.3 billion for health information technologies, Aboriginal health initiatives, patient safety and other health-related federal initiatives). CHST increases included $3.9 billion in unrealized increases committed under the original time frame of the 2000 Accord (up to and including 2005-2006).

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

The Canada Health Transfer

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

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

2004 10-year Plan to Strengthen Health Care

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

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

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

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

http://www.fin.gc.ca/fedprov/ftpte.html

History of Federal Transfers Related to Health Care

1957 *The Hospital Insurance and Diagnostic Services Act* is passed unanimously in both the House of Commons and the Senate, establishing a cost-shared program providing universal insurance coverage and access to hospital services to all residents of participating provinces. By 1961, all provinces and territories have joined this program.

1966 The Canada Assistance Plan (CAP) is introduced, establishing a cost-shared program with provinces and territories for the provision of adequate assistance and institutional care programs for persons in need, including certain health care service (for example drugs and dental care services not covered under provincial programs or under existing transfer programs).

1968 The *Medical Care Act* is enacted, establishing a cost-sharing program that empowers the federal Minister of Health to make financial contributions to those provinces and territories that operate medical care insurance plans and meet minimum delivery criteria. By 1972, all provinces and territories are participating in this program.

1977 The *Federal-Provincial-Territorial Fiscal Arrangements and Established Programs Financing Act* (EPF Act) is passed. The Extended Health Care Services Program is established providing virtually unconditional per capita funding for certain types of long-term residential care services, home care and adult day care services.

1984 The *Canada Health Act* is passed, amalgamating the provisions of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. The Act also includes the extended health care services provisions, which had previously been included under the EPF. The CHA now provides for dollar-for-dollar deductions regarding extra-billing and user charges, and discretionary deductions relating to other elements of the criteria and conditions set out in the Act.

The EPF Act is re-named *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, 1977.

1995 It is announced in the federal budget that in "established programs" funding under the EPF Act and CAP, cost-sharing will be replaced by Canada Health and Social Transfer (CHST) block fund beginning April 1, 1996. CHST entitlements are set at $26.9 billion for 1996-1997. CHST entitlements for 1996-1997 are to be allocated in the same proportion as combined EPF and CAP entitlements for 1995-1996.

Section 6 of the CHA (amount payable for extended health care services) was deleted in 1995 to reflect the new fiscal arrangements adopted by the government (i.e. Canada Health and Social Transfer) that required one payment to provinces and territories rather than multiple payments. This change did not reduce the scope of insured health services under the Act. Extended health care services are not and never were insured health services under the CHA.

1996 A five-year CHST funding arrangement (1998-1999 to 2002-2003) is announced in the federal government budget. It provides a cash floor transfer to provinces and territories originally set at $11 billion per year.

1998 The *Federal-Provincial-Territorial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* is amended to put in place a $12.5 billion CHST cash floor, beginning in 1997-1998 and extending to 2002-2003.

1999 Increases in provincial and territorial CHST cash entitlements of $11.5 billion over five years are announced in the federal government budget. The $11.5 billion is

provided to address fiscal pressures in the health care sector.

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

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

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

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

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

2004 In September, the First Ministers sign the 10 Year Plan to Strengthen Health Care. In support of the Plan, the Government of Canada commits $41.3 billion in additional funding to provinces and territories for health, including $35.3 billion in increases to the CHT, $5.5 billion in Wait Times Reduction funding, and $500 million in support of medical equipment. The CHT base cash contribution amount will be increased to $19 billion starting in 2005-2006 and an escalator of six per cent annually will be applied to the CHT effective 2006-2007 to provide continued predictable growth in federal support for health.

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

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

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

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* (CHA) program criteria and conditions in 2004-2005.

