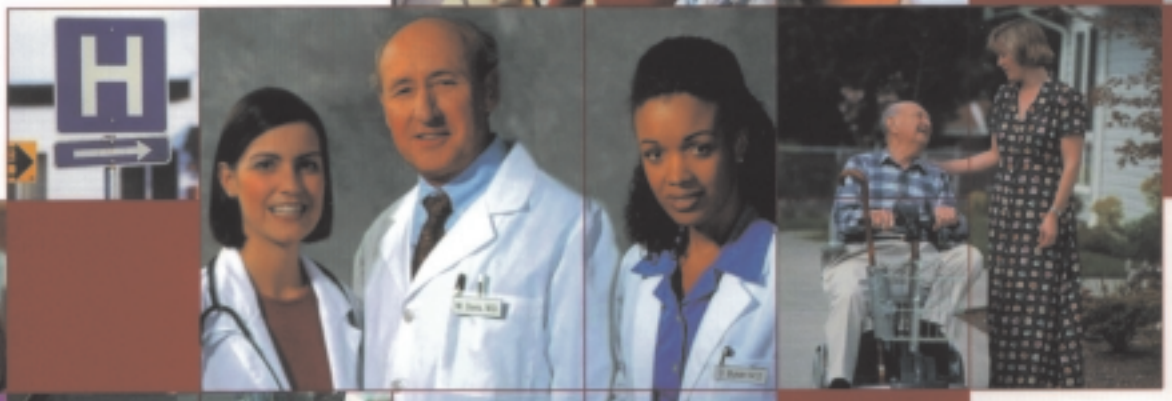
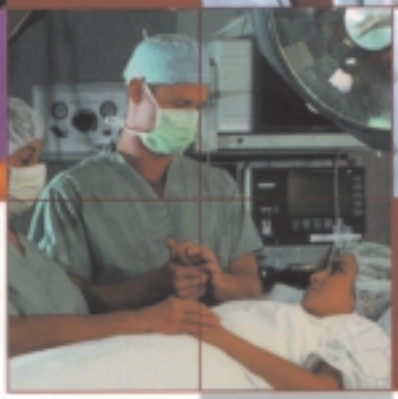
Health Canada Santé Canada

Canada Health Act

Annual Report 2000-2001





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maintain and improve their health.

Health Canada

Ce document est également disponible en français sous le titre
Rapport annuel de 2000-2001 sur l'application de la Loi canadienne sur la santé

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Minister of Health Ministre de la Santé

The Honourable/L'honorable A. Anne McLellan

Ottawa, Canada K1A 0K9

Her Excellency, the Right Honourable Adrienne Clarkson, Governor General and Commander-in-Chief of Canada

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year ended March 31, 2001.

A. Anne McLellan

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 bring you this report on the administration and operation of the *Canada Health Act*:

Newfoundland and Labrador Department of Health and Community Services

Prince Edward Island Health and Social Services

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

Ministère de la Santé et des Services sociaux du Québec

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

British Columbia Ministry of Health Services
British Columbia Ministry of Health Planning

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

We also greatly appreciate the extensive work effort that was put into this report by our production team: the desktop publishing unit, the translators, editors and concordance experts, and staff of Health Canada at headquarters and in the regional offices.

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Introduction

The five principles of the *Canada Health Act* are the cornerstone of the Canadian health care system, and have iconic status for Canadians. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* provides the provinces and territories with criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

This report is produced in accordance with the requirement set out in section 23 of the *Canada Health Act:*

> "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."

Under the *Canada Health Act*, provinces and territories are required to provide information on the operation of their health care plans as they relate to the criteria and conditions of the Act. The approach to this information gathering has been collaborative, where provinces, territories and the federal government have worked together to supply the information needed by the Minister to fulfill his responsibilities.

Chapter 1 provides an overview of the *Canada Health Act* and information concerning its administration, interpretation, compliance and deductions made in 2000-2001. Chapter 2 presents descriptions of the provincial and territorial health insurance plans related to programs and services that came under the scope of the *Canada Health Act* for the year ending March 31, 2001. Six annexes, listed below, are also appended to this report, providing an array of additional information relevant to the administration of the Act and its place in the Canadian health care system.

Statistical data on insured hospital, physician and surgical dental health care services in each province and territory are detailed in Annex A. A copy of the *Canada Health Act* and its regulations (unofficial consolidation to June 2001) is available in Annex B. Annex C provides copies of the two key policy statements that clarify the federal interpretation of the criteria and conditions of the *Canada Health Act*. Annex D summarizes the deductions and refunds from federal transfers under the provisions of the Act. Annex E describes the evolution of federal transfers for health care in Canada. Annex F provides a glossary of terminology used in this report. Inside the back cover you will find contact information for provincial and territorial departments of health.

Chapter 1 – Canada Health Act: Overview, Administration, Interpretation, Compliance and Deductions

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

(Justice Emmett M. Hall)

Overview

The Canada Health Act

What is it?

The *Canada Health Act* is Canada's federal health insurance legislation.

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.

The *Canada Health Act* establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

The aim of the *Canada Health Act* 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.

What is Covered?

There are two categories of service defined in the *Canada Health Act*:

- insured health care services, and
- extended health care services.

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

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in- and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and x-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

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

Who is Covered?

Insured persons are eligible residents of a province or territory. A resident is defined in the *Canada Health Act* in relation to a province 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 not covered by the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Requirements of the Canada Health Act

The *Canada Health Act* contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

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

The Criteria

1. Public Administration

This criterion applies to the health care insurance plans of the provinces and territories, not to hospitals or other facilities providing hospital care. The health care insurance plans are to be administered and operated on a non-profit basis by a public authority. The public authority must be accountable to the provincial and territorial governments and subject to audits of its accounts and financial transactions.

2. Comprehensiveness

The health care insurance plans of the provinces and territories must insure all insured health services (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners.

3. Universality

All insured residents of a province or territory must be entitled to the insured health services provided by the plans 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 care services.

4. Portability

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

Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to permit one 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, insured services are to 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 may also be required before coverage is extended for elective (non-emergency)

services to a resident while temporarily absent from the home province or territory.

5. Accessibility

The health care insurance plans of the provinces and territories must provide:

- reasonable access to insured health care 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). Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
- reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- payment to hospitals to cover the cost of insured health care services.

The Conditions

Information — the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

Recognition — the provincial and territorial governments are to recognize appropriately the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

Extra-billing — this occurs if a physician or dentist directly charges an insured person for an insured service that is in addition to the amount that would normally be paid for by the provincial or territorial health insurance plan. For example, if a physician were to charge patients five dollars for an office visit that is insured by a health insurance plan, the five-dollar charge would be extra-billing.

User charges — these are direct charges to patients, other than extra-billing, for insured services of a province's health insurance plan that are not payable, directly or indirectly, by the health insurance plan. For example, if patients were charged a fee before being provided treatment at a hospital emergency department, the fee would be considered a user charge.

Other Elements of the Act

Regulations

The Governor in Council may make regulations for the administration of the *Canada Health Act* and for putting its purposes and provisions into effect.

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 a 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. (For a copy of these regulations, please see Annex B).

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments. For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary Penalty Provisions

Breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction is based on the gravity of the default.

The *Canada Health Act* stipulates a consultation process with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have never been applied.

Health Care Services not Covered by the Act

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, 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 may include home care, pharmacare, ambulance services, optometric services and dental services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children or seniors), 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.

Health care services covered by provincial workers' compensation legislation are outside the scope of the *Canada Health Act*.

Administration

The Canada Health Act Division

The Division, part of the Intergovernmental Affairs Directorate, Health Policy and Communications Branch, Health Canada, administers the *Canada Health Act*. It provides policy advice related to the *Canada Health Act*, monitors a broad range of sources to assess provincial and territorial compliance with the criteria and conditions of the Act, informs the Minister of possible non-compliance with the Act and recommends appropriate action. The Division also develops interpretations under the Act, provides support to legal counsel in court cases in which the *Canada Health Act* is involved, and maintains a centre of expertise on the Canadian health insurance system.

The Division works in conjunction with Health Canada's regional offices to obtain information about developing issues, new directions, and policies in provinces and territories that may be needed for administration of the Act. A funding increase of $4 million per year announced in May 2000 by the Minister of Health, in response to recommendations made by the Auditor General in 1999, resulted in increased staff at headquarters and in the regions, and strengthened Health Canada's policy analysis and reporting capacity vis-à-vis the *Canada Health Act*.

Another strategic initiative to provide the Minister with better information in a timely manner is the development of a more systematic method of intelligence gathering, storage and retrieval. Health Canada staff at headquarters and in the regions contribute to the Canada Health Act Information System by reviewing, analyzing and cataloguing information relevant to the administration of the Act and the provision of health care in Canada.

The Division responds to enquiries about the Act and health insurance issues received by telephone, mail and the Internet, from the public, Members of Parliament, government departments, stakeholder organizations and the media. During 2000-2001, the Division responded to more than 2,000 such enquiries. Media relations staff within the Branch also responded to approximately 350 media enquiries related to the *Canada Health Act*.

The Division compiles information for dissemination to the provinces and territories through the Additional Benefits Information System. This information relates to services outside the scope of the *Canada Health Act*, which the provinces and territories provide to their residents at their discretion, and on their own terms and conditions.

The Division also makes information concerning the Act and other health insurance topics available via its Internet site, www.hc-sc.gc.ca/medicare. In 2000-2001, our web site received an average of 4,729 visits per week. This means that a page from our site is referred to, on average, every two minutes.

The Division is also involved in the following activities.

Coordinating Committee on Reciprocal Billing

The Canada Health Act Division chairs the Federal/Provincial/Territorial Coordinating Committee on Reciprocal Billing (CCRB) and acts as a secretariat for the Committee.

The Committee was formed in 1991 to identify and resolve administrative issues related to interprovincial/territorial billing arrangements for medical (physician) and hospital services. The general intent of 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. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. These agreements are interprovincial/territorial, not federal, and signing them is not a requirement of the *Canada Health Act*.

A federal/provincial/territorial working group mandated by the CCRB reviews, updates, and provides administrative clarifications to an interprovincial/territorial agreement on eligibility and portability. This agreement sets minimum standards with respect to interprovincial/territorial eligibility and portability of health insurance programs.

Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Diagnostic Services

The growth in the use of Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services in recent years is illustrative of the emergence and adaptation of health care technologies, which are part of the ongoing evolution of Canada's health care system. These services have been embraced by both public and private providers as part of a modern and responsive health care system, which brings many challenges for governments, health care providers and the public in terms of managing costs and establishing and understanding guidelines for access to and availability of these services.

To gain a better understanding of these issues, the Federal/Provincial/Territorial Working Group on Supply, Demand and Delivery of MRI and CT Services in Canada was formed in the summer of 2000 to review the provision and delivery of MRI and CT services within Canada's health care system. All provinces and territories named members to the Working Group (Quebec's representative participated as an observer). The Working Group also examined options to prevent insured persons from paying or being charged for medically necessary high-technology diagnostic services, as such incidents had been brought to the attention of the federal Minister of Health and are a concern under the *Canada Health Act*.

The mandate of the Working Group was two-fold: first, to document the supply, demand and delivery of MRI and CT diagnostic services in all jurisdictions of Canada in order to provide a "situation report" on how these services are provided to Canadians; and second, to provide

recommendations to the Conference of Federal/Provincial/Territorial Deputy Ministers of Health on how to ensure appropriate and timely access, on uniform terms and conditions, to these diagnostic services through the publicly funded health care system.

Dispute Avoidance and Resolution

On September 10, 2000, the Honourable Allan Rock, federal Minister of Health, wrote to the Honourable Gary Mar, Minister of Health and Wellness for Alberta, to indicate the federal government's willingness to initiate a collaborative process among health ministries to develop a *Canada Health Act* dispute avoidance and resolution mechanism, consistent with commitments in the Social Union Framework Agreement (SUFA) and the federal government's obligations under the Act.

In October 2000, the Conference of Federal/Provincial/Territorial Ministers of Health agreed to create a federal/provincial/territorial working group to undertake this work, with Health Canada and Alberta as co-chairs. Other members of the working group include Saskatchewan, Ontario and Newfoundland and Labrador.

Interpretation, Compliance and Deductions

Interpretation

Epp Letter

Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp letter (see Annex C) remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

At the Federal/Provincial/Territorial Health Ministers' Meeting of September 1994 in Halifax, all ministers of health present, with the exception of Alberta's, 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 (see Annex C). Her letter provided the federal interpretation of the *Canada Health Act* as it related to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics that also receive funding for these services from provincial/territorial health insurance plans. 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, as set out in Minister Marleau's letter. These penalties are in the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer.

Compliance

Investigations

Compliance with the *Canada Health Act* is monitored through review of provincial and territorial submissions to the Canada Health Act Annual Report, through other provincial and territorial reporting mechanisms, through monitoring media reports of health care issues, and through complaints and enquiries received from the general public or from concerned organizations and medical personnel.

Health Canada's approach to resolving possible compliance issues emphasizes transparency, consultation and dialogue. In most instances, issues are resolved through consultation and discussion with the provinces and territories, based on a thorough examination of the facts. Penalties are only applied when other means of resolving issues have failed.

Of the three compliance issues under investigation in 1999-2000, the issue regarding queue-jumping by an individual in Alberta in relation to eye surgery has been resolved. With respect to the other issues mentioned in the Canada Health Act Annual Report 1999-2000, consultations with the provinces affected are ongoing.

Compliance Issues Raised in 2000-2001

During 2000-2001, Health Canada initiated investigations on three specific issues – the provision of abortion services, user charges, and Magnetic Resonance Imaging (MRI) services at private clinics.

Abortion Services

The federal government continues to work with provincial and territorial governments in an effort to ensure that, in all provinces where abortion clinics exist, this service is provided to residents as a fully insured service on uniform terms and conditions.

Officials from Health Canada and the New Brunswick Ministry of Health and Wellness met in January 2001 to discuss this outstanding federal concern. Additional information-sharing continues between the two levels of government on this issue.

Outstanding abortion issues also exist in Prince Edward Island, Quebec and Manitoba. In each case, Health Canada officials have raised the issue with their provincial counterparts.

User Charges

In June 2000, Health Canada learned that an insured resident of British Columbia had privately purchased insured health services at a surgical centre in the province under the guise of third-party payment. By so doing, the individual in effect jumped the queue for treatment.

Officials from Health Canada and British Columbia conducted an exchange of correspondence on this matter. Work continues on the issue.

Magnetic Resonance Imaging (MRI)

Private MRI clinics exist in British Columbia, Alberta and Quebec. At issue are patient charges at these clinics for medically necessary MRI services. Health Canada is continuing its discussions and information-sharing concerning the provision of MRI and other high-technology diagnostic services in an effort to ensure that patients are not being charged for these services when they are medically necessary.

Deductions

With respect to fiscal year 2000-2001, the Canada Health and Social Transfer for Nova Scotia was reduced by $4,817 per month, or $57,804. This mandatory penalty was applied because Nova Scotia does not pay the facility fees charged for abortions performed at a private clinic. Nova Scotia was the only province in 2000-2001 for which a deduction was made for non-compliance with the *Canada Health Act*.

Please refer to Annex D for a detailed chart of all discretionary and mandatory penalties under the *Canada Health Act*, and Annex E for further information on the Canada Health and Social Transfer.

Chapter 2 – Provincial and Territorial Health Care Insurance Plans in 2000-2001

During 2000-2001, provincial and territorial governments continued to provide access to a comprehensive range of hospital, physician, and extended health care services. The information in this chapter was provided by the provinces and territories, and describes how the health care insurance plans operated within the context of the *Canada Health Act* for the fiscal year ending March 31, 2001.

All provinces and territories provide a range of health services that go beyond the requirements of the *Canada Health Act*. These additional benefits include programs such as pharmacare, home care, ambulance services, and aids to independent living. Such services and benefits are provided at provincial and territorial discretion, on their own terms and conditions.