Officials in the provincial, territorial and federal governments have collaborated to produce the detailed plan overviews contained in Chapter 3. While all provinces and territories have submitted detailed descriptive information on their health insurance plans, New Brunswick and Quebec have chosen not to submit supplemental statistical information which is contained in the tables in this year's report. The information that Health Canada requested from the territorial departments of health for the report consists of two components:

- a narrative description of the provincial or territorial health care system relating to the five criteria and the first condition (that of providing the Minister of Health with information in relation to insured health services and extended health care services) of the CHA, which can be found following this chapter; and
- statistics identifying trends in the provincial and territorial health care systems.

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

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

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

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

Insurance Plan Descriptions

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

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

Improvements to Accessing Health Care Services

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

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

Provincial and Territorial Health Care Insurance Plan Statistics

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

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

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

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

Organization of the Information

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

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

Public Facilities: Statistics on facilities providing insured hospital services, excluding psychiatric hospitals and nursing homes (which are not covered under the CHA), are provided in fields two and three

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

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

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

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

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

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

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

Annex A – Canada Health Act and Extra-Billing and User Charges Information Regulations

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original act, which includes any amendments that have been made since the Act's passage.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. These regulations are also presented in an office consolidation format.

This unofficial consolidation is current to June 2001.

CANADA

OFFICE CONSOLIDATION

Canada Health Act

R.S., 1985, c. C-6

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

L.R. (1985), ch. C-6

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Preamble

Whereas the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

And whereas the Parliament of Canada wishes to encourage the development of health

CHAPITRE C-6

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

services throughout Canada by assisting the provinces in meeting the costs thereof;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act.*

1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" *« contribution pécuniaire »*

"cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" *« dentiste »*

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" *« services complémentaires de santé »*

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" *« surfacturation »*

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" *« régime d'assurance-santé »*

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" *« professionnel de la santé »*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *« hôpital »*

"hospital" includes any facility or portion

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

« assuré » "insured person"

« assuré » Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) des membres de la Gendarmerie royale du Canada nommés à un grade;

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la Loi sur le système correctionnel et la mise en liberté sous condition;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

« contribution » [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » "cash contribution"

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé et de programmes sociaux qui peut être versée à une province au titre des paragraphes 15(1) et (4) de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces.

«dentiste » "dentist"

« dentiste » Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

« frais modérateurs » *"user charge"*

« frais modérateurs » Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables, soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *« services hospitaliers »*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *« services de santé assurés »*

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

« habitant » *"resident"*

« habitant » Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

« hôpital » *"hospital"*

« hôpital » Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

« loi de 1977 » [Abrogée, 1995, ch. 17, art. 34]

« médecin » *"medical practitioner"*

« médecin » Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

« ministre » *"Minister"*

« ministre » Le ministre de la Santé.

« professionnel de la santé » *"health care practitioner"*

« professionnel de la santé » Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

« régime d'assurance-santé » *"health care insurance plan"*

« régime d'assurance-santé » Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

« services complémentaires de santé » *"extended health care services"*

« services complémentaires de santé » Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

« services de chirurgie dentaire » *"surgical-dental services"*

« services de chirurgie dentaire » Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

"insured person" *« assuré »*

"insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" *« médecin »*

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" *« ministre »*

"Minister" means the Minister of Health;

"physician services" *« services médicaux »*

"physician services" means any medically required services rendered by medical practitioners;

"resident" *« habitant »*

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" *« services de chirurgie dentaire »*

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" *« frais modérateurs »*

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c.8, s. 32; 1999, c. 26, s. 11.

« services de santé assurés » *"insured health services"*

« services de santé assurés » Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

« services hospitaliers » *"hospital services"*

« services hospitaliers » Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

« services médicaux » *"physician services"*

« services médicaux » Services médicalement nécessaires fournis par un médecin.

« surfacturation » "extra-billing"

« surfacturation » Facturation de la prestation à un assuré par un médecin ou un dentiste d'un service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

RAISON D'ÊTRE

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36.

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé et de programmes sociaux (ci-après, Transfert).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36.

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

1984, c. 6, s. 7.

CONDITIONS D'OCTROI

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à :

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé :

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province :

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

1984, c. 6, s. 11.