The purpose of this chapter is to demonstrate the extent to which the provincial and territorial health insurance plans fulfilled the requirements of the *Canada Health Act* during this time. In order to help ensure consistency and thoroughness, provincial/territorial submissions have been prepared according to a template that Health Canada discussed with representatives in each province and territory. Officials were asked to provide narrative descriptions of their health insurance plans according to the program criteria areas of the *Canada Health Act*. In addition, provinces and territories were asked to describe how their governments met the *Canada Health Act* requirement for recognition of federal contributions in support of insured and extended health care services. Finally, provincial and territorial officials were asked to describe the range of extended health care services provided in their jurisdictions; where extended health care includes nursing home intermediate care services, adult residential care services, home care services, and ambulatory health care services.

Following a joint review with the provinces and territories of material submitted for the 1999-2000 Annual Report, further improvements were made to ensure the completeness, consistency and accuracy of the information in the new report. Another change to the reporting process for 2000-2001 has been the submission by provinces and territories of published documents and materials that relate to the five criteria of the *Canada Health Act*, as well as to the recognition condition. These documents were provided by each jurisdiction or were found on provincial or territorial government websites.

Please note that the description of Quebec's health insurance plan was submitted according to the format used in previous editions of the Canada Health Act Annual Report. Quebec chose not to submit its information in the manner and detail requested by Health Canada, as noted in a preface to Quebec's narrative.

Newfoundland and Labrador

Introduction

Fourteen regional boards operate most health services in Newfoundland and Labrador. Of these, eight are institutional health boards, four are community services boards and two are integrated boards, delivering both institutional and community services. Included in the eight institutional boards is a provincial board for cancer services and a regional board for nursing homes, both located in St. John's.

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

In Newfoundland and Labrador almost 20,000 health care providers and administrators provide health services to the 536,400 residents of the province.

Planning for the future of the Province's health care system requires a clear understanding of the Province's main challenges. These are:

- rapidly rising costs that threaten the affordability of Medicare;
- an aging population that generally requires more services than younger groups;
- the cost of new drugs and advanced technologies;
- rising salaries and fees in other provinces that cause pressure for raises in Newfoundland and Labrador; and
- the need for more investment in early intervention and prevention in order to promote wellness.

Planning will include decision making based on the principles of accessibility, quality, accountability and sustainability. The major planning areas include health services structure, funding, and human resources; a wellness focus; the health services delivery model; and accountability.

Highlights of Initiatives in 2000-2001

The Government of Newfoundland and Labrador made a significant investment in health care in 2000-2001, raising health and community services expenditures to approximately 42 per cent of all government program expenditures. $136 million in new spending was committed for 2000-2001.

The total Health and Community Services budget for 2000-2001 was nearly $1.3 billion, the largest budget of all government departments in the Province.

A special review team was established in 2000-2001 to work with institutional boards to identify core services, priorities, new directions and efficiencies. The work of the review teams and the boards was essential in identifying ways to optimize our health system, and begin to define the system of the future.

In 2000-2001, the Government allocated $23.7 million to modernize diagnostic and therapeutic equipment in health facilities. Of this amount, $8.8 million came from the federal government as part of the First Ministers' Agreement on Health Renewal. Purchases will include new and replacement equipment to improve patient throughput and reduce travel inconveniences in some rural areas.

Hundreds of millions of dollars have been committed over the past five years for new health facilities and renovations of existing health facilities.

A sum of $138 million has been allocated for the redevelopment of major hospital services in St. John's which is scheduled for completion in 2001**.** St. John's is the major centre for referrals for all areas of Newfoundland and Labrador.

Redevelopment includes the new state-of-the-art Janeway Children's Health and Rehabilitation Centre that will provide in-patient facilities for 103 children; transfer of adult acute services from the Grace General Hospital to St. Clare's Mercy Hospital and the Health Sciences Centre, and closure of the Grace. Upgrades have also taken place at the Miller Centre at an additional cost of $2.6 million.

In addition to redevelopment in St. John's, two new hospitals opened in other areas of the province. In Happy Valley-Goose Bay, a new 24-bed health centre opened in 2000-2001. The total cost of this facility was $30.5 million. A new 21-bed Harbour Breton health centre also opened at a cost of $8.4 million.

Enhanced community based services were achieved through the implementation of the new *Child, Youth and Family Services Act*, and through other initiatives such as the National Child Benefit program. In addition, the Government approved $410,000 in the 2000-2001 fiscal year to support children with autism. This is part of the government's three-year $2.2 million commitment for autistic children in Newfoundland and Labrador.

The Government also allocated another $300,000 in 2000-2001 for implementation of a tobacco reduction strategy, and maintained its commitment to curb smoking among youth. This is part of a $900,000 commitment over three years to reduce smoking in the Province.

One million dollars was committed in 2000-2001 for increases in subsidies and rates for the personal care home industry.

The Government also approved $3.3 million for improved road ambulance services in the Province.

Almost $1 million was approved to continue pilot projects in Happy Valley-Goose Bay, Twillingate and Port aux Basques to seek innovative ways to deliver primary health care through a team approach to health and well-being.

A sum of $6 million was provided for a King Air 350 air ambulance to replace the old King Air 100.

Additional funding of $5.4 million was provided for the coverage of new and proven drugs under the Province's drug program, and for increased utilization.

The Government allocated $600,000 to give incentives to graduating student nurses who commit to work in the province. Government also allocated $75,000 of a three-year $225,000 program to assist nursing students in gaining experience in rural areas of the province. $1.2 million was allocated for the hiring of Nurse Practitioner program graduates.

An amount of $2.1 million was budgeted to hire new salaried physicians. This was in addition to approximately $8.5 million annualized funding provided in 1999-2000 for more than 50 salaried physicians. A further $1.9 million was added to the $32 million Physician Services Memorandum of Understanding (MOU) in 2000-2001 because of increased numbers of fee-for-service physicians in the province.

Additional information on health and health care in Newfoundland and Labrador is available from the website of the Department of Health and Community Services at:

www.gov.nf.ca/health/

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

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

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act provides that the Minister may make regulations for the provision of insured services upon uniform terms and conditions to residents of the Province under the conditions specified in the *Canada Health Act* and Regulations. Governing regulations include the Hospital Insurance Regulations.

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999 and came into force on April 1, 2000. This Act replaced the *Medical Care Insurance Act,* which was previously in effect. Essentially, the new act discontinued the Medical Care Commission previously responsible for the administration of the MCP, with Plan resources being integrated with the Department of Health and Community Services.

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

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

1.2 Reporting Relationship

The Support Services Branch of the Department of Health and Community Services is mandated with the administration of the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes, e.g., Public Accounts.

The Government has created the Strategic Social Plan (SSP) to be able to measure progress towards its goals and objectives and to report publicly on the results. A Social Audit currently under development uses process indicators to measure outputs and impact indicators to measure outcomes. Public accountability for health care is a major part of the Social Audit component of the SSP.

In September 2000 the Government established an Accountability Policy Framework for public bodies, including health boards, which will lead to better planning, performance monitoring and reporting. In the health sector, the Accountability Policy Framework will help ensure that financial and human resources are used efficiently and effectively to address the health needs of the population and improve health system performance.

1.3 Audit of Accounts

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

Hospital boards are subject to Financial Statement Audits, Reviews, and Compliance Audits. Financial Statement Audits are performed by independent auditing firms that are selected by the boards under the terms of the *Public Tendering Act*. Review engagements and compliance audits are carried out by personnel from the Department of Health and Community Services. Physician audits are performed by personnel from the Department of Health and Community Services under the authority of the Newfoundland *Medical Care Insurance Act* (1999). Physician records are reviewed to ensure that the record supports the service billed and that the service is insured under the Medical Care Plan.

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

The Newfoundland Medical Care Commission Annual Report for the fiscal year 1999-2000, which was released in the fall 2000, provided a status report of the 48 provider audits underway for the Medical Care Plan as of March 31, 2000. As well, 113 beneficiary audits were at various stages of completion at year's end. A report by the provincial Auditor General is included in the *Medical Care Commission Annual Report*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

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

Insured hospital services are mainly provided in 32 facilities throughout the Province. Insured in-patient services include:

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

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;
- rehabilitative services;
- out-patient and emergency visits;
- day surgery;
- drugs, biologicals and related medically necessary preparations when administered in hospital.

2.2 Insured Physician Services

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

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

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

Licensed medical practitioners are allowed to provide insured physician services under the insurance plan. A physician must be licensed to practise in the Province by the Newfoundland Medical Board.

In 2000-2001, 755 fee-for-service physicians provided insured services in the province.

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

"Where a physician providing insured services is not a participating[1] physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

> (a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and
>
> (b) provide the beneficiary to whom the physician has provided the insured service with the information required by the Minister to enable payment to be made under this Act to the beneficiary in respect of the insured service."

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

- all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and regulations made under the Act.

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

There are no limitations on the services covered, provided they qualify under one or more of the conditions listed above.

No services were added in 2000-2001 to the list of insured physician services covered by the health care insurance plan in Newfoundland and Labrador.

Ministerial direction is required to add a physician service to the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial Medical Association. Public consultation is involved.

2.3 Insured Surgical-Dental Services

Surgical-dental treatments properly and adequately provided to a beneficiary and carried out in a hospital by a dentist are covered by the MCP if the treatment is of a type specified in the surgical-dental services Schedule.

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

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

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

- preferred accommodation at the patient's request;
- cosmetic surgery and other services deemed to be medically unnecessary;
- ambulance or other patient transportation prior to admission or upon discharge;
- private duty nursing arranged by the patient;
- non-medically required x-rays or other services for employment or insurance purposes;
- drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital;
- bedside telephones, radios or television sets for personal, non-teaching use;
- fibreglass splints;
- services covered by Workers' Compensation legislation or by other federal or provincial legislation; and
- services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the Newfoundland Medical Board.

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

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

- any advice given by a physician to a beneficiary by telephone;
- the dispensation by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for or on behalf of, or any communication to or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an

initial assessment specifically related to diagnosis of the illness proposed to be treated by acupuncture;

- examinations not necessitated by illness or at the request of a third party except as specified by the appropriate authority;
- plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for the purpose of determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma;
- circumcision of newborns;
- hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside of Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the Province at a facility not approved by the Newfoundland Medical Board;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- *in-vitro* fertilization and OSST (ovarian stimulation and sperm transfer);
- reversal of previous sterilization procedure;
- surgical diagnostic or therapeutic procedures not provided in facilities other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d); and
- other services not within the ambit of section 3 of the Act.

All diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the Province. Hospital policy on access ensures that third parties are not given priority access.

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

Surgical-dental and other services not covered by the Dental Health Plan are the dentists', oral surgeons' or general practitioners' fees for routine dental extractions in hospital, and fluoride dental treatment for children under six years of age.

3.0 Universality

3.1 Eligibility

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

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

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

Persons not eligible for coverage under the plans include:

- students and their dependants already covered by another province or territory;
- dependants of residents if covered by another province or territory;
- certified refugees and refugee claimants and their dependants;

- foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
- foreign students and their dependants;
- tourists, transients, visitors and their dependants;
- Canadian Armed Forces and Royal Canadian Mounted Police personnel;
- inmates of federal prisons; and
- armed forces personnel of other countries who are stationed in the Province.

3.2 Registration Requirements

Registration under the Medical Care Plan and possession of a valid Medical Care Plan card are required in order to access insured services. New residents are advised to apply for coverage as soon as possible upon arrival in Newfoundland and Labrador.

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

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

As of April 11, 2001 there were a total of 616,944 active beneficiaries registered with the Medical Care Plan.

3.3 Other Categories of Individual

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

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage as of the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage as of the day of arrival. The same applies to discharged members of the Canadian Forces and the Royal Canadian Mounted Police, and released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the Medical Care Plan. Immediate coverage is provided to persons from outside Canada who are authorized to work in the Province for one year or more.

4.2 Coverage During Temporary Absences In Canada

Coverage is provided to residents during temporary absences within Canada. The Province has entered into formal agreements with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient high-cost procedures and out-patient services are payable based on national rates agreed to by provincial and territorial health plans.

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

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

medical and hospital care coverage during absences include:

- prior to leaving the Province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate;
- beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate for up to 12 months' duration. Upon return, beneficiaries are required to reside in the Province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months' coverage;
- students leaving the Province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized school located outside the Province;
- persons leaving the Province for employment purposes may receive a certificate for up to 12 months' coverage. Verification of employment may be required;
- persons must not establish residency in another province, territory, or country while maintaining coverage under the Newfoundland Medical Care Plan;
- for out-of-province trips lasting 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request;
- for out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside province; and
- failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay the entire cost of any medical or hospital bills incurred outside the Province.

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

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergency, sudden illness and elective procedures at established rates. The maximum amount payable by the Government's hospitalization plan for out-of-country in-patient hospital care is $350 per day if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $220 per treatment. The approved rates are paid in Canadian funds.

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

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories.

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

Prior approval is not required for physician services; however, it is suggested that physicians obtain prior approval from the Plan so that patients may be made aware of any financial implications. General practitioners and

specialists may request prior approval on behalf of their patients. Prior approval is not granted for out-of-country treatment of elective services if the service is available in the Province or elsewhere within Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

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

5.2 Access to Insured Hospital Services

As of March 31, 2000 Newfoundland and Labrador had 1,643 staffed hospital beds in 14 hospitals and 18 community health centres, including 1,417 acute care beds, 22 rehabilitation beds, and 204 psychiatric beds.

Information on acute care beds used for day-care services is not available.

The total number of practising registered nurses in the Province in 2000-2001 was 5,592. Approximately 85 percent of the 2000 graduates chose to remain in the Provinces with the availability of a signing bonus of $3,000. This is available to 2001 graduates for a second year with similar uptake.

There were 12 new nurse practitioner positions created in rural areas, thereby improving public access to primary health care. Nurse practitioner positions have now increased to over 30, with a small number of specialist positions in tertiary care. Licensed practical nurse enrolment has increased steadily since 1999. Other initiatives include nurse practitioner student bursaries; a six to nine percent remuneration increase for Registered Nurses and approximately three percent for licensed practical nurses following occupational reviews of each occupational group; a Northern Incentive package for nurses in remote and northern locations; and a three-year pilot to assist with rural and remote clinical placements of nursing students.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2000, the ratio of Registered Nurses to population in Newfoundland and Labrador (100/10,000) was higher than in other provinces and higher than the rate for Canada as a whole (75.4/10,000). Despite the high Registered Nurse per 10,000 population ratio, some hospitals have experienced shortages of nursing staff, particularly shortages of nurses with specialized training in critical and cardiac care.

There are shortages in other professional groups, such as physiotherapy, speech language pathology, audiology and occupational therapy, as well as psychology. Focused recruitment and incentive programs such as bursaries and seat purchases are in place, and new approaches continue to be developed. The supply of psychologists was enhanced with an amendment to the *Psychologists Act,* which established a Master's degree as the entry level to practise.

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

- Magnetic Resonance Imaging (MRI) is located in St. John's only;
- Computed Tomography (CT) scanners are available in St. John's (three machines), Clarenville, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- renal dialysis is provided in St. John's, Grand Falls/Windsor and Corner Brook;
- cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and satellite clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- approximately 82 percent of surgery services are provided in St. John's, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony. A full range of basic and some

sub-specialty surgical services is available in all locations. Tertiary surgery, e.g., trauma, cardiac, and neuro is available in St. John's only; and

- an additional 18 percent of surgery services are provided in six mid-sized hospitals at Carbonear, Clarenville, Burin, Stephenville, Happy Valley/Goose Bay and Labrador City. These facilities offer basic surgical services.

A number of significant measures were taken in 2000-2001 to improve access to insured hospital services.

- Access to CT scanning services was improved with the provision of services in Clarenville and Gander. Additional CT units are planned for Carbonear and Happy Valley/Goose Bay in 2001-2002.
- Bone density testing services became available in Gander, Grand Falls/Windsor and Corner Brook.
- The Government approved an annualized investment of $2.7 million in operating funds for the cardiac program to meet current and future demands. In addition, $1.2 million was allocated to renovate and purchase new equipment to enhance the provincial cardiac program. The program in St. John's was expanded by approximately 150 surgeries annually to reduce patient wait times.
- Planning and related activities occurred for a new community based renal dialysis service in Clarenville, scheduled to open in July 2001.
- New hospitals became operational in Harbour Breton and Happy Valley/Goose Bay. Capital redevelopment and related planning and design activities continued in Gander, Fogo, Stephenville, and Bonne Bay.
- the Cervical Cancer Screening Program in Western Newfoundland was allocated $130,000 for 2000-2001.

5.3 Access to Insured Physician and Dental-Surgical Services

The number of physicians practising in the Province is relatively stable. The Department of Health and Community Services is working with regional health boards to develop a human resource plan for physicians based on the principle of access to services.

Improvement in salary scales and retention bonuses for salaried physicians reflective of geography have been implemented to improve rural recruitment. Premiums on hospital-based services provided by general practitioners in rural hospitals have also been applied.

Service levels and accessibility (wait time) issues are monitored by regional health boards with adjustments made as required, such as increasing the number of cardiac surgeries performed weekly.

During 2000-2001, 12 new physicians who entered practice had at some point received financial assistance from the Department of Health and Community Services through the Travelling Fellowship Program, the Medical Specialist Resident Bursary Program, the Medical Student and Resident Practice Incentive Program or the Psychiatry Resident Bursary Program.

With regard to surgical-dental services, four certified dental surgeons and one non-certified oral surgeon practised in the Province. A total of 21 general-practice dentists have hospital privileges.

5.4 Physician Compensation

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association, with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. The dispute resolution mechanism agreed to as a result of the current negotiations is mediation. The term of the current agreement is from April 1, 1999 to September 30, 2002.

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

5.5 Payments to Hospitals

The Department of Health and Community Services is responsible for funding the Regional Health Care Boards and Health and Community Services Boards for ongoing operations and capital equipment purchases. Funding for insured services is provided to the Boards as an annual global budget and these annual funds are distributed in 12 monthly advance payments. As part of their accountability to the Government, Boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. This process is consistent for all Regional Health Care Boards, Health and Community Services Boards and other grant-funded organizations within the Province.

Payments are made to Regional Health Care Boards and Community Health Services Boards in accordance with the *Department of Health and Community Services Act* and the *Hospitals Act.*

All Regional Health Care Boards and Health and Community Services Boards operate on a global budget basis, whereby funding provided by the Province for approved programs is allocated by the Boards. The global budgeting process devolves the budget allocation authority, responsibility, and accountability to all appointed Boards in the discharge of their mandates.

Throughout the fiscal year, the Health Boards may forward additional funding requests to the Department of Health and Community Services for changes in program areas or increased workload volume. These requests will be reviewed, and if approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for negotiated salary increases, additional approved positions or program changes are funded based on the implementation date of such increases and the cash flow requirement in a given fiscal year.

Boards are continually facing challenges in providing the required health care services and increased demands of the health system when costs are rising, staff workloads are increasing, patient expectations are higher, and new technology introduces new demands for time, resources, and funding. Boards are continuing to work with the Department of Health and Community Services to address these issues and provide effective, efficient and quality health care.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador through press releases, government websites, and various other documents. For fiscal 2000-2001 these documents included the following:

- the 1999-2000 Public Accounts Volume I,
- the Estimates 2001-2002, and
- the Budget Speech 2001

These reports were tabled by the Government to the House of Assembly and are publicly available to Newfoundland and Labrador residents.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community based programs as an alternative to hospital services. These programs are provided by seven regional Boards. Services include the following.

Nursing Home Services

Long-term residential accommodations are provided for clients requiring high levels of nursing care in 18 community health centres and 19 nursing homes. There are approximately 2,800 beds located in these 37 facilities. Residents pay a maximum of $2,800 per month based on each client's assessed ability to pay, using provincial financial assessment criteria. The balance of funding required to operate these facilities is provided by the Department of Health and Community Services.

Personal Care Homes

Persons requiring protective oversight or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,400 beds located in 103 homes across the Province. These homes are operated by the private for-profit sector. Residents pay a maximum of $968 per month, based on an individual client assessment using standardized financial criteria. In 2000-2001, an additional 136 subsidies were provided under a five-year plan to enable more elderly persons to access this type of residential service.

Home Care Services

Home care services include professional and non-professional supportive care to enable people to remain in their own homes for as long as possible without risk. Professional services include nursing and some rehabilitative programs. These services are publicly funded and delivered by staff employed with six regional Boards.

Non-professional services include personal care, household management, respite and behaviourial management. These services are delivered by home support workers through agency or self-managed care arrangements. Eligibility for non-professional services is determined through a client financial assessment using provincial criteria. The 2000 ceiling for home support services was $2,268 for seniors and $3,240 for the physically and developmentally delayed population.

Special Assistance Program

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

Drug Programs

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

Other Programs

The Department of Health and Community Services administers the Emergency Air and Road Ambulance programs through the Emergency Health Services Division. The Air Ambulance Program provides transportation and medical care to patients within the Province of Newfoundland and Labrador, and to hospitals outside the Province where warranted. Air Ambulance will also transport patients, medical staff and equipment to and from isolated communities when required. The Road Ambulance Program provides medical care and transportation to residents accessible by road at a reasonable cost to the user. User fees are charged for both Road and Air Ambulance Program use.

Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance when the recipient is a Newfoundland and Labrador resident eligible for coverage under the Newfoundland Hospital Insurance Plan and the Medical Care Plan. Residents who travel by commercial air to access medically necessary insured services that are not available within their area of residence or within the Province, may qualify for financial assistance under the Medical Transportation Program.

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at 6-month intervals; cleanings at 12-month intervals; fluoride applications for children ages 6 to 12 at 12-month intervals; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. These basic services are also available under the income support component to recipients aged 13 to 17 years. Adults

receiving social assistance are eligible for emergency care and extractions. Beneficiaries covered under the dental plan must pay an amount directly to the dentist for each service provided. In circumstances where the beneficiary is receiving income support, a co-payment is paid by the Dental Health Plan.

Prince Edward Island

Introduction

The Ministry of Health and Social Services is a very large and complex system of integrated services that protect, maintain and improve the health and well-being of Islanders.

The continued sustainability of the system is a primary concern. Spending on health and social services has grown rapidly in recent years to 42 percent of total provincial government program expenditures. At this rate of growth, spending could reach 50 percent of overall spending within the next five years. The availability of health professionals is also affecting our ability to sustain services.

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

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

Overview of the Health and Social Services System

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*. Many other health and social services are funded in whole, or in part, by the provincial government.

The system includes a wide range of integrated health and social services such as acute care, addictions, mental health, social assistance and housing services. Some specialty services such as cardiac surgery and neurotrauma services are within the purview of the regional health care system.

Facilities

PEI has two referral hospitals and five community hospitals, with a combined total of 474 beds. Along with seven government manors that house 546 long-term care nursing beds, Islanders have access to an additional 407 beds in private nursing homes. The system also operates several addictions and mental health facilities, 1,178 seniors' housing units, and 460 family housing units.

A new 40-bed provincial addictions facility and a new provincial Cancer Treatment Centre were opened in 2000. Construction of a new $50 million health facility will be completed in Summerside in 2003. CT scanning and a wide range of diagnostic imaging services are available at the referral hospitals, and new linear accelerator and MRI services are now being established.

Human Resources

The public sector health and social services workforce has approximately 4,000 employees. Prince Edward Island has 200 health care professionals per 10,000 residents, compared with the national average of 182 per 10,000.[1]

Structure

The system includes the Department of Health and Social Services and five Regional Health Authorities, which are governed by the Regional Health Boards. The Department works with the

[1] Canadian Institute for Health Information, 1997.

Regional Health Authorities to establish system goals and objectives, develop policy and outcome standards, and allocate resources. The Regional Health Authorities plan and deliver core programs and services to meet system standards.

Financial Resources

During the past 10 years, provincial spending on health and social services increased from $250 million to more than $353 million, an average increase of about three percent per year. Increased costs are due to inflation, population growth, new technologies, and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 33%; Social Services, 24%; Long Term Care, 11%; Physician Services, 12%; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 20%.

Combined public and private sector spending per capita is $2,516 per year, compared with a Canadian average of $2,700. Spending as a percentage of provincial Gross Domestic Product is the second highest in the country at 11.7 percent.[2]

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruitment and retention of skilled employees is expected to be a challenge throughout the labour market in coming years as we experience a major demographic shift. The effect of this trend is being felt first in the health sector, which is labour-intensive and dependent on a specialized workforce, and particularly in less-populated areas like Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases, and the supply of available graduates declines. For example, it is expected that in the next 10 years in PEI, 40 percent of the physician workforce and more than 200 nurses will retire from the public sector. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

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

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

Appropriate access to primary health services

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

Personal health practices

Individuals who understand and accept responsibility for health are more able to take control over and improve their health.

[2] Canadian Institute for Health Information, 1997.

People's capacity to accept responsibility for health is influenced by social and economic conditions, and comprehensive strategies are needed to address these conditions. It is critical that the health system increase its capacity to work with others to assist individuals, families and communities to accept responsibility for, and achieve good health.

Aging population

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

Disease prevention and management

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

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid 1970s, compared with 45 cases per month in the mid 1990s. It is projected that this number will grow to 65 cases per month in 2006. There is clear and undisputable evidence that good blood sugar control can prevent or delay the onset of serious complications from diabetes, such as heart disease, blindness and kidney disease, which have enormous human and financial costs. The prevalence of cancer and diabetes in this province is expected to increase significantly as the population ages. It is imperative that our system step up its efforts to assist Islanders to prevent, delay and manage these conditions.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

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

Under Part I of the Act, it is the function of the Minister, and the Minister has the power to:

- ensure the development and maintenance throughout the Province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;
- approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;
- approve or disapprove all grants to hospitals for construction and maintenance;
- establish and operate, alone or in cooperation with one or more organizations, institutes for training of hospital and related personnel;
- conduct surveys and research programs and to obtain statistics for its purposes;
- approve or disapprove hospitals and other facilities for the purposes of the Act in accordance with the Regulations;
- subject to the approval of the Lieutenant Governor in Council, to do all other acts and things that the Minister considers necessary or advisable for carrying out effectively the intent and purposes of the Act.

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

- administer the plan of hospital care insurance established by this Act and the Regulations;
- determine the amounts to be paid to hospitals and to pay hospitals for insured services provided to insured persons under the plan of hospital care insurance, and to make retroactive adjustments with hospitals for under-payment or over-payment for insured services according to the cost as determined in accordance with the Act and the Regulations;
- receive and disburse all monies pertaining to the plan of hospital care insurance;
- approve or disapprove charges made to all patients by hospitals in Prince Edward Island to which payments are made under the plan of hospital care insurance;
- enter into agreements with hospitals outside Prince Edward Island and with other governments and hospital care insurance authorities established by other governments for providing insured services to insured persons;
- to prescribe forms necessary or desirable to carry out the intent and purposes of the Act;
- appoint inspectors and other officers with the duty and power to examine and obtain information from hospital accounting records, books, returns, reports and audited financial statements and reports thereon;
- appoint medical practitioners with the duty and power to examine and obtain information from the medical and other hospital records, including patients' charts with medical records and nurses' notes, reports, and accounts of patients who are receiving or have received insured services;
- appoint inspectors with the duty and power to inspect and examine books, accounts, and records of employers and collectors to obtain information related to the hospital and insurance plan;
- withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;
- act as a central purchasing agent for the purchase of drugs, biologicals, or related preparations for all hospitals in the Province, to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the Province and to withhold or reduce payments under this Act to a hospital that does not comply with regulations respecting the purchasing of drugs, biologicals or related preparations; and
- supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under this Act to a hospital that does not comply with the regulations respecting the use of such aids and procedures.

The Health Ministry, through the Department of Health and Social Services, has the responsibility for the overall efficiency and effectiveness of the provincial health system. Specifically, the Department is responsible for:

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

The five regional health authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and

hire physicians, nurses and other health-related workers. Their responsibilities include:

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

1.2 Reporting Relationship

An annual report is submitted by the Department of Health and Social Services to the Minister responsible and is tabled by the Minister in the Legislative Assembly. The Annual Report provides information on the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions, and statistical highlights for the year.

Each of the five regional health authorities are required by statute to submit an annual report to the Minister of Health and Social Services. The Minister has the authority to request other information as deemed necessary on the operations of the Authorities and their delivery of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

The provincial auditor general conducts annual audits of the Public Accounts of the Province of Prince Edward Island. The Public Accounts of the Province include the financial activities, revenues and expenditures of the Department of Health and Social Services.

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

The provincial auditor general, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program-specific basis with respect to the operations of the Department of Health and Social Services, as well as each of the five Regional Health Authorities.

2.0 Comprehensiveness

2.1 Insured Hospital Services

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

- necessary nursing services;
- laboratory;
- radiological and other diagnostic procedures;
- accommodations and meals at a standard ward rate;

- formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital;
- operating room, case room and anaesthetic facilities;
- routine surgical supplies; and
- radiotherapy and physiotherapy services performed in hospital.

As of March 2001, there were seven acute care facilities participating in the Province's insurance plan. In addition to 454 acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, as defined under the *Hospitals Act* (1988) and seven insured chronic care beds. An additional facility, Prince Edward Home, has 50 insured chronic care beds. In addition, Prince Edward Island utilizes the equivalent of 60 acute care beds outside the Province.

2.2 Insured Physician Services

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

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The number of practitioners who billed the insurance plan as of March 31, 2001 was 215.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Insurance Plan is not eligible to bill the plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that the physician advise the patient that he or she is not a participating physician or practitioner and provide the patient with sufficient information to enable them to recover the cost of services from the Minister of Health.

Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the Regulations and in respect of a particular patient or a particular basic health service, to collect fees outside of the Plan, or selectively opt out of the plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2001 no physicians had opted out of the health care insurance plan.

Any basic health services rendered by physicians that are medically required are covered by the Health Care Insurance Plan. These include:

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

No services were added to the list of insured physician services in 2000-2001.

The process to add a physician service to the list of insured services is negotiated between the Department of Health and Social Services and the medical society of the Province.

2.3 Insured Surgical-Dental Services

Dental services are not an insured service in the Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in

the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital as confirmed by the attending physician.

The addition of a surgical-dental service is conducted through negotiations with the Dental Association and the Department of Health and Social Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

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

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

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

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

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations; section 3 defines eligibility to the health care insurance plans. The plans are designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital

and medical services on the first day of the third month following the month of arrival.

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

Ineligible residents may become eligible in the following cases: members of the CAF, RCMP, and penitentiary prisoners on discharge, release, or release following the termination of rehabilitation leave where such is granted by the CAF, the province where incarcerated or stationed at time of release of discharge, or the province where resident on the completion of rehabilitation leave as may be appropriate will provide initial coverage for the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged parolees.

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

3.2 Registration Requirements

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

The number of residents registered for the health care Insurance plan in Prince Edward Island as of March 31, 2001 was 138,205.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There were 58 Kosovar Refugees registered for Medicare as of March 31, 2001.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences, must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the Province, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the Province for up to 182 days in a 12-month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the Province under the above circumstances must notify the Registration Department prior to leaving.

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

The payment rates are $576 per day for hospital stays. The standard inter-provincial out-patient rate is $110. The methodology used to derive these rates are as if the patient had the services provided on Prince Edward Island.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5.(1)(e) of the *Health Services Payment Act*.

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

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

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

The amount paid for insured emergency services outside of Canada for 2000-2001 was $75,500.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency out-of-province medical or hospital services. Prince Edward Island residents seeking such required services may apply for prior approval through a PEI physician. Full coverage may be provided for (Prince Edward Island-insured) non-emergency or elective services, provided the physician completes an application to the Department. Prior approval is required from the Medical Director of the Department of Health and Social Services to receive out-of-country hospital or medical services not available in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

5.2 Access to Insured Hospital Services

The seven acute care facilities in Prince Edward Island have a total of 474 (454 acute care + 20 rehabilitative) approved beds. There are also 16 acute care beds providing insured hospital services in a psychiatric facility. There are no admission data for these 16 beds. During the 2000-2001 fiscal year, the total number of in-patient admissions was 18,340. The number of in-patient days in Prince Edward Island hospital acute care beds totalled 142,302 (excluding newborns), with an average stay of 7.8 days. Due to system changes, out-of-province hospital data for 2000-2001 are not available at this time. There are no data available on admissions, length of stay, and in-patient days for chronic care beds.