Définition de «services de santé assurés facultatifs»

(3) Pour l'application du paragraphe (2), « services de santé assurés facultatifs » s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

1984, ch. 6, art. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

Accessibilité

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Rémunération raisonnable

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)c) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa a), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les organisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa b), sauf par une loi de la province.

1984, ch. 6, art. 12.

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre

(*b*) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to

prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37.

MANQUEMENTS

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas

12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

EXTRA-BILLING AND USER CHARGES

ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Entrée en vigueur du décret

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Nouvelle application des réductions ou retenues

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

Application aux exercices ultérieurs

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

SURFACTURATION ET FRAIS MODÉRATEURS

Surfacturation

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

1984, ch. 6, art. 18.

Frais modérateurs

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Réserve

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

RÈGLEMENTS

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a*) à *d*) de la définition de «services complémentaires de santé» à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13a) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13b).

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)a) ou b) qu'avec l'accord de chaque province.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the Federal-Provincial Fiscal Arrangements Act, as it read immediately before April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40.

REPORT TO PARLIAMENT

Annual report by Minister

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

1984, c. 6, s. 23.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)a) s'ils sont sensiblement comparables aux règlements pris en vertu de la Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces, dans sa version précédant immédiatement le 1er avril 1984.

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)c) ou d) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40.

RAPPORT AU PARLEMENT

Rapport annuel du ministre

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

Extra-billing and User Charges Information Regulations

SOR/86-259

CODIFICATION ADMINISTRATIVE

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

WARNING NOTE

Users of this office consolidation are reminded that it is prepared for convenience of reference only and that, as such, it has no official sanction.

AVERTISSEMENT

La présente codification administrative n'est préparée que pour la commodité du lecteur et n'a aucune valeur officielle.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(a) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH Pprovince

SHORT TITLE

1. These Regulations may be cited as the Extra-billing and User Charges Information Regulations.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; (*Loi*)

"Minister" means the Minister of National Health and Welfare; (*ministre*)

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. (*exercice*)

TYPES OF INFORMATION

3. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

4. For the purposes of paragraph 13(a) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13a) DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. Règlement concernant les renseignements sur la surfacturation et les frais modérateurs.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

« exercice » La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. (*fiscal year*)

« Loi » *La Loi canadienne sur la santé*. (*Act*)

« ministre » Le ministre de la Santé nationale et du Bien-être social. (*Minister*)

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. Pour l'application de l'alinéa 13a) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(*a*) in respect of the estimates referred to in paragraphs 3(*a*) and 4(*a*), before April 1 of the fiscal year to which they relate; and

(*b*) in respect of the financial statements referred to in paragraphs 3(*b*) and 4(*b*), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(*a*) and 4(*a*) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a*) et 4*a*), avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b*) et 4*b*), avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3a) et 4a), avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

Annex B – Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

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

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

Federal Policy on Private Clinics

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

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

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

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985

OTTAWA, K1A 0K9

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act*. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role – both financial and otherwise – to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the *Canada Health Act* is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act*.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily

absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/ territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad- based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;
2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp

Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- ☐ weakened public support for the tax funded and publicly administered system;
- ☐ the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- ☐ the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- ☐ the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system – resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly

funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> "we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau

Minister of Health

Annex C – Dispute Avoidance and Resolution Process under the Canada Health Act

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

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

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

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

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the CHA dispute avoidance and resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the Canada Health Act Dispute Avoidance and Resolution process.

Minister of Health  Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act.*

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act.* This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act,* will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

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

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and health ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

Fact Sheet: Canada Health Act Dispute Avoidance and Resolution Process

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act issues*; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

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

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

Annex D – Documents Related to the Canadian Health Care System

The following is a listing of provincial and territorial documents and materials that relate to the five criteria of the *Canada Health Act* and to the recognition condition. These documents include annual reports of health care departments, financial documents relating to provincial and territorial health care, audit and evaluation reports and references to provincial and territorial legislation. Also included is some material that is national in scope.

Provincial/Territorial References to the Health Care System

Government of Newfoundland and Labrador

- ☐ Department of Health and Community Services. *Annual Report, 2004-2005*
  www.health.gov.nl.ca/health/publications/default.htm
- ☐ Department of Health and Community Services. *HealthScope 2004. Reporting to Newfoundlanders and Labradorians on Comparable Health and Health System Indicators*
  www.health.gov.nl.ca/health/publications/pdfiles/healthscope_report_2004.pdf
- ☐ Office of the Auditor General. *Report of the Auditor General to the House of Assembly on Reviews of Departments and Crown Agencies for the year ended March 31, 2004*
  www.ag.gov.nl.ca/ag/2004AnnualReport/AR2004.htm
- ☐ Legislation
  www.health.gov.nl.ca/health/legislation/default.asp

Government of Prince Edward Island

- ☐ PEI Department of Health. *Annual Report 2003-2004*.
  www.gov.pe.ca/photos/original/hss_ar_03_04.pdf
- ☐ PEI Department of Health. *Prince Edward Island's Second Report on Common Health Indicators*.
  www.gov.pe.ca/photos/original/HSS_CHI_04.pdf
- ☐ PEI Department of Health. A System that Meets the Priority Needs of the Citizens.
  www.gov.pe.ca/photos/original/DH_WaitTimes.pdf
- ☐ PEI Department of Health. *Hospital and Medical Services Insurance on Prince Edward Island*.
  www.gov.pe.ca/photos/original/hss_hms_ins_pei.pdf
- ☐ Office of the Auditor General. *2005 Report of the Auditor General to the Legislative Assembly*.
  www.gov.pe.ca/photos/original/ag_2004_report.pdf
- ☐ Legislation
  www.gov.pe.ca/law/statutes/index.php3

Government of Nova Scotia

- Department of Health. *Annual Accountability Report for the Fiscal Year 2004-2005*
  www.gov.ns.ca/health/downloads/2004-2005_Annual_Accountability_Report.pdf
- Department of Health. *2005 2006 Business Plan*
  www.gov.ns.ca/health/downloads/2005 2006%20DoH%20Business%20Plan.pdf
- Nova Scotia Wait Times: *Getting Healthcare Services*
  www.gov.ns.ca/health/waittimes/
- Auditor General of Nova Scotia: *Chapters from the Annual Reports of 1996 2004 relating to Health*
  www.gov.ns.ca/audg/health.html
- Legislation: *Consolidated Public Statutes*
  www.gov.ns.ca/legislature/legc/

Government of New Brunswick

- Department of Health and Wellness. *2003-2004 Annual Report*.
  www.gnb.ca/0051/pub/pdf/2003 04_AnnualReport.pdf
- Department of Health and Wellness. *Budget 2004-2005 Backgrounder*.
  www.gnb.ca/0051/budgets/pdf/Backgrounders2004 05 e.pdf
- Department of Health and Wellness. *Reporting to New Brunswickers - The New Brunswick Health Care Report Card 2004*
  www.gnb.ca/0051/pub/pdf/2947e final.pdf
- Department of Health and Wellness. *Healthy Futures: Securing New Brunswick's Health Care System. The Provincial Health Plan 2004-2008*
  www.gnb.ca/0051/pdf/healthplan 2004 2008_e.pdf
- Legislation: Department of Health and Wellness. Statutes Under the Jurisdiction of the Minister of Health and Wellness and Administered by the Department of Health and Wellness.
  www.gnb.ca/0062/deplinks/ENG/Haw.htm

Government of Quebec

- Ministère de la Santé et des Services sociaux. [Department of Health and Social Services] *Rapport annuel de gestion 2004-2005*.
  http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05 102 01.pdf
- Ministère de la Santé et des Services sociaux. [Department of Health and Social Services] *Report on the progress made regarding the bilateral agreement entered into during the federal provincial territorial meeting of the first ministers on health*, (September 2004)
  http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05 720 01A
- Vérificateur générale du Québec. [Auditor General of Quebec] *Report to the National Assembly for 2004-2005*
  www.vgq.gouv.qc.ca/publications/Rapp_2005_1/Highlights/Highlights.pdf
- Legislation.
  www.justice.gouv.qc.ca/english/sites/lois a.htm