Linear Accelerator

In April 2000, the Government announced plans to expand the range of services that can be provided at the PEI Cancer Treatment Centre, through the addition of linear accelerator services. An impact analysis and functional plan for expanded cancer treatment services is now in the process of being completed. Expanded cancer treatment services are expected to be operational in late 2002.

Magnetic Resonance Imaging (MRI)

In April, 2000, the Government announced that diagnostic imaging services for Islanders will be expanded through the purchase of a Magnetic Resonance Imaging (MRI) unit for the Queen Elizabeth Hospital. A committee has been established to oversee the planning phase for the establishment of the MRI service, which is

expected to be operational in late 2002. An impact analysis has been completed and the functional plan is in the process of being finalized.

Ambulance Services

Amendments to the *Public Health Act* related to Emergency Medical Services and accompanying Regulations were approved for proclamation January 1, 2001. This act provides for enhancements in administration and delivery of emergency medical services.

In April 2000, the Government announced the Out of Province Medical Transport Support Program to cover a portion of the cost of out-of-province ground ambulance transportation. This program reduces the user fee for eligible Island residents who need specialized medical care outside the province.

Accessibility – New Initiatives

The Nurse Recruitment Strategy, announced in the 2000 PEI Budget, is in its second year of operation. All strategies have been implemented in PEI. While the Nurse Recruitment Strategy addresses all sectors of health care, priority is given to the institutional sector, which is acute and long term care services. The Department is currently developing an evaluation framework for the formal evaluation of the strategies.

5.3 Access to Insured Physician and Dental-Surgical Services

Physician services are accessible throughout the Province except for specialties where there are vacancies. Recruitment processes were undertaken for family physicians, one ear, nose and throat specialist, psychiatrists, a radiologist and one obstetrician. A recruitment strategy was announced that included incentives for recent graduates and new recruits, and an increase in medical seat resources for Prince Edward Island residents at medical schools outside the Province.

5.4 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and government to represent their interest in the process. A new three-year agreement was negotiated and is in effect until March 31, 2004.

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

Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments.

5.5 Payments to Hospitals

Regional Health Authorities are responsible for the delivery of hospital services in the Province under the *Health and Community Services Act*. The financial (budgetary) requirements are established annually through consultation with the Department of Health and Social Services and are subject to approval by the Legislative Assembly through the annual budget process.

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

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

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 2000-2001 Annual Budget and related budget documents, and its 2000-2001 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

Extended health care services are not an insured service, with the exception of the insured chronic care beds noted in section 2.1. Extended care services are provided through the five Regional Health Authorities of the Health and Social Services system. Nursing home services are available upon approval from regional admission and placement committees for placement into government manors and licensed private nursing homes. The standardized Services Assessment Screening Tool is used for determining service needs of residents for all admissions to nursing homes. There are 18 government and private nursing home facilities in the Province, with a total of 953 beds, including respite beds. The Province subsidizes 71 percent of residents in nursing homes as per the Welfare Assistance Act Regulations, Part 2. The federal government subsidizes approximately eight percent of residents. The remaining 21 percent of residents pay their own way. Nursing homes in Prince Edward Island provide Levels 4 and 5 care.

In addition to nursing home facilities, there are 31 licensed community care facilities in Prince Edward Island. As of March 31, 2001, the total number of licensed community care facility beds was 871. The 31 percent of residents who are subsidized require a financial assessment as per the *Welfare Assistance Act*, Part 1. The remaining 69 percent pay their own way. Community Care facilities provide Levels 1 to 3 care.

Home Care and Support services, also uninsured, are another component of extended care. Support services include home care nursing, visiting homemakers, community support, adult protection, and occupational and physiotherapy supports. The Senior's Assessment Tool is used to determine the nature and type of service needed. Professional services in home care are currently provided at no cost to the client but are subject to a budget cap. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment. The demand for home care continues to increase in PEI.

Nova Scotia

Introduction

The year 2000-2001 took Nova Scotia further toward its goal of developing an affordable, high quality, sustainable health care system. The main thrust of this change involved the passage of the *Health Authorities Act*, which came into effect on January 1, 2001, to establish nine District Health Authorities (DHAs) that will be charged with the management of day-to-day health services delivery.

This new legislation ensures greater financial accountability. The DHAs will be required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. Required annual reports will provide updates on the implementation of DHA business plans. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

In addition, a clinical services planning process was initiated to anticipate required changes in the system to ensure that Nova Scotians, no matter where they live, receive reliable high quality and sustainable health services. The results of that planning process were released and shared with the nine DHAs in February 2001 in a document entitled *Making Better Health Care Decisions for Nova Scotia*.

During this ongoing period of change, Nova Scotia has remained committed to the delivery of medically necessary services that are consistent with the principles of the *Canada Health Act*.

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

www.gov.ns.ca/health

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

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

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

Section 3 of the *Health Services and Insurance Act* states that subject to this act and the Regulations, all residents of the Province are entitled to receive insured hospital services from hospitals on uniform terms and conditions, and that all residents of the Province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend, or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Maritime Medical Care Incorporated (MMC), by virtue of the 1992 Memorandum of Agreement, is mandated to:

- determine the eligibility of providers participating in the Plan;
- plan and conduct information and education programs necessary to ensure that all persons and providers are informed of

their entitlements and responsibilities under the Plan;

- make payments under the Plan for any claim or class of claims for insured health services for which the Province is liable; and
- develop an audit and assessment system of claims and payments, to maintain a continuous audit process and to establish any other administrative structures required to fulfil its mandate.

1.2 Reporting Relationship

Maritime Medical Care is required to submit to the Province, no later than the twentieth day of each month, monthly expenditure reports, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, MMC is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. MMC is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc., that are charged to the MSI Plan. Reports prepared by Maritime Medical Care are forwarded directly to the Insured Programs Branch of the Department of Health for review and follow-up.

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

1.3 Audit of Accounts

The Auditor General's office audits Pharmacare, the provincial drug program. The Department of Health's internal auditors perform a financial audit of the administration contract at Maritime Medical Care. MMC also has an external audit conducted, which includes the administrative contract. No official audit is performed on Medicare payments, however, this is being recommended by the Auditor General's office.

Under Section 12(2) of the Hospital Insurance Regulations, every hospital board is required to submit to the Minister of Health by May 31 each year, an audited financial statement for the preceding fiscal year.

The Report of the Auditor General of Nova Scotia, tabled on January 19, 2001, contained three audits that are relevant to the *Canada Health Act*:

- a broad scope audit of government user fees in the Department of Health;
- an audit of the Cape Breton Healthcare Complex; and
- an assessment of the Alternative Funding Initiatives for the remuneration of Nova Scotia physicians.

1.4 Designated Agency

Maritime Medical Care Incorporated administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement between the Department of Health and MMC. MMC receives written authorization from the Department on the payees to which it may make payments. The rates of pay and specific amounts are dependent on the physician contract negotiated between the Medical Society of Nova Scotia and the Department of Health. MMC abides by the terms and conditions of the contract and its payment mechanism.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Thirty-six facilities deliver insured hospital services to in-patients and out-patients in Nova Scotia. Accreditation is not mandatory but most facilities are accredited at a facility or regional level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18, and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made

pursuant to the *Health Services and Insurance Act*.

In-patient services include:

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

Out-patient services include:

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

2.2 Insured Physician Services

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

Under the *Health Services and Insurance Act* a general practitioner means a person who engages in the general practice of medicine or a physician who is not a specialist within the meaning of the clause, and a specialist who is a physician and is recognized as a specialist by the appropriate licensing body of the jurisdiction in which he or she practises. Physicians (general practitioner or specialist) must be licensed by the College of Physicians and Surgeons in Nova Scotia in order to be eligible to bill the MSI system. Dentists receiving payment under the MSI Plan must be registered with the Provincial Dental Board and be recognized as dentists. In 2000-2001, 1,946 physicians and 39 dentists were paid through the MSI Plan.

Physicians retain the ability to opt into or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing their billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2001, no physicians had opted out.

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

No new large-scale services were added to the list of insured physician services in 2000-2001. On a quarterly ongoing basis, new specific fee codes are approved that represent either enhancements, new technologies or new ways of delivering a service.

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

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

2.3 Insured Surgical-Dental Services

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

To be permitted to provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Association of Dentists and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. As of March 31, 2001, there were no dentists who had opted out. In 2000-2001, 39 dentists were paid through the MSI Plan for providing insured surgical-dental services.

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

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

Uninsured physician services include:

- those a person is eligible for under the *Workers' Compensation Act* or under any other federal or provincial legislation;
- mileage, travelling or detention time;
- telephone advice or telephone renewal of prescriptions;
- examinations required by third parties;
- group immunizations or inoculations unless approved by the Department;
- preparation of certificates or reports;
- testimony in court;
- services in connection with an electrocardiogram, electromyogram or

electroencephalogram, unless the physician is a specialist in the appropriate specialty;

- cosmetic surgery;
- acupuncture;
- reversal of sterilization; and
- *in-vitro* fertilization.

All residents of the Province are entitled to those insured services covered under the *Health Services and Insurance Act*. If there is the ability for a patient to purchase enhanced goods and services, such as the foldable interocular lens or a fibreglass cast, patients are required to be fully informed about the cost and are not to be denied service based on their inability to pay. The Province provides alternatives to any of the enhanced goods and services.

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

The de-insurance of insured physician services is accomplished through a negotiation process between the Medical Society of Nova Scotia and the Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Plan Regulations pursuant to section 17 of the *Health Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival as permanent residents. Persons moving to Nova Scotia from another country to live permanently are eligible on the date of their arrival in the Province, provided they are Canadian citizens.

Members of the Royal Canadian Mounted Police, members of the Canadian Armed Forces, federal inmates and members of the North Atlantic Treaty Organization are ineligible for MSI coverage. When their status changes, they become eligible on the first day of the third month following the month in which their eligibility status changed.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Forms must be returned to MSI with the name and mailing address of a witness (a Nova Scotia resident who can confirm that all the information on the application is correct). The application must also be accompanied by a Canadian birth certificate, a Canadian immigration certificate or other verification that the applicant is entitled to remain in Canada. If the application is complete and the eligibility criteria have been met, MSI will then issue a health card, which must be shown for each insured service received. Renewal notices are sent out from MSI to the permanent address of the resident of Nova Scotia. Upon return of a signed renewal notice, MSI will issue a new health card. Each application and health card number is unique and allocated on an individual basis.

As of March 31, 2001, the number of residents registered with MSI was 947,963.

There is no legislation in Nova Scotia forcing residents of the Province to apply for MSI. There are residents who, therefore, are not members of the health insurance plan. Failure to provide a renewal notice effectively cancels the right to service, until the resident renews.

3.3 Other Categories of Individual

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

Immigrants: Persons in possession of landed immigrant documents and who are referred to as permanent residents are eligible on the date of their arrival in Nova Scotia. Persons in possession of any other documents, who have applied in Canada for permanent residence status, are eligible on the date of application for permanent resident status, provided they are in possession of a letter from Citizenship and Immigration Canada.

After residing in Nova Scotia for six months, persons with employment visas are eligible for coverage retroactive to the day of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, and provided they intend to be employed in Nova Scotia for a further six months.

Work Permits: Persons moving to Nova Scotia from another country who are in possession of an employment authorization are eligible to apply for MSI on the first day of the seventh month following the date of arrival as a worker, provided they have not been absent from Nova Scotia for 31 consecutive days, except in the course of employment.

Students: Persons moving to Nova Scotia from another country who are in possession of a student authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days.

Sebaticans: Persons on employment sabbatical are treated in the same manner as all other Nova Scotia residents. Sebaticans must return to Nova Scotia within 12 months. All absences of more than the usual six months must receive prior approval before MSI coverage will be extended.

Refugees: Refugees are not insured if they are not legally entitled to remain in Canada. This includes persons awaiting a decision from Citizenship and Immigration Canada as to whether they will be permitted to remain in Canada. Refugees with work permits are governed by the eligibility provisions for persons with work permits.

As of March 31, 2001 there were 928 individuals residing in Nova Scotia who were covered under the above conditions.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services. As well, several Orders-in-Council, including MSI Regulation Order-in-Council 72-783, ensure that portability will be provided.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months as per the Eligibility and Portability Agreement. Students temporarily absent from Nova Scotia and in full-time attendance at an educational institute remain eligible for MSI on a yearly basis, provided they supply a letter each year stating they are registered as full-time students.

Workers on work permits who leave Nova Scotia to seek employment elsewhere will remain covered by MSI for up to 12 months, provided they do not establish residence in another province, territory, or country.

Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates

in the Hospital Reciprocal Billing Agreement as well as the Medical Reciprocal Billing Agreement. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the Plan in 2000-2001 for in- and out-patient hospital services received in other provinces and territories were: $9,559,303 for out-of-province in-patient services, and $4,083,677 for out-of-province out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal billing situations.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident has not been out of the country for more than six months, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. In order to be covered, procedures of a non-emergency basis must have prior approval before they will be covered by the MSI.

Students temporarily absent from Nova Scotia and in full-time attendance at an educational institution remain eligible for MSI, provided they demonstrate registered, full-time student status.

Workers who leave Nova Scotia to seek employment elsewhere remain covered by MSI for up to 12 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent for 2000-2001 for insured in- and out-patient emergency services provided outside of Canada was $1,736,104. (Daily rate = CDN $525 per day).

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services in another province or outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a physician in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the Province, or if it can be provided in another province or only out-of-country. The decision of the Medical Consultant is relayed to the patient's physician. The patient is then covered under the Reciprocal Billing Agreement for elective services in another province or territory. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions.

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

No barriers to access exist in Nova Scotia.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to place emphasis on the provision of sustainable, quality health care services to its citizens.

As of March 31, 2001, 3,044 acute care hospital beds were available in Nova Scotia.

Table 1 provides a breakdown of key health professions that are licensed to practise in Nova Scotia. Not all of these health professionals were actively involved in delivering insured health services.

Table 1: Health Personnel in Nova Scotia (2000)	
Health Occupation	**Registered/ Licensed to Practice[1]**
Physicians	1,788[2]
Dentists	443[3]
Registered Nurses	9,327
Licensed Practical Nurses	3,349
Medical Radiation Technologists	483
Respiratory Therapists[4]	–
Pharmacists	945
Occupational Therapists	245
Speech-Language Pathologists	207
Chiropractors	52
Opticians	173
Optometrists	73
Denturists	65
Dietitians	386
Psychologists	369

1 Not all professionals licensed to practise actually work.

2 Not all physicians provide services under the provincial insurance system due to the presence of Department of National Defence and Aboriginal populations.

3 A limited number of licensed dentists are approved for insured dental services.

4 Data not available.

In Nova Scotia in 2000-2001, Telehealth was also used to provide the services listed in Table 2.

Table 2: Telehealth Services in Nova Scotia (2000-2001)	
Type of Telehealth Event	**Number of "Events"**
Tele-radiology Cases	14,763
Education Sessions	1,831
Clinical Consultations	729
Administrative Meetings	383
Clinical Case Conferences	281

5.3 Access to Insured Physician and Dental-Surgical Services

As of December 31, 2000, there were 1,757 physicians and 39 dentists actively providing insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

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

5.4 Physician Compensation

The *Health Services and Insurance Act* RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between the Medical Society of Nova Scotia and the Nova Scotia Department of Health. The Medical Society of Nova Scotia is recognized as the sole bargaining agent in support of physicians in the Province. When negotiations take place representatives from the Medical Society and the Department of Health negotiate the total funding and other terms, and conditions and enhancements that the Medical Society may bring to the table in light of the fiscal restraints on the Province. Each negotiated agreement contains a provision for binding arbitration, should there be an impasse in a dispute resolution. The current master agreement negotiated April 1, 1987 and which expired March 31, 2001, contains an alternate dispute resolution mechanism.

The agreement lays out what the master unit value will be for physician services and addresses issues of stand-by or call-back compensation, members' benefit fund, Canadian Medical Protective Association funding and royalty stabilization funding. As well, there is provision for a Harmonized Sales Tax rebate. Fee-for-service is still the most prevalent method of payment for physician services. Other payment methods include hourly rate funding, hourly funding, and sessional funding.

During 2000-2001, payments for fee-for-service in Nova Scotia totalled $220,399,923. The Department paid an additional $4,766,189 for insured physician services provided to Nova Scotia residents outside the Province, but within Canada.