Government of Ontario

- Ministry of Health and Long-term Care. *Ontario's Health System Performance Report 2004*
  www.health.gov.on.ca/english/public/pub/ministry_reports/pirc_04/pirc_04.html
- Ministry of Health and Long-term Care. *2003–2004 Report Card for Ontario Drug Benefit Program*
  www.health.gov.on.ca/english/public/pub/ministry_reports/odb_report03/drug_rep.html
- Ministry of Health and Long-Term Care. *Wait Times in Ontario*
  www.health.gov.on.ca/transformation/wait_times/wait_mn.html
- Office of the Auditor General of Ontario. *Reports by Topic: Health*
  www.auditor.on.ca/en/reports_health_en.htm
- Legislation: *Commitment to the Future of Medicare Act, 2004*
  www.health.gov.on.ca/english/public/legislation/bill_8/hu_medicare.html

Government of Manitoba

- Manitoba Health. *Departmental Annual Report 2004-2005*
  www.gov.mb.ca/health/ann/index.html
- Manitoba Health. *Manitoba Infohealth Guide.*
  www.gov.mb.ca/health/guide/index.htm
- Manitoba Health. *Wait Time Information*
  www.gov.mb.ca/health/waitlist/index.html
- Office of the Auditor General of Manitoba.
  www.oag.mb.ca/reports/reports_fr.htm
- Legislation: *Consolidated Statutes*
  http://web2.gov.mb.ca/laws/statutes/index.php

Government of Saskatchewan

- Saskatchewan Health. *Its for Your Benefit - A Guide to Health Coverage in Saskatchewan.*
  http://www.health.gov.sk.ca/mc_dp_skhealthbooklet.pdf
- Saskatchewan Health. *2004-2005 Annual Report.*
  www.health.gov.sk.ca/mc_dp_skhlth_2004 05_ar.pdf
- Drug Plan and Extended Benefits Branch. *Annual Statistical Report 2004-2005*
  http://formulary.drugplan.health.gov.sk.ca/publications/2004-2005_Annual_Report.pdf
- Medical Services Branch. *Annual Statistical Report 2004-2005*
  www.health.gov.sk.ca/mc_dp_msb_asr04_05.pdf
- Saskatchewan Health Information Network. *Annual Report 2004-2005*
  www.health.gov.sk.ca/mc_dp_shin_ar_2004 05.pdf
- Office of the Provincial Auditor of Saskatchewan.
  www.auditor.sk.ca
- Saskatchewan Health Legislation.
  www.health.gov.sk.ca/mc_legislation.html

Government of Alberta

- Alberta Ministry of Health and Wellness. *Annual Report 2004-2005*
  www.health.gov.ab.ca/resources/publications/AR04_05/index.html
- Ministry of Health and Wellness. *Health Costing in Alberta: 2005 Annual Report*
  www.health.gov.ab.ca/resources/publications/pdf/Health_Costing_2005.pdf
- Ministry of Health and Wellness. *Business Plan 2005 2008*
  www.finance.gov.ab.ca/publications/budget/budget2005/health.html
- Ministry of Health and Wellness. *2005-2006 Regional Health Authority Global Funding Methodology and Funding Manual*
  www.health.gov.ab.ca/resources/publications/pdf/RHA05to06FundManual.pdf
- Auditor General of Alberta.
  www.oag.ab.ca/
- Legislation
  www.health.gov.ab.ca/about/Minister_legislation.html

Government of British Columbia

- Ministry of Health. *2004-2005 Annual Service Plan Report*.
  http://www.bcbudget.gov.bc.ca/annualreports/hs/hs.pdf
- Ministry of Health. B.C. S*urgical Wait Times*.
  www.healthservices.gov.bc.ca/waitlist/
- Ministry of Health. British Columbia Medical Association. *Rural Programs 2004 07: A Guide for Rural Physician Programs in British Columbia*.
  www.healthservices.gov.bc.ca/cpa/publications/rural_programs.pdf
- Ministry of Health. *Facts About Residential Care*.
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Annex E – Glossary of Terms Used in the Annual Report

The terms discribed in this glossary are defined within the context of the *Canada Health Act*. In other situations, these terms may have different definition or interpretation.

Term	Description
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health care insurance plans of provinces and territories provide: ❑ insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; ❑ payment for insured health services according to a system of payment authorized by the law of the province or territory; ❑ reasonable compensation for all insured health care services rendered by physicians and dentists; and ❑ payment to hospitals to cover the cost of insured health care services.
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Block Fee	This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Canada Health Act (CHA)	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 replaced the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The health portion of the CHST was replaced by the Canada Health Transfer effective April 1, 2004.

Term	Description
Canada Health and Social Transfer (CHST)	Coming into effect April 1, 1996, the Canada Health and Social Transfer (CHST) to provinces and territories provided support of health care, post-secondary education, social assistance and social services. The CHST replaced the Canada Assistance Plan, which cost-shared provincial and territorial social assistance programs. It also replaced the Established Programs Financing (EPF), which provided funding to support health care and post-secondary education. The CHST was composed of a tax transfer and a cash transfer. The tax transfer component went back to 1977 when, under EPF, the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates in all provinces while they increased their tax bases by an equivalent amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments. The CHST gave provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the CHA and the condition that there be no period of minimum residency with respect to social assistance.
Canada Health Transfer (CHT)	Effective April 1, 2004, the CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the *Canada Health Act*. The CST is a block fund in support of post-secondary education, social assistance and social services. It provides provinces and territories with the flexibility to allocate funds among social programs according to their respective priorities.
Chronic Care	Chronic care is care required by a person who is chronically ill or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable and who requires a range of services and medical management that can only be provided by a hospital.
Chronic Care Facility	A chronic care facility is a health care facility that provides ongoing, long-term, in-patient medical services. Chronic care facilities do not include nursing homes.
Comprehensiveness	A criterion of the *Canada Health Act* (section 9), which states that the health insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where provided by law in a province or territory, services rendered by other health care practitioners.
Consultation Process	Under Section 14(2) of the *Canada Health Act*, the Minister of Health must consult with a province or territory with respect to a potential breach of the five criteria and two conditions of the Act, before discretionary penalties can be levied for that province or territory.
Convention Refugee	A Convention refugee is a person who meets the definition of refugee in the *1951 United Nations Convention Relating to the Status of Refugees*. In general, it is someone who has left his or her home country and has a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group and is unable or, by reason of his or her fear, unwilling to seek the protection of the home country. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.

Term	Description
Coordinating Committee for Reciprocal Billing (CCRB)	Please see "Interprovincial Health Insurance Agreements Coordinating Committee."
Diagnostic Imaging	A procedure that detects or determines the presence of various diseases and/or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
Diagnostic Physician Service	For purposes of reporting on the *Canada Health Act*, a diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach of any of the five criteria or two conditions of the *Canada Health Act* have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Dispute Avoidance and Resolution (DAR)	In April 2002, provincial and territorial governments accepted a *Canada Health Act* dispute avoidance and resolution (DAR) process that would apply to the interpretation of the principles of the *Canada Health Act* as outlined by the Honourable A. Anne McLellan, federal Minister of Health, in a letter to the Honourable Gary Mar, Alberta Minister of Health and Wellness. The *Canada Health Act* dispute avoidance and resolution process commits governments to continue to actively participate in ad-hoc federal, provincial and territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise. Health Canada will also continue to provide advance assessments on provincial and territorial measures and direction, when requested. Please see Annex C of this report for a more detailed description of the DAR process.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.