Payment rates for dental services in the Province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a similar process to physician negotiation. Dentists are paid on a fee-for-service basis. The current agreement expired on March 31, 2001.

5.5 Payments to Hospitals

The Department of Health establishes budget targets for health care services. It does this by receiving business plans from the nine newly created District Health Authorities and the IWK Health Centre. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

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

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

In 2000-2001, there were a total of 3,044 (3.1 per 1,000 population) hospital beds in Nova Scotia. Department of Health direct expenditures for insured hospital services' operating costs were increased to $877.02 million. Payments to out-of-province hospitals for insured services to Nova Scotia residents were $9.6 million. Total separations from all hospitals decreased slightly to 201,415.

6.0 Recognition Given to Federal Transfers

In Nova Scotia the *Health Services and Insurance Act* RS Chapter 197 acknowledges the federal contribution in respect of the cost of insured hospital services and insured health services provided to residents of the Province. The residents of Nova Scotia are aware, through press releases and media coverage of ongoing negotiations between the provinces and the federal government that Canada Health and Social Transfer (CHST) funding partially assists in the provision of insured medical services in the Province.

The Government of Nova Scotia also recognized the federal contribution under the CHST in various published documents including the following documents released in 2000-2001:

- Public Accounts 1999-2000;
- Budget Estimates 2001-2002; and
- Department of Finance Year-End Forecast.

7.0 Extended Health Care Services

These following services are not considered medically necessary and, as such, are not insured under the *Canada Health Act*.

Nursing Homes

Nursing homes in Nova Scotia provide care primarily to seniors at Level I and Level II. Level I care deals with residents in homes requiring personal care and assistance with activities of daily living. Level II care involves Level I care plus specific nursing care. This level of care is increasing dramatically as the population ages. The aging-in-place phenomenon means those seniors who were Level I are rapidly moving into Level II.

Adult Residential Care Services

Adult residential care services in Nova Scotia continue to be under the jurisdiction of the Department of Community Services and are not considered to be insured services for the purposes of the *Canada Health Act*.

Home Care Services

Home Care Nova Scotia was introduced in 1995. This program assists seniors to remain in their own homes longer, thus delaying admission to a long-term care facility. Primarily, Home Care Nova Scotia provides personal care in clients' homes along with nursing care, if required. The two major components of the program are chronic and acute patient care. The chronic component makes up approximately 80 percent of home-care clients with the remaining 15 to 20 percent being acute home care, which allows for early discharge from hospital. Home Care Nova Scotia also provides a home oxygen program. This program is still developing, and other components will be added in the future, such as occupational therapy, physiotherapy, social work, palliative care, paediatrics, and others as deemed necessary.

Nova Scotia has embarked on a single-entry access model demonstration, with plans for full implementation in April 1, 2002.

New Brunswick

Introduction

Currently there are eight Region Hospital Corporations (RHCs), established by legislation, that provide health services in New Brunswick. Each RHC includes a regional facility and a number of smaller facilities, all of which provide insured services to in- and out-patients. Each RHC has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

The population of New Brunswick is approximately 750,000, of which 33 percent is francophone. The RHCs have a mandate to deliver services to all segments of the population.

Hospital programs are divided into three general categories of complexity/resource intensity and distributed to allow the system to be as equitable as is clinically and financially feasible. Primary care in the hospital system is delivered in all facilities. Secondary care, which is specialized care requiring more sophisticated and complicated diagnostic procedures and treatment is, for the most part, found in larger facilities. More specialized services, such as nuclear medicine, would be found in the eight regional hospitals. Tertiary services are found only in a few designated centres, and in some cases these services may be designated as a provincial service. For example, the Cardiac Surgery Unit located in Region 2 (Saint John) has a provincial mandate.

The Premier's Health Quality Council was established in January 2000 to make recommendations to government on renewing New Brunswick's health system. A discussion paper was released in the spring of 2001 that aimed at forging a discussion with New Brunswickers on how to best achieve a community based, individual focused sustainable health system.

The thoughts contained in the discussion paper are preliminary and the Council has asked New Brunswickers for their opinions on the initial thoughts and directions. The input will form an important part of the final report, which is due in late 2002.

One of the recommendations is that the Province establish eight Regional Health Authority Boards as the governing bodies for eight Regional Health Authorities (RHAs). The RHAs will, with minor modifications, mirror the current health regional boundaries.

New Brunswick, like other jurisdictions, is dealing with the sustainability of its health care system. Total expenditures for the Department of Health and Wellness are approximately 28 percent of total government expenditures. The Department's budget has been increasing at a greater rate than the entire provincial budget. The Department's actual expenditures increased by 5.8 percent in 2000-2001, while provincial expenditures increased by 3.6 percent.

On April 1, 2001, the Department of Health and Wellness introduced "A Nursing Resource Strategy for New Brunswick" that will be phased in over three years. The Strategy will enhance the ability of Region Hospital Corporations to recruit and retain nurses.

Additional information may be obtained on the government website [www.gnb.ca], which has a link to the Department of Health and Wellness.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick the health care insurance plan is known as the Medical Services Plan and the public authority responsible for operating and administering the Plan is the Minister of Health and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

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

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

1.2 Reporting Relationship

The Medicare Branch of the Public Health and Medical Services Division of the Department of Health and Wellness is mandated with the administration of the Medical Services Plan. The Minister reports either through the Department's Annual Report or through the regular legislative processes.

In February 2000, the New Brunswick government adopted a framework for Region Hospital Corporation accountability as outlined in the document *Building on our Strengths: A Framework for Region Hospital Corporation Accountability*. This document outlined the respective roles of the Department and the RHCs, and established the RHC System Planning Committee as the key process supporting RHC accountability.

1.3 Audit of Accounts

There are three groups with the mandate to audit in the area of the Medical Services Plan.

1. The Auditor General

- In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which include the financial records of the Department of Health and Wellness. For 2000-2001, all transactions of the Department were exposed to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report on identified errors and control weaknesses.

2. The Office of the Comptroller

- The Comptroller is the chief internal auditor for the Province of New Brunswick and is charged with carrying out internal audit activity in accordance with responsibilities and authority under the *Financial Administration Act*. The objective of an internal audit is to fulfill the Comptroller's mandate as it relates to Appropriations Audit, Information Systems Audit, Statutory Audits and Value-for-Money Audits. The audit work performed by the Office varies, depending on the nature of the entity audited.
- No reviews were done in fiscal 2000-2001.

3. Department of Health and Wellness Internal Audit

- The Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives.

- Reviews of program areas are usually done on a cyclical basis with a major program covered once every three to four years. No reviews were performed on these programs for 2000-2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes:

- the *Hospital Services Act*, 1973, and its Regulation 86-74, section 9 of the Regulation identifies entitled services, and
- the *Hospital Act*, assented to May 20, 1992 and its Regulation 92-84.

There are eight Region Hospital Corporations, established by legislation. Each RHC includes a regional facility and a number of smaller facilities, all of which provide insured services to both in- and out-patients. Each RHC has other health facilities or health centres, without designated beds, that provide a range of entitled services to entitled persons. See Appendix 1 to this section of the report for a listing of RHC facilities by type. Note that facilities are categorized as those providing in-patient beds and those that do not provide in-patient services.

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

"*(a)* in-patient services in a hospital facility operated by an approved hospital corporation as follows:

(i) accommodation and meals at the standard ward level;

(ii) necessary nursing service;

(iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;

(iv) drugs, biologicals and related preparations, as provided for in Schedule 2;

(v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;

(vi) routine surgical supplies;

(vii) use of radiotherapy facilities, where available;

(viii) use of physiotherapy facilities, where available, and

(ix) services rendered by persons who receive remuneration therefor from the hospital corporation.

(b) out-patient services in a hospital facility operated by an approved hospital corporation as follows:

(i) laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner, where approved facilities are available;

(i.1) laboratory and diagnostic procedures together with the necessary interpretations, where approved facilities are available, when performed for the purposes of a mammography screening service that has been approved by the Minister, and

(ii) the hospital component of available out-patient services when prescribed by a medical practitioner and provided in the out-patient facility of an approved hospital corporation for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability, excluding the following services:

(A) the provision of any proprietary medicines;

(B) the provision of medications for the patient to take home;

(C) diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;

(D) visits solely for the administration of drugs, vaccines, sera or biological products; and

(E) any out-patient service which is an entitled service under the *Medical Services Payment Act*."

2.2 Insured Physician Services

The enabling legislation providing for insured physician services in New Brunswick is the *Medical Services Payment Act* (MSPA).

The MSPA was assented to on December 6, 1968. Regulation 84-29 was filed on February 13,1984, Regulation 93-143 on July 26,1993, Regulation 96-113 on November 29, 1996 and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13,1999.

No changes were introduced in 2000-2001.

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

- to maintain current registration/licence with the New Brunswick College of Physicians and Surgeons;
- membership in the New Brunswick Medical Society;
- holding privileges in a Region Hospital Corporation; and
- signing the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's *Medical Services Payment Act* as of March 31, 2001 was 1,355.

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

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

a) if the charges do not exceed the Medicare tariff, the practitioner must complete the specified Medicare claim forms and indicate the exact total amount charged the patient. The beneficiary seeks reimbursement by certifying on the claim form that the services have been received and by forwarding the claim form to Medicare;

b) if the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the service that:
   - they are opting out and charging fees above the tariff;
   - in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and
   - the patient is entitled to seek services from another practitioner who participates in the Plan.

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

As of March 31, 2001 no physicians rendering health care services had elected to opt out of the Plan.

The range of entitled services under Medicare New Brunswick includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed either by a physician or by a dental surgeon in a hospital facility.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and the rest of Canada. Considerations under the term "medically

necessary" include services required for the purpose of maintaining health, preventing disease and /or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

The range of surgical-dental services under New Brunswick Medicare are payable only to oral and maxillofacial surgeons. A general dental practitioner may be paid to assist another dentist for services that are medically required to be performed in a hospital and are included in Schedule 4 of Regulation 84-20 (filed June 23, 1998) under the *Medical Services Payment Act*. Schedule 4 identifies the insured surgical-dental services that can be provided by a qualified medical practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital.

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

The number of dental practitioners registered with New Brunswick Medicare is 57, although many do not provide insured services.

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured Hospital Services

Uninsured services include:

- patent medicines;
- take-home drugs;
- third-party requests for diagnostic services;
- visits for the administration of drugs, vaccines, sera or biological products;
- televisions, telephones;
- preferred accommodation at the patient's request; and
- hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*.

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

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

Uninsured Physician and Surgical-Dental Services

The services listed in Schedule 2 of the Regulation (84-20) under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

"*(a)* elective plastic surgery or other services for cosmetic purposes;

(a.01) correction of inverted nipple;

(a.02) breast augmentation;

(a.03) otoplasty for persons over the age of 18;

(a.04) removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;

(a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;

(a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract

itself, due to the existence of an illness or other complication;

(b) medicines, drugs, materials, surgical supplies or prosthetic devices;

(c) vaccines, sera, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;

(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;

(f) dental services provided by a medical practitioner;

(f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

(f.2) services that are provided in conjunction with or in relation to the services referred to above;

(h) testimony in a court or before any other tribunal;

(i) immunization, examinations or certificates for purposes of travel, employment, emigration, insurance, or at the request of any third party;

(j) services provided by medical practitioners to members of their immediate family;

(k) psychoanalysis;

(l) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;

(m) laboratory procedures not included as part of an examination or consultation fee;

(n) refractions;

(n.1) services provided within the Province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;

(o) the fitting and supplying of eyeglasses or contact lenses;

(p) transsexual surgery;

(p.1) radiology services provided in the Province by a private radiology clinic;

(q) acupuncture;

(r) complete medical examinations when performed for purposes of a periodic check-up and not for medically necessary purposes;

(s) circumcision of the newborn;

(t) reversal of vasectomies;

(u) second and subsequent injections for impotence;

(v) reversal of tubal ligations;

(w) intrauterine insemination;

(x) gastric stapling or gastric by-pass; and

(y) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility."

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

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

No medical or surgical-dental services were removed from the insured service list in 2000-2001.

3.0 Universality

3.1 Eligibility

The *Medical Services Payment Act* and its Regulation 84-20, sections 3 and 4 define eligibility for the health care insurance plan.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian Immigration permit. A resident is defined as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient or visitor to the Province.

All persons entering or returning to New Brunswick have a waiting period prior to becoming eligible for coverage. Coverage commences the first day of the third month following the month of arrival. An exception was made to grant first-day coverage for bona fide missionaries who were previously registered residents of New Brunswick at time of their departure from the country.

Residents who are ineligible include:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police;
- federal Inmates;
- persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian immigration permits. An example would be a Student Authorization.

Provisions to become eligible include:

- non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to an eligible New Brunswick resident.

Provisions when status changes include:

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

3.2 Registration Requirements

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

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

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two to three months prior to the expiry date of the Medicare card(s). A beneficiary who wishes to remain eligible to receive entitled services is required to confirm the information on the Notice of Expiry, to make any changes as appropriate and to sign and return the form to Medicare. Upon receipt of the completed form the file is updated and new card(s) issued bearing a revised expiry date.

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

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

The number of residents registered as of March 31, 2001 was 738,598.

Residents may opt out if they choose. They are asked to provide a written confirmation of their intention. This information is then added to their file and benefits are terminated. As of March 31, 2001, only three residents had elected to opt out of the Plan.

3.3 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided they are legally married to an eligible New Brunswick resident and remain in possession of a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. In 2000-2001, approximately 50 individuals were covered under these conditions.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period. Coverage commences the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

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

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

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

Residents who are temporarily employed in another province or territory are granted coverage for up to 12 months provided they:

- do not establish residence outside the Province;
- do not receive coverage in another province or territory; and
- intend to return to New Brunswick.

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

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

During 2000-2001, New Brunswick paid to other provinces and territories:

Hospital In-patient	Hospital Out-patient	Medical
$21,561,907	$4,702,219	$7,697,923

4.3 Coverage During Temporary Absences Outside Canada

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

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

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

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

Exception to Temporary Workers: Mobile Workers are residents whose employment requires them to travel frequently outside the Province. Certain guidelines must be met to receive Mobile Worker designation. They are:

- their applications must be submitted in writing;
- documentation is required as proof of Mobile Worker status, e.g., a letter from an employer or a photocopy of an Immigration Permit;
- permanent residence must remain in New Brunswick; and
- the person must return to New Brunswick during their off-time.

Mobile Worker designation is assigned for a maximum of three years, after which the resident must reapply and resubmit documentation to confirm status.

For teachers employed in Louisiana there is a special provision for a maximum two-year coverage.

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

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

2000-2001		
Hospital In-patients	**Hospital Out-patients**	**Medical Services**
$458,759	$180,712	$362,709

4.4 Prior Approval Requirement

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

- the required service(s) must be unavailable in Canada;
- it must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (Guide to United States Hospitals, Health Care Systems, Networks, Alliances, Health Organizations, Agencies and Providers);
- the service(s) must be rendered by a medical doctor; and
- the service(s) must be an accepted method of treatment recognized by the medical community and scientifically proven. Experimental procedures are not covered.

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

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

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

Prior approval is also required for referral of patients to psychiatric hospitals and centres outside the Province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received from the referring physician(s).

5.0 Accessibility

5.1 Access to Insured Health Services

Since there are no health care user fees in New Brunswick, all residents have equal access to insured health services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds by the Region Hospital Corporation. The number of approved beds is shown in Table 1.

Table 1: Approved Beds as of March, 2001

Bed Type		Number	Percent of Total Beds
Non-Tertiary	Acute	2,878	72
	Restorative	397	10
	Addictions	174	4
	Corrections Canada	2	0
	Veterans Affairs Canada	187	5
	Sub-Total	3,638	91
Tertiary	Oncology	80	2
	Cardiac Surgery	26	1
	Neurosurgery	46	1
	Tertiary Psychiatry	206	5
	Tertiary Rehabilitation	20	0
	Sub-Total	378	9
Provincial Total		4,016	100

All facilities that provide *Canada Health Act* insured services have the appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2001 there were nine Computed Tomography (CT) scanners operating in the Province, one in each of the eight Region Hospital Corporations, with an additional unit in the Atlantic Health Sciences Corporation (Region #2). The Province also has two mobile Magnetic Resonance Imaging (MRI) units in operation, and one fixed-site MRI system.