Term	Description
Epp Letter	In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*. Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the *Canada Health Act*. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the *Canada Health Act*. The letter has been reproduced for reference purposes in Annex B of this report.
Established Programs Financing (EPF)	Introduced in 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, also known as the *EPF Act*, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories. The EPF transfer was a block fund which increased annually on the basis of economic and population growth. Under the EPF, cash and tax transfers were provided to provinces and territories in support of health and post-secondary education. Tax transfers consisted of income tax points transferred by the federal government to provincial and territorial governments in 1977. In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion in EPF entitlement (cash plus tax), 71.2 percent of which was intended for health care and the rest for post-secondary education. The EPF transfer was replaced in 1996 by the Canada Health and Social Transfer.
Extended Health Care Services	Section 2 of the *Canada Health Act* defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.
Extra-billing	Section 2 of the *Canada Health Act* defines extra-billing as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Extra-billing and User Charges Information Regulations	The only regulations in force under the *Canada Health Act* are the Extra-billing and User Charges Information Regulations, which require provincial and territorial governments to provide to the federal Minister of Health, prior to the beginning of a fiscal year, estimates of extra-billing and user charges that are permitted to exist under their health care insurance plans so that appropriate deductions to federal transfers can be levied. Provincial and territorial governments are also required under these Regulations to provide financial statements showing the amounts of extra-billing and user charges actually charged in a fiscal year so that reconciliations with previously estimated deductions can be applied. A copy of these regulations is provided in Annex A of this report.

Term	Description
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Diane Marleau wrote to each of her provincial and territorial counterparts, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995. These penalties take the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer. The Marleau Letter is included in Annex B of this report.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	The *Canada Health Act* (section 2) defines a health care insurance plan as a plan or plans established by the law of a province or territory to provide for insured health services as defined under this same Act. (Please refer to definition of insured health services in this glossary.)
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*. The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the *Canada Health Act* in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been 5 applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.

Term	Description
Hospital	Section 2 of the *Canada Health Act* defines a hospital as any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include a hospital or institution primarily for the mentally disordered, or a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows for the reciprocal processing of out-of-province or out-of-territory claims for hospital in- and out-patient services from either jurisdiction. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Insured Health Services	Under Section 2 of the *Canada Health Act*, insured health services means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any act of the legislature of a province that relates to workers' or workmen's compensation.
Insured Hospital Services	Under Section 2 of the *Canada Health Act* and the Federal Policy on Private Clinics, insured hospital services include any of the following services provided to in-patients or out-patients at a hospital or clinic if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely: ❑ accommodation and meals at the standard or public ward level and preferred accommodation if medically required; ❑ nursing service; ❑ laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; ❑ drugs, biologicals and related preparations when administered in the hospital or clinic; ❑ use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; ❑ medical and surgical equipment and supplies; ❑ use of radiotherapy facilities; ❑ use of physiotherapy facilities; and ❑ services provided by persons who receive remuneration from the hospital or clinic.

Term	Description
Insured Person	An insured person is interpreted under the *Canada Health Act* as a resident of a province or territory other than ❑ a member of the Canadian Forces, ❑ a member of the Royal Canadian Mounted Police who is appointed to rank therein, ❑ a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or ❑ a resident of the province or territory who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province or territory for eligibility for or entitlement to insured health services.
Insured Physician Service	Please see "Physician Services."
Insured Surgical-Dental Service	Please see "Surgical-Dental Services."
Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)	The Interprovincial Health Insurance Agreements Coordinating Committee, comprised of federal, provincial and territorial health department officials, was established in 1991 as the Coordinating Committee for Reciprocal Billing (CCRB), with the mandate to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of the provincial/territorial reciprocal billing agreements is to ensure that eligible Canadians have access to medically necessary health services when referred for these services outside their province or territory, when travelling or during educational leave or temporary employment. In 2002, the Committee changed its name to the Interprovincial Health Insurance Agreements Coordinating Committee to better reflect that the Committee's scope also extends to eligibility for health insurance coverage as well as interprovincial/territorial billing issues.
Mandatory Penalties	Provinces that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from federal transfer payments. Mandatory penalties are outlined in sections 20 to 21 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach any of the extra-billing and user charges provisions of the *Canada Health Act* has been identified and could not otherwise be resolved through consultations between the respective levels of government.
Medical Necessity	Under the *Canada Health Act*, the provincial and territorial governments are required to provide medically necessary hospital and physician services to their residents on a prepaid basis, and on uniform terms and conditions. The Act does not define medical necessity. The provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, are primarily responsible for determining which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by public health insurance to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.