In 2000-2001, the following initiatives served to improve access to insured hospital services in New Brunswick:

- introduction of a fixed-site MRI at the Region 1 Hospital Corporation (South East);
- Family Medicine opened a “swing unit” to reduce emergency room gridlock during winter flu season at the Region 2 Hospital Corporation;

- expansion of renal dialysis service at the Region 3 Hospital Corporation;
- expanded use and development of telehealth to improve access to services in several program areas at the Region 3 Hospital Corporation;
- the Region 6 Hospital Corporation has placed a greater emphasis on telemedicine in its patient programs;
- the Region 6 Hospital Corporation has set up an Anticoagulation Therapy Clinic; and
- the Department of Health and Wellness has established financial incentives in order to recruit and retain radiation therapists, Medical Radiation Technologists and Dosimetrists involved in providing radiation therapy services at cancer centres.

5.3 Access to Insured Physician and Dental-Surgical Services

A total of 645 family practitioners, 710 specialists, 9 dentists and 5 oral surgeons provided insured services in New Brunswick during fiscal 2000-2001.

In fiscal 2000-2001, the Department operationalized the recruitment and retention strategy aimed at attracting newly licensed family practitioners and specialists that was announced in 1999-2000. This included, in part: establishment of a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities, providing location grants of $25,000 for family practitioners and $40,000 for specialists willing to practise in hard-to-recruit areas; purchasing 10 additional seats at Memorial University Medical School, increasing government involvement in post-graduate training of family physicians, expanding the summer rural preceptorship program for medical students from 12 to 30 and moving physician remuneration toward relative parity with other Atlantic jurisdictions.

5.4 Physician Compensation

An arbitration panel awarded New Brunswick physicians a 10 percent increase for 2000-2001 and 8 percent for 2001-2002. Distribution of the wage increases has been completed, however discussions are ongoing in order to resolve outstanding issues that were not addressed by the arbitration panel.

A dispute resolution mechanism which includes mediation and binding arbitration is provided for in the Legislation.

There is no formal negotiation process for dental practitioners.

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

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

5.5 Payments to Hospitals

The primary acts of legislation governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Services Act,* which governs the financing of hospitals.

There were no changes during fiscal year 2000-2001 affecting the hospital payment process.

The Department utilizes two components to distribute available funding to the Region Hospital Corporations.

1) The main component is a “Current Service Level” (CSL) base. This component addresses five main patient-care delivered services as follows:
   - tertiary services (cardiac, dialysis, oncology);
   - psychiatric services (psychiatric units and facilities);

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

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

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

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

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

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

6.0 Recognition Given to Federal Transfers

The Province routinely recognizes the federal role regarding its contributions under the Canada Health and Social Transfer (CHST) through public documentation presented through the legislative or administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on March 27, 2001;
- the Public Accounts presented by the Minister of Finance on December 7, 2000; and
- the Main Estimates presented by New Brunswick's Minister of Finance in March 2001.

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

7.0 Extended Health Care Services

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

Residential and Extended Care Services

Table 2 identifies residential and extended-care services available in New Brunswick as of March 31, 2001. Nursing homes are private not-for-profit organizations, except for one that is owned by the Province. In order to be admitted to a nursing home, clients go through an evaluation process based on specific health condition criteria.

Adult Residential Facilities are for the most part private for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open or close residences. Clients are admitted after going through the same evaluation process used for nursing homes.

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

Table 2: Availability of Residential and Extended Care

Service	Number of Units or Beds
Nursing Home Beds	4,140
Adult Residential Facilities* (beds)	5,341
Public Housing (Units)	2,088
Provincial Total	11,569

* Includes Special Care Homes and Community Residences.

Ambulatory Health Care

In New Brunswick, “ambulatory health care” includes services provided in hospital emergency rooms, day/night care in hospitals, and in clinics as may be available in hospital facilities and health centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also called the “hospital at home” program, is an active treatment program of acute, palliative and long term health care provided in community environments, (e.g., an individual’s home, nursing home, or public school). The eight Region Hospital Corporations have been responsible for the delivery of the Extra-Mural Program since 1996. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists, and speech language pathologists. This service is considered an insured service under the provincial Hospital Services Plan.

Appendix 1: New Brunswick Hospital Facilities, September 2001

Hospital Corporation	Facilities Providing Insured Health Services *(Location)*	Other Facilities / Health Centres *(Location)*
Region 1 Hospital Corporation (South-East) South-East Health Care Corporation	The Albert County Hospital Inc. *(Albert)* The Moncton Hospital *(Moncton)* The Sackville Memorial Hospital *(Sackville)*	Petitcodiac Health Centre *(Petitcodiac)* Health Services, Rexton *(Rexton)*
Region 1 Hospital Corporation (Beauséjour) Corporation Hospitalière Beauséjour	Hôpital Docteur Georges L. Dumont *(Moncton)* L'Hôpital Stella Maris de Kent *(Sainte-Anne-de-Kent)*	Centre médical régional de Shédiac (Shédiac)
Region 2 Hospital Corporation Atlantic Health Sciences Corporation	Saint John Regional Hospital Facility *(Saint John)* The Charlotte County Hospital Facility *(St. Stephen)* Sussex Health Centre Facility *(Sussex)* St. Joseph's Hospital Facility *(Saint John)* The Grand Manan Hospital Limited Facility *(Grand Manan Island)* Centracare Saint John Inc. * *(Saint John)*	Campobello Health Centre Facility *(Campobello Island)* Deer Island Health Centre Facility *(Deer Island)* Fundy Hospital Association Limited Facility *(Black's Harbour)*
Region 3 Hospital Corporation	Northern Carleton Hospital *(Bath)* Queens North Health Complex *(Minto)* Oromocto Public Hospital (*Oromocto)* L'Hotel-Dieu Saint-Joseph de Perth-Andover Inc. *(Perth-Andover)* Dr. Everett Chalmers Hospital *(Fredericton)* The Tobique Valley Hospital *(Plaster Rock)* Stan Cassidy Centre for Rehabilitation * *(Fredericton)* The Carleton Memorial Hospital *(Woodstock)*	MacLean Memorial Hospital *(McAdam)* Chipman Health Services Centre (*Chipman)* Upper Miramichi Health Services Centre *(Doaktown)* Upper Miramichi Health Services Centre *(Boiestown)* Stanley Health Services Centre *(Stanley)* Fredericton Junction Health Services Centre *(Fredericton Junction)* Harvey Community Hospital *(Harvey Station)*
Region 4 Hospital Corporation	L'Hôpital régional d'Edmundston *(Edmundston)* Grand Falls General Hospital Inc. *(Grand Falls)* L'Hotel-Dieu Saint Joseph de Saint-Quentin Inc. *(Saint-Quentin)*	Centre de Santé de Ste Anne de Madawaska *(Sainte-Anne-de-Madawaska)*
Region 5 Hospital Corporation	L'hôpital régional de Campbellton *(Campbellton)* Restigouche Hospital Centre Inc. **(Campbellton)* L'Hôpital St. Joseph de Dalhousie *(Dalhousie)*	Centre de santé de Jacquet River *(Belledune)*
Region 6 Hospital Corporation Réseau Santé NOR'EST / NOR'EAST Health Network	L'hôpital régional Chaleur *(Bathurst)* Centre hospitalier de l'Enfant-Jesus inc. *(Caraquet)* Centre hospitalier de Lamèque *(Lamèque)* Centre hospitalier de Tracadie *(Tracadie)*	Centre de santé de Paquetville *(Paquetville)* Centre de santé de Chaleur *(Pointe Verte)*
Region 7 Hospital Corporation	Miramichi Regional Facility *(Miramichi)*	Baie Ste. Anne Health Centre *(Baie Ste-Anne)* Neguac Health Centre *(Neguac)* Blackville Health Centre *(Blackville)* Rogersville Health Centre *(Rogersville)*

Notes:
1. "Insured Health Services" are defined in the *Canada Health Act*.
2. Addictions Services, Veterans Units, and Extra-Mural Program Units are not identified on this list.

* indicates provincial tertiary centre

Quebec

Statement from Quebec

In this report, the information pertaining to Quebec is presented in the same way as in the previous annual reports prepared by Health Canada to meet the legislative requirements that have existed since the adoption of the *Canada Health Act*.

The government of Quebec, owing to its constitutional jurisdiction in the area of health, is accountable to the National Assembly and to Quebeckers for its management of health services. In that connection, it regularly makes public various documents and reports on, among other things, the health of the population, patient satisfaction and the organization of health and social services in its territory. Most of these documents can be accessed on the Internet site of Quebec's Ministère de la Santé et des Services sociaux at www.msss.gouv.qc.ca and that of the Régie de l'assurance maladie du Québec at www.ramq.gouv.qc.ca.

Federal Response to Quebec

The Federal Minister of Health is accountable to Parliament and to Canadians regarding the monitoring of compliance by provinces and territories with the *Canada Health Act*. Section 23 of the *Canada Health Act* requires that an annual Report to Parliament be prepared by no later than December 31 of each year on the Act's administration and operation for the preceding fiscal year. The annual report is to include "all relevant information on the extent to which provincial health care plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act". The provincial and territorial governments are the source of the information required for fulfilling this statutory reporting obligation.

In 1999, the Auditor General of Canada recommended that "in its annual reports to Parliament, Health Canada should clearly indicate the extent to which each provincial and territorial health care insurance plan has satisfied the *Canada Health Act* criteria and conditions. Where it does not provide this information in the reports, it should clearly explain the reasons." In responding to the Auditor General's recommendation that *Canada Health Act* monitoring and compliance assessment activities be improved, Health Canada worked collaboratively with the provinces and territories during 2000 and 2001 to implement a standardized format for the Canada Health Act Annual Report and expanded the content to enable a better understanding of whether the *Canada Health Act* is being complied with by provinces and territories.

All provinces and territories were advised of the change in format and content requirements, including a statistical annex that provides a quantitative context for the administration and operation of the *Canada Health Act*. Officials from provinces and territories were offered technical advice and assistance in the completion of their submissions through numerous teleconferences and multilateral meetings. All provinces and territories, Quebec excepted, agreed to fulfill the revised format and content required.

For this annual report, Quebec has provided some statistical information that is included in *Annex A – Provincial and Territorial Health Care Insurance Plan Statistics* but it is not of the type or in the manner requested. The federal government is concerned that Quebec is not providing sufficient information to effectively assess compliance with the *Canada Health Act* and satisfy the recommendations of the Auditor General. The federal government will continue to work with Quebec to ensure that information is made available to demonstrate compliance with the *Canada Health Act*.

Quebec

Public Administration

Hospital Insurance and Medical Care Plans

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

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

Comprehensiveness

Hospital Insurance Plan

The network of establishments under the Ministry of Health and Social Services includes hospital centres, certain residential and extended-care facilities (formerly extended-care hospital centres[1]) and local community services centres.

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

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

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

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

Other services covered by insurance are mechanical, hormonal or chemical contraception; surgical sterilization (tubal ligation or vasectomy); and reanastomosis of the fallopian tubes or vas deferens; and removal of tooth or root when the health status of the person requires or demands hospital services.

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

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

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

Medical Care Plan

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

The following services are not considered insured: any examination or service not related to a process of cure or prevention of illness; psychoanalysis in every form, unless such service is rendered in an institution authorized by the Ministry of Health and Social Services; any service provided for purely aesthetic purposes; any refractive surgery, except in cases where there is documented failure of more than 3.00 diopters or anisometropia of more than 5.00 diopters, measured at the cornea, when corrective lenses or corneal lenses are worn; any consultation by telecommunication or by correspondence; any service rendered by a professional to the person's spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than the person who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examination, vaccination, immunization or injections given to a group or for certain purposes; any service rendered by a professional based on an agreement or a contract with an employer, an association or an organization; any adjustment of eyeglasses or contact lenses; any surgical removal of a tooth or tooth fragment carried out by a physician, except in certain cases where the service is provided in a hospital centre; all acupuncture procedures; the injection of sclerosing substances and the examination made at that time; thermography, mammography used for screening purposes, unless this service is not delivered in a place designated by the Minister in either case, either to a recipient who is 40 or over and under 50 years of age and who presents a significant risk factor associated with breast cancer, and on condition that such an examination has not been performed on the recipient in the previous two years, or to a recipient 50 years of age or older, on condition that such an examination has not been performed on the recipient in the previous two years; mammography for detection purposes, tomodensitometry, Magnetic Resonance Imaging, the use of radionuclides *in vivo* in a human, and ultrasonography, unless all these services are rendered in a hospital centre; any radiological or anaesthetic service provided by a physician if it is required with a view to dispensing an uninsured service, with the exception of a dental service provided in a hospital centre, or in case of a radiology, if it is required by a person other than a physician or a dentist; and any surgical service provided for the purposes of transsexualism unless such a service is provided upon the recommendation of a physician specializing in psychiatry and is carried out in a hospital centre recognized to this end; and any services not associated with a pathology and that are rendered by a physician to a patient between the ages of 18 and 65 years, unless that individual is the holder of a claim card for colour-blindness or a refraction problem, for the purpose of obtaining or renewing a prescription for eyeglasses or contact lenses.

In addition to the basic insured services, the *Régie* also covers, with some limitations regarding certain residents of Quebec as defined by the *Loi sur l'assurance maladie* and Employment Assistance recipients, optometric services; dental care for children and Employment Assistance recipients, and acrylic dental prostheses for Employment Assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids or other equipment for persons with physical disabilities; external breast prostheses; ocular prostheses; supplementary hearing aids and visual aids for people with visual or auditory handicaps; and permanent ostomy appliances.

Moreover, since January 1, 1997, in terms of drug insurance, the *Régie* covers over and above its regular clientele (Employment Assistance recipients and seniors 65 years and older), individuals who do not otherwise have access to a private drug insurance plan. The new drug insurance plan covers 3.2 million insured persons.

Universality

Hospital Insurance and Medical Care Plans

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

Portability

Hospital Insurance and Medical Care Plans

Minimum Residence

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

If outside Quebec for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec in the first case for four consecutive calendar years at most, and in the second case for two consecutive calendar years at most. Quebec government civil servants, employees of non-profit organizations with head offices in Canada and employed abroad in assistance or cooperation programs recognized by the Minister of Health and Social Services, and the spouses and dependants of all such persons maintain their resident status, provided the *Régie* is notified of their absence.

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

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

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

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

Payment Arrangements in Canada

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

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

Payment Arrangements Outside Canada

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

However, haemodialysis treatments are covered to a maximum of $220 per treatment. In such cases, the *Régie* reimburses the associated professional services. Services must be dispensed in a recognized establishment accredited as a hospital or hospital centre by the competent authorities. No reimbursements are made for nursing homes, spas or similar establishments.

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

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

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

Permanent Moves out of the Province

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

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

Accessibility

Hospital Insurance and Medical Care Plans

Reasonable Access

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

There is no extra-billing by physicians in the Province of Quebec. While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration in accordance with the provincial fee schedule; and non-participating professionals who practise outside the plan entirely, so that neither they, nor their patients, receive reimbursement from the Régie.

As of March 31, 2001, Quebec counted 125 institutions operating as hospital centres for a clientele suffering from serious diseases with 21,804 acute and psychiatric care beds allotted to these institutions. From April 1, 1999 to March 31, 2000[2], hospital institutions counted more than 736,500 admissions for short-term stays and close to 78,000 registrations for day

[2] Latest year for which figures are available.

surgeries. These hospitalizations represented a total number of more than 5,555,738 patient-days.

Payment to Hospitals

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

The payments transferred in 1999-2000 to institutions operating as hospital centres for insured health services for Quebec residents amounted to $5.5 billion and payments transferred to hospital centres outside Quebec amounted to approximately $73,363,000.

System of Payment for Medical Care

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

Reasonable Compensation

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

In 2000-2001, the *Régie* had paid $2,553.1 million to doctors in the Province and the amount evaluated for medical services outside the province had reached $8.9 million.

Extended Health Care Services

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

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

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

Ontario

Introduction

The Ontario Ministry of Health and Long-Term Care is responsible for administering the health care system in the Province and providing services to the Ontario public through such programs as health insurance, drug benefits, assistive devices, care for the mentally ill, long-term care, home care services, community and public health, health promotion and disease prevention. The Ministry also regulates hospitals, nursing homes and long-term care facilities, operates psychiatric hospitals and medical laboratories, and coordinates emergency health services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is established under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided in hospitals and health facilities and by physicians and other health care practitioners. The health insurance plan is administered on a non-profit basis by the Ministry of Health and Long-Term Care (see section 10 of the *Health Insurance Act*).

1.2 Reporting Relationship

OHIP is a part of the Ministry of Health and Long-Term Care. Its activities and operational reports are included in general Ministry publications, including the Ministry's Annual Business Plan.

1.3 Audit of Accounts

OHIP's accounts and transactions are audited by the Provincial Auditor and are published annually in the Public Accounts of Ontario.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services in Ontario are governed by the *Health Insurance Act*, and Regulation 552 under that Act. The Act and Regulation define both in-patient and out-patient insured services.

Insured in-patient hospital services include:

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

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;
- use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- use of diet counselling services;
- use of home renal dialysis and home hyperalimentation equipment, supplies and medication;
- provision of equipment, supplies and medication to haemophiliac patients for use at home;
- cyclosporine to transplant patients;
- zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
- biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
- drugs for treatment of cystic fibrosis and thalassemia;

- erythropoietin to patients with anaemia of end-stage renal disease;
- alglucerase to patients with Gaucher disease;
- clozapine to patients with treatment-resistant schizophrenia; and
- the administration of a rabies vaccine.

In addition to insured hospital benefits, Ontario provides long-term care services, mental health services (including the operation of provincial psychiatric hospitals), the residential component of the Homes for Special Care Program, ambulance services (air and land) with a patient co-payment component, dental treatments for patients with cleft lip-palate who are registered at a designated clinic, and funding for a breast cancer screening program.

The *Public Hospitals Act* is the enabling legislation for public hospitals in Ontario and includes Regulation 964 on the Classification of Hospitals and Regulation 965 on Hospital Management.

In 2000-2001 there were 155 public hospital corporations (excluding specialty hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and nursing homes) staffed and in operation in the Province. This includes 140 acute care hospital corporations, 11 chronic care hospitals and 4 general and special rehabilitation units. Facilities are categorized by major activity, though they provide a mix of hospital services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation. Public hospitals may be accredited by the Canadian Council on Health Services Accreditation (CCHSA).

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

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

2.2 Insured Physician Services

Under section 37(1) of Regulation 552 under the *Health Insurance Act*, a service rendered by a physician in Ontario is an insured service if it is medically necessary, referred to in the Schedule of Benefits and rendered in such circumstances or under such conditions as are specified in the Schedule of Benefits.

Physicians are registered to practise medicine in Ontario by the College of Physicians and Surgeons of Ontario. There are approximately 20,700 physicians registered to submit claims to OHIP.

Physicians may submit claims directly to OHIP for all insured services rendered to insured persons, or they may bill the insured person directly for all insured services as specified in section 15 of the *Health Insurance Act* (see also the *Health Care Accessibility Act*). Physicians who do not bill OHIP directly are commonly referred to as "opted-out". An opted-out physician bills the patient (not more than the amount payable for the service in the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. The percentage of opted-out physicians has fallen to approximately one percent since the enactment of the *Health Care Accessibility Act* in 1986.

Insured physician services in facilities, physicians' offices or in a patient's home are detailed in the Schedule of Benefits, pursuant to Ontario Regulation 552 under the *Health Insurance Act*. In general terms, these include:

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

Services are added to or deleted (de-insured) from the Schedule of Benefits for Physician Services on the recommendation of the Central Tariff Committee of the Ontario Medical Association in consultation with the Ministry of Health and Long-Term Care. The Schedule of Benefits Working Group, comprised of members from the Ontario Medical Association and the Ministry, reviews the Schedule of Benefits on a regular basis. Public consultation may also be undertaken. Services are added to or deleted from the Schedule of Benefits for Physician Services by regulation.

2.3 Insured Surgical-Dental Services

Approximately 350 dentists and dental/oral surgeons provided insured surgical-dental services in 2000-2001.

Insured hospital surgical-dental services, prescribed in section 16 and Schedules 13, 14, and 15 of Regulation 552 under the *Health Insurance Act*, include the following where it is medically necessary that they be rendered in hospital:

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Insurance Act* and Regulations are insured. All other services are uninsured. Section 24 of Regulation 552 contains a non-exhaustive list of services, which are prescribed as uninsured.

Uninsured hospital services include:

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

Uninsured physician services include:

- services that are not medically necessary;
- travelling to visit an insured person outside the area of the practice;
- toll charges for long-distance telephone calls;
- preparing or providing a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;
- advice given by telephone at the request of the insured person or the person's representative;
- an interview or case conference (in limited circumstances);
- preparation and transfer of records at the insured person's request;
- a service that is received wholly or partly for the production or completion of a document or the transmission of information to a "third party" in specified circumstances;

- the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances;
- provision of a prescription when no concomitant insured service is rendered;
- cosmetic surgery;
- acupuncture procedures;
- psychological testing;
- group screening programs; and
- research and survey programs.

The above list is not exhaustive and is subject to exceptions. Refer to section 24 of Regulation 552 under the *Health Insurance Act*, the Schedule of Benefits for Physician Services, and section 11.2 of the *Health Insurance Act*.

Furthermore, section 11.2(2) of the *Health Insurance Act* provides that services to which a person is entitled under the *Workplace Safety and Insurance Act* (1992), or under the *Homes for Special Care Act* or under any Act of the Parliament of Canada, except the *Canada Health Act*, are not insured services.

"Third-party requests" for services are not generally insured by OHIP.

Ontario's health insurance policy states that enhanced medical goods, such as fibreglass casts, are provided to the patient, without charge, where those enhanced medical goods are medically necessary.

It is a provincial offence for a physician to charge patients, or to accept payment from patients, for more than the amount payable by OHIP. A physician may charge for services that are not insured under OHIP. The Ministry does not regulate charges for uninsured services as these charges are governed by the College of Physicians and Surgeons of Ontario. The Ontario Medical Association publishes a schedule of suggested fees for uninsured services.

In 2000-2001, the Schedule of Benefits Working Group recommendations were implemented in three areas. The fee for Miscellaneous Therapeutic Procedures was de-listed from the Schedule of Benefits for Physician Services and a fee was added for Ultraviolet Light Therapy for dermatology. Hearing Aid Evaluations and re-evaluations have also been delisted from the Physicians' Schedule, and at the same time the definitions of who can perform Basic and Advanced Diagnostic Hearing Tests (DHTs) have been clarified (for payment purposes). A further change has set payment at a maximum of eight nerve blocks per patient per day for any combination of nerve blocks.

3.0 Universality

3.1 Eligibility

With certain exceptions, all residents of Ontario are eligible for coverage, subject to a three-month waiting period. Regulations under the *Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are subject to the three-month waiting period (refer to section 11(1) of the *Health Insurance Act* and Regulation 552 thereunder).

Every resident of Ontario who seeks OHIP coverage is required to register for health insurance. To be considered a resident of Ontario for the purpose of obtaining OHIP coverage, a person must:

- hold prescribed citizenship or immigration status (section 1.1(1) of Regulation 552, under the *Health Insurance Act*);
- make his or her permanent and principal home in Ontario in accordance with Regulation 552; and
- generally speaking, be physically present in Ontario for at least 153 days in any 12-month period.

With certain exceptions set out in sub-section 3(4) of Regulation 552, most new and returning residents are subject to a three-month waiting period. The Ministry will determine whether or not an individual is subject to a three-month waiting period at the time of the application. Former federal inmates and newly determined Convention Refugees are among those who are exempt from the waiting period.

Among those who are ineligible for Ontario health coverage are individuals without citizenship or immigration status as prescribed under s. 1.1 (1) of Regulation 552, federal penitentiary inmates, and refugee claimants. Persons previously ineligible for coverage but whose status has changed (e.g., change in immigration status or release from a federal penitentiary) may, upon application, be eligible for OHIP coverage subject to the requirements of Regulation 552.

There were no changes to legislation in 2000-2001 that affected client eligibility.

3.2 Registration Requirements

A health card is issued to residents upon application to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing permanent residence in the Province. Registration is done through local OHIP offices.

Applicants for Ontario health coverage must complete and sign a Registration for Ontario Health Coverage form and provide the Ministry with proof of immigration status, residency and identity. Original documents from each category are to be provided by the applicants upon registration. Once eligibility has been determined, applicants over the age of 15½ are generally required to have their photographs and signatures captured for their photo health cards.

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

The Ontario Ministry of Health and Long-Term Care is the sole payor for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service covered by OHIP.

Approximately 12,000,000 Ontario residents were registered with OHIP as of March 31, 2001.

3.3 Other Categories of Individual

Ontario's Ministry of Health and Long-Term Care provides coverage to several categories of individual other than Canadian citizens and landed immigrants. Generally, these individuals are required to provide proof of citizenship or acceptable immigration status, residency and identity in the same manner as individuals with permanent resident status who apply for Ontario health coverage. However, applicants from within these categories may also be required to provide specific documentation to confirm their entitlement to OHIP coverage or they may be exempted from certain requirements. Clients applying for coverage under any of these categories should contact their local OHIP office for details. A general overview of eligibility for applicants in other categories is included below.

The following categories of individual will be eligible if they otherwise meet the definition of resident in Regulation 552:

Applicants for Landing – Applicants for Landing are persons who are being processed toward landing by Citizenship and Immigration Canada (CIC) and, generally speaking, have met CIC medical requirements. An immigrant who has been "landed" is a permanent resident of Canada. Approximately 4,500 individuals were registered as Applicants for Landing as of March 31, 2001.

Convention Refugees – The Immigration and Refugee Board designates a person as a Convention Refugee when that person has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group, or political opinion. Approximately 76,400 individuals were registered as Convention Refugees as of March 31, 2001.

Minister's Permit Holders – Holders of Minister's Permits are persons who do not meet immigration requirements to remain permanently in Canada. Holders of case types 80 (adoption only), 86, 87, 88, or 89 Minister's Permits who are ordinarily residing in Ontario are eligible for OHIP coverage for the duration of their immigration documents. Holders of case type 90 Minister's Permits are not eligible for

OHIP. Approximately 800 individuals were registered as holders of eligible Minister's Permits as of March 31, 2001.

Clergy, Foreign Workers and their Accompanying Family Members – An eligible foreign clergy person is a person who is sponsored by a religious organization or denomination who has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months and who is ordinarily a resident of Ontario. Approximately 1,100 individuals were registered as eligible foreign clergy as of March 31, 2001.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer situated in Ontario and has been issued an Employment Authorization by Citizenship and Immigration Canada that names the Canadian employer, states the person's prospective occupation, and has been issued an Employment Authorization for a period of at least six months. Approximately 11,400 individuals were registered as eligible foreign workers as of March 31, 2001.

Eligible accompanying family members are the spouses and dependent children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker who is to be employed for at least three consecutive years and who is ordinarily a resident of Ontario. Approximately 7,700 individuals were registered as eligible accompanying family members as of March 31, 2001.

Migrant Farm Workers – Migrant farm workers are persons who have been issued an Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by Citizenship and Immigration Canada. Due to the special nature of their employment, migrant farm workers are not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period. Approximately 2,900 individuals were registered as migrant farm workers as of March 31, 2001.

Live-in Caregivers – Live-in Caregivers are persons who have been issued an employment authorization under the Live-in Caregivers in Canada Program (LCP) or the Foreign Domestic Movement (FDM) administered by the federal department of Citizenship and Immigration. An eligible Live-in Caregiver is a person who possesses an employment authorization issued by Citizenship and Immigration Canada that indicates LCP or FDM and who is ordinarily a resident of Ontario. The employment authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers and the three-month waiting period applies to Live-in Caregivers.

3.4 Premiums

The payment of premiums was abolished in 1990.

4.0 Portability

4.1 Minimum Waiting Period

Individuals who move to Ontario and who were previously insured by another Canadian province or territory are entitled to OHIP coverage beginning the first day of the third month after establishing residency in Ontario. New or returning Ontario residents who were not previously insured by another province or territory's health plan are entitled to coverage three full months after establishing residency in Ontario.

These requirements are set out in section 3 of Regulation 552 of the *Health Insurance Act*.

4.2 Coverage During Temporary Absences in Canada

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability. In accordance with that agreement, insured residents who are outside Ontario temporarily can use their Ontario Health Cards to obtain insured health services. Insured residents who leave Ontario temporarily to

travel within Canada without establishing residency in another province or territory will continue to be covered for a period of up to 12 months.

Out-of-province services are covered under sections 28(1), 30(1) and 32 of Regulation 552 of the *Health Insurance Act*. It is also possible for Ontario residents to maintain continuous health coverage while temporarily working or studying in another Canadian province or territory.

A person insured by OHIP who seeks or accepts employment in another province or territory is provided with OHIP coverage for a maximum of 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, are eligible for continuous health coverage for the duration of their studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, students should provide the Ministry with letters from their educational institution confirming registration as full-time students. Family members of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

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

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

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

4.3 Coverage During Temporary Absences Outside Canada

Coverage during temporary absences outside Canada is governed by sections 28.1 through 31 (inclusive) of Regulation 552 of the *Health Insurance Act*.

In accordance with sections 1.1(3), 1.1 (4), 1.1(5) and 1.1(6) of Regulation 552 of the *Health Insurance Act*, the Ministry of Health and Long-Term Care may provide insured Ontario residents with continuous OHIP eligibility for absences of longer than 212 days in a 12-month period. In most cases, applicants must provide the Ministry with a document explaining the reason for their absence from Ontario to qualify for an approved absence. Applicants must also have been present for at least 153 days in each of the two consecutive 12-month periods prior to the expected date of departure in order to be approved for an extended absence.

Approved absences vary in duration depending on the reason for the absence.

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

Family members may also qualify for continuous OHIP eligibility while accompanying the primary applicant on an approved absence and should contact their local OHIP office for details.

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

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

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

Medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) as well as laboratory tests required on an emergency basis, are reimbursed only at the rates listed in the Ontario Ministry of Health and Long-Term Care's Schedule of Benefits, Regulation 552, or the amount billed, whichever is less. Charges for medically necessary emergency out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed hospital or health facility.

In 2000-2001 payments for out-of-country in-patient and out-patient insured hospital and medical services amounted to $34.4 million for emergency services. Prior approval for elective services is addressed in Section 4.4.

4.4 Prior Approval Requirement

Prior approval is required for payment for elective services provided outside the country. These provisions are set out in section 28.4 of Regulation 552 of the *Health Insurance Act*.

Under section 28.4 of Regulation 552, where medically accepted treatment is not available in Ontario, or in those instances where the patient faces a delay in accessing treatment in Ontario that would threaten the patient's life or cause irreversible tissue damage, the patient may be entitled to full Ministry funding of out-of-country health services.

There is no formal prior approval process for services provided to Ontario residents outside the province but within Canada. The interprovincial agreement between the provinces includes a schedule for high-cost services. In rare circumstances where this schedule does not cover the costs in another province, Ontario may be asked to guarantee payment before the service is provided.

In 2000-2001, total payments for prior approved treatment outside Canada was $27.7 million.

5.0 Accessibility

5.1 Access to Insured Health Services

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

All insured persons are entitled to all insured hospital and medical services, as defined in the *Health Insurance Act*. Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured. Under the *Health Care Accessibility Act*, physicians (both opt-in and opt-out) are prohibited from charging more than the amount for an insured service than is allowed in the Schedule of Benefits for Physician Services. Extra-billing by physicians is also prohibited. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

The Ministry of Health and Long-Term Care implemented Health Number/Card Validation to aid health care providers and patients with access to health services and claim payment. Providers may subscribe for validation privileges to verify their patient eligibility and health number/version code status (card status). If patients require access to health services and do not have a health card in their possession, the provider may obtain the necessary information by submitting to the Ministry a Health Number Release Form signed by the patient. An accelerated process for obtaining health numbers for patients who are

unable to provide a health number and require emergency treatment is available to emergency room facilities through the Health Number Look Up service.