Term	Description
Medical Practitioner	Section 2 of the *Canada Health Act* defines a medical practitioner as a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person.
Medical Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licenced physician to residents of the other jurisdiction. Where a reciprocal billing agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physician	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at provincial or territorial fee schedule rates. The provincial or territorial plans reimburse patients of opted-out physicians for charges up to, but not more than the amount paid by the plan under fee schedule agreement.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Diagnostic Care	Out-patient diagnostic care includes health care services in a health care facility for procedures that do not require an overnight stay and that detect and/or determine various diseases or health conditions.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician/Dentist	These are licensed physicians or dentists who are enrolled in provincial or territorial health insurance plans.
Physician Services	Section 2 of the *Canada Health Act* defines physician services as any medically required services rendered by medical practitioners.
Portability	This criterion of the *Canada Health Act* (section 11) requires that provincial and territorial health insurance plans not impose any minimum period of residence, or waiting period in excess of three months before residents become eligible for insured health services. In addition, the plans must cover and pay for insured services provided to insured persons while they are temporarily outside the province and during any period of residence, or waiting period imposed by the health care insurance plan of another province or territory.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends or profits to its owners, shareholders, operators or members.

Term	Description
Private (not-for-profit) Health Care Facility	This is a privately owned health care facility that is recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Provision of Information Condition	The *Canada Health Act* (section 13 (a)) requires that provincial and territorial governments provide information to the federal minister of health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of administering the Act.
Public Administration Criterion	The public administration criterion set out in section 8 of the *Canada Health Act* requires that each provincial and territorial health care insurance plan be administered and operated on a non-profit basis by a public authority that is responsible to the provincial or territorial government, and whose accounts and financial transactions are publicly audited.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides insured health care services under a provincial or territorial health care insurance plan on an in- or out-patient basis.
Recognition Condition	The *Canada Health Act* (section 13(b)) requires that provincial and territorial governments give recognition to the Canada Health and Social Transfer (CHST) in any public documents, advertisements or promotional material relating to insured health care services and extended health services in the province or territory.
Refugee Claimant	A refugee claimant is a person of non-Canadian nationality who has arrived in Canada and has applied for refugee protection status in Canada under the *Immigration and Refugee Protection Act*. If a refugee claimant receives a final determination from the Immigration and Refugee Board that he or she meets the definition of refugee in the 1951 *United Nations Convention Relating to the Status of Refugees*, then he or she may apply for permanent residence status in Canada.
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required by a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	Section 2 of the *Canada Health Act* defines a resident as a person lawfully entitled to be or to remain in Canada who resides and is ordinarily present in the province or territory, but does not include a tourist, a transient or a visitor to the province or territory.

Term	Description
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology, and urology.
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Surgical-Dental Services	Section 2 of the *Canada Health Act* defines surgical-dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.
Surgical Physician Service	For purposes of reporting on the *Canada Health Act*, a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	Under the portability criterion of the *Canada Health Act* (section 11(1)(b)), the term "temporarily absent" is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.
Universality	This criterion of the *Canada Health Act* (section 10) requires that each provincial or territorial health care insurance plan entitle one hundred per cent of the insured persons of the province or territory to the insured health services provided for by the plan on uniform terms and conditions.
User Charge	Section 2 of the *Canada Health Act* defines a user charge as any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charge imposed by extra-billing. Please refer as well to the definition for extra-billing.