5.2 Access to Insured Hospital Services

In 2000-2001, there were 155 public hospital corporations staffed and in operation in the Province, which included chronic, general and special rehabilitation units. There were 6,975,200 acute patient days, 2,390,403 chronic patient days and 646,839 rehabilitation patient days delivered by public hospitals during fiscal year 2000-2001.

Some examples of improved access to services are:

- introduction of first pulmonary thromboendarectomy program;
- introduction of a provincial stroke strategy that includes piloting telemedicine at three sites;
- increased cardiac and renal services through implementation of new and expanded programs;
- construction and expansion of cancer centres;
- additional medical and critical care beds to relieve pressure on emergency departments;
- addition of new long-term care beds;
- free tuition to medical students willing to practice in rural and northern areas;
- introduction of a policy to ensure emergency room patients are seen within 15 minutes;
- enhanced pre-school speech and language program;
- invested in treatment of young people with eating disorders; and
- improved access to cervical screening in remote areas.

5.3 Access to Insured Physician and Dental-Surgical Services

Reasonable access to physician services in Ontario is ensured by an adequate supply of physicians.

An Underserviced Area Program (UAP) provides residents of rural and remote areas of the Province with improved access to general physician services. Four programs enhance access to health services for residents of northern Ontario: the Northern Group Funding Plan and Community Sponsored Contracts provide alternative funding arrangements that pay a group of physicians a global amount (not fee-for-service) for primary care services, the Incentive Grant Program for physicians provides financial assistance to general practitioners and specialists locating to designated underserviced areas and the Northern Health Travel Grant financially assists patients who must travel to receive hospital and specialist medical services.

Currently, there are 100 communities in Ontario designated as underserviced by general/family practitioners and 12 communities designated as underserviced by specialists.

As of March 2001, there were approximately 20,700 active physicians, most of whom provided insured physician services in Ontario. Of this total 10,281 (49.7 percent) were family physicians and 10,392 (50.3 percent) were specialists.

Some initiatives announced in the early part of 2000-2001 to enhance access to physician services include providing free tuition and a location incentive to medical students and residents who agree to practise in underserviced areas for a minimum of three years, and an initial increase in undergraduate medical school enrolment of 40 positions for the fall 2000 academic year. This increase brings the total number of entry positions to 572 from 532 across five medical schools.

Under the Physician Outreach Program, regularly scheduled primary care clinics may be provided to remote communities which have UAP-funded nursing stations and to provide telephone back-up to the nurse/nurse-practitioners working at the nursing station.

5.4 Physician Compensation

Insured services provided by 20,500 physicians and 350 dentists in the Province are paid primarily on a fee-for-service basis, according to the Schedules of Benefits for Physician Services under the *Health Insurance Act*.

In April 2000, the Government of Ontario negotiated a four-year agreement with the Ontario Medical Association to determine funding amounts for physician services with respect to fee-for-service payments. In 2000-2001, fee-for-service physicians were paid $4.5 billion for medical, surgical and diagnostic services provided to Ontario residents.

A Schedule of Benefits Working Group, composed of Ministry of Health and Long-Term Care and Ontario Medical Association representatives, was given the mandate in the agreement to identify changes in the existing Schedule of Benefits that will result in annual savings of at least $50 million. These savings are accomplished through a mix of tightening and modernization initiatives. The first set of recommendations, projected to save $20 million annually, was implemented on August 13, 2001. The remaining $30 million in savings measures is targeted for implementation in the next fiscal year.

The Resource Based Relative Value Schedule (RBRVS) Commission was jointly established in 1997 by the Ontario Medical Association and Ministry of Health and Long-Term Care, with a mandate to recommend a relative value schedule to replace the current OHIP Schedule of Benefits on a revenue-neutral basis. A draft report assigning a new value to a selected list of over 800 services was presented to the Ontario Medical Association, Ministry of Health and Long-Term Care and relevant stakeholders on September 7, 2001 for review and feedback. Consultations with the Ontario Medical Association continue.

Representatives of government and the Ontario Dental Association negotiate agreements on adjustments to the Plan's Schedule of Benefits that cover insured dental services provided in hospital. In 1999-2000, dental expenditures were $8.1 million. The last funding agreement expired on March 31, 2000, and was extended to March 31, 2001. Discussions for a new multi-year agreement commenced in fall 2000.

5.5 Payments to Hospitals

Hospitals submit annual operating plans that are the product of a broad consultation within the facilities (all levels of staff, unions, physicians, board and so on) and within the community and region. The operating plan is first and foremost a planning document but it also has a substantial budget component, both financial and statistical. The District Health Council (DHC) and staff of the Ministry of Health and Long-Term Care then review this operating plan. The Ministry review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarification with the facility.

Payments made by the health care plan to hospitals for insured services come under the *Health Insurance Act* and are calculated on an annual budget basis. The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority programs, and cost increases in respect of above-average growth in volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

Payments for services rendered in independent health facilities are governed by the *Independent Health Facilities Act*.

Chronic care co-payment regulations and rates are revised annually following changes in the Canada Pension Plan (CPP).

Priority programs are diverse and require highly specialized human resources and infrastructure. The programs are often high-cost and high-growth. They can be associated with newly developed treatments that include advanced therapies and technologies. Generally, these programs are managed provincially and are designed to ensure equitable access. The Ministry determines funding based on population needs and clinical outcome evidence.

Priority programs include:

- acquired brain injury;
- cancer, cardiac services;
- cochlear implants;
- cleft lip and palate dental program;
- end stage renal disease;
- genetics services (cytogenetic labs, maternal serum screening, molecular/ DNA labs);
- HIV/AIDS clinics;
- imaging (MRI);
- maternal newborn services;
- orthopaedic hip and knee implants;
- regional geriatric program;
- stroke;
- sexual assault treatment centres;
- transplants (solid organ, bone marrow); and
- trauma centres.

The Ministry measures and rewards relative cost efficiency in hospitals through the Integrated Population-Based Allocation model. Payments are made to those hospitals that spend less than expected, taking into consideration the individual characteristics of the hospital.

In addition, specialized methodologies are used for incremental funding for specific policy and program initiatives (i.e. Nursing Enhancements, 60-hour post-partum guarantee length of stay).

Funding for patient care in hospitals increased by more that $1.3 billion in 2000-2001, bringing the total funding for hospitals to over $8.7 billion in 2000-2001 from over $7.4 billion in 1999-2000.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfers in its 2000-2001 publications.

7.0 Extended Health Care Services

Extended health care, funded by the Ministry of Health and Long-Term Care, is provided by nursing homes, homes for the aged (long-term care facilities) and home-care service providers. The Ministry participates in the compliance monitoring process for long-term care facilities in many ways. It provides dietary, environmental and medical consultation services within facilities; reviews health, safety, building and dietary standards and monitors how these standards are met, and assists in the development of corrective action plans, where necessary.

Home-care services (professional services, personal support and homemaking services) are funded by the Ministry and provided through Community Care Access Centres for people of all ages. The Ministry funds attendant services for physically disabled adults and supportive housing services for seniors, physically disabled adults, adults with acquired brain injuries and persons living with HIV/AIDS. The Ministry also funds a variety of community support services such as adult day programs, meal services, and transportation services.

In addition to insured hospital benefits, Ontario provides a wide range of health services, including long-term care services; mental health services that include the operation of provincial psychiatric hospitals; community-based mental health treatment and support services; the residential component of the Homes for Special Care Program; air ambulance with a patient co-payment; dental treatments for patients with cleft lip/palate who are registered at a designated clinic; and funding for a breast cancer screening program.

Additional Materials Submitted to Health Canada

Annual Reports

- Ministry of Health and Long-Term Care Business Plan: www.gov.on.ca/health/english/pub/ministry/bplan01/bplan01.html

Audit Reports

- Ontario Health Insurance Plan 1998 (Report of Provincial Auditor): www.gov.on.ca/opa/english/e98/306.htm
- Ontario Health Insurance Plan – Follow-up 2000 (Report of Provincial Auditor): www.gov.on.ca/fin/english/budeng.htm#public

Financial Reports

- Budget Papers 2000-2001: www.gov.on.ca/FIN/english/budeng.htm#Budget
- Public Accounts 2000-2001: www.gov.on.ca/FIN/english/budeng.htm#public

Legislation

- *Health Insurance Act*
- *Health Insurance Act Regulations*
- *Public Hospitals Act*
- *Independent Health Facilities Act*
- *Health Care Accessibility Act*

Manitoba

Introduction

Health Care is a Top Priority for Manitobans

Manitoba has been nationally recognized by the Canadian Institute for Health Information as having the best plan in the country for ending hallway medicine. Through expansions to home care, better coordination of hospital resources, and the largest flu vaccination program in the Province's history, Manitoba managed to decrease the number of hallway patients by 80 percent in the year 2000.

Manitoba=s five-point plan to ending hallway medicine in hospitals was introduced in 2000 and consisted of the following measures:

- opening new beds;
- improving admission and discharge procedures;
- expanding community-based services;
- strengthening prevention programs like flu immunization; and
- increasing home care and adult day-care programs.

Manitoba faces the national and global challenge of addressing a shortage of health professionals. Past failures to provide needed training resulted in staff shortages and increased waiting lists for tests and treatment. Progress is being made to redress this shortage through a range of training, recruitment and retention strategies.

Every day nurses throughout Manitoba demonstrate their commitment to the well-being of Manitobans through the professional, skilled care they provide. In turn, the Manitoba government has made a commitment to nurses in two key areas. These are:

- the recruitment of adequate numbers of nurses in a variety of areas of nursing; and
- the retention of nurses in workplaces that respect and maximize the professional skills and experience of nurses for the well-being of patients and clients.

In spring of 2000, the Manitoba government announced a five-point nursing strategy to address the concerns raised by nurses and other stakeholders within the health care system. The plan is to:

1. improve working conditions
2. increase the supply of nurses
3. increase access to continuing education
4. improve the utilization of all categories of nurses, and
5. increase nurses' input into decision making.

The Role of Manitoba Health

Manitoba Health is a line department within the government structure and operates under the provisions of statutes and responsibilities charged to the Minister of Health. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for the planning and delivery of services.

It is the mission of Manitoba Health to provide leadership and support to protect, preserve and promote the health of all Manitobans. This mission is accomplished through a structure of comprehensive envelopes encompassing program, policy, and fiscal accountability; by the development of a healthy public policy; and by the provision of appropriate, effective and efficient health and health care services. Services are provided through regional delivery systems, hospitals and other health care facilities. The Department also makes payments for insured health benefits on behalf of Manitobans related to the costs of medical, hospital, personal care, Pharmacare and other health services.

It is Manitoba Health's vision to lead the way in quality health care, built with creativity, compassion, confidence, trust and respect, empower Manitobans through knowledge, choices and access to the best possible health resources, and build partnerships and alliances for health and supportive communities.

It is also the role of Manitoba Health to foster innovation in the health care system. This is accomplished through developing mechanisms to assess and monitor quality of care, utilization and cost effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems, and alternative and less expensive services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by the Department of Health under the *Health Services Insurance Act*, R.S.M. 1987, c. H35. The Act was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to the Department of Health. The dissolution took effect on March 31, 1993.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care and medical services and other health services referred to in Acts of the Legislature or Regulations thereunder. The Act was amended effective January 1, 1999 to provide for insurance with respect to out-patient services provided in relation to insured medical services provided in surgical facilities.

The Minister of Health is responsible for the administration and operation of the Plan. Under section 3(2), the Minister has the power:

> "(a) to provide insurance for residents of the Province in respect of the costs of hospital services, medical services and other health services, and personal care;
>
> (b) to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
>
> (c) to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained;
>
> (d) to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the minister considers necessary to ensure that such a consulting service is provided;
>
> (e) to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals required by the Government of Canada are submitted; and
>
> (f) in cases where residents do not have available medical and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents."

The Minister may also enter into contracts and agreements with any person or group that the Minister considers necessary for the purposes of the Act. He or she may also make grants to any person or group for the purposes of the Act on such terms and conditions as considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the Regulations.

1.2 Reporting Relationship

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

1.3 Audit of Accounts

Section 7 of the *Health Services Insurance Act* requires that the Provincial Auditor (or another auditor designated by the Provincial Auditor) audit the accounts of the Plan annually and prepare a report of that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 1999-2000 fiscal year and is contained in the *Manitoba Health Annual Report 1999-2000*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

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

As of March 31, 2001, there were 98 facilities in Manitoba providing insured hospital services to both in-patients and out-patients. Hospitals are designated by regulation under the *Health Services Insurance Act*.

Services specified by regulation as insured in-patient and out-patient hospital services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologics and related preparations;
- routine medical and surgical supplies;
- use of operating room, case room and anaesthetic facilities; and
- use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

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

Physicians providing insured services in Manitoba must be lawfully entitled to practise medicine in Manitoba, registered and licensed under the *Medical Act.* As of March 31, 2001, there were 2,045 physicians on the Manitoba Health Registry.

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

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

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services, rendered to an insured person by a physician, that are not excluded under the Excluded Services Regulation (Regulation 46/93) under the *Health Services Insurance Act*. During fiscal year 2000-2001, a number of new insured services were added to a revised fee schedule.

In order for a physician's service to be added to the list of services covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). The proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (Regulation 48/93) under the *Health Services Insurance Act*. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This regulation also provides benefits in respect of the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthdate, when provided by a registered orthodontist. As of March 31, 2001, 555 dentists were registered with Manitoba Health, of whom 105 had received payments for insured services.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and cannot charge to or collect from an insured person a fee in excess of the benefits payable under the Act or Regulations. There were no opted out providers of dental services as of March 31, 2001.

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured medical services include:

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

The *Health Services Insurance Act* states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The Regional Health Authorities and Manitoba Health monitor compliance.

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

No services were removed from the list of those insured by Manitoba Health in 2000-2001.

3.0 Universality

3.1 Eligibility

The *Health Services Insurance Act* is the legislation that defines the eligibility of Manitoba residents for coverage under the health care insurance plan of the Province. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or a visitor, transient or tourist.

The Residency and Registration Regulation extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment, and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have an employment authorization of 12 months or more.

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

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

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civil War Pensions and Allowances Act*; *Government Employees Compensations Act*; *Merchant Seaman's Compensation Act*; *National Defence Act*; *Pensions Act*; *Royal Canadian Mounted Police Act*; *Veterans Rehabilitation Act* or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The exclusions include residents who are members of the Armed Forces, the Royal Canadian Mounted Police and federal inmates. These residents become eligible for Manitoba Health coverage upon ceasing to be a member of the Canadian Armed Forces; a member of the RCMP; or an inmate of a penitentiary who has no resident dependants. Upon change of status these persons have one month to register with Manitoba Health (Residency and Registration Regulation, subsection 2(3)).

3.2 Registration Requirements

The process of issuing health insurance cards requires that individuals inform Manitoba Health that they are legally entitled to be in Canada, of their intention to be physically present in Manitoba for six months, and that they provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration certificate for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all hospital and medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for the provincial drug program.

During 2000-2001, 1,149,904 residents were registered with the health care insurance plan.

There is no provision for a resident to opt out of the Manitoba health plan.

3.3 Other Categories of Individual

The Residency and Registration Regulation, sub-section 8(1), requires that temporary workers be in possession of an Employment Authorization issued by Citizenship and

Immigration Canada (CIC) for at least 12 months, be physically present in Manitoba and be legally entitled to be in Canada before receiving Manitoba Health coverage.

In 2000-2001, 899 individuals with Employment Authorizations were covered under the Manitoba Health Services Insurance Plan.

The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration Act* (Canada). Five individuals were covered under Minister's permits in 2000-2001.

4.0 Portability

4.1 Minimum Waiting Period

The Residency and Registration Regulation, section 6, identifies the waiting period for other insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arrival in Manitoba is entitled to benefits upon the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation, subsection 7(1), defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies.

Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals must return and reside in Manitoba upon completion of their leave.

Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

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

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

In 2000-2001, Manitoba Health made payments totalling approximately $16,241,775 for hospital services and $6,201,408 for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

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

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba upon completion of their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for a period of up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational

institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba upon completion of their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation. Hospital services received outside Canada due to an emergency or sudden attack of illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per diem rate according to hospital bed size:

- 1-100 beds: $280
- 101-500 beds: $365
- over 500 beds: $570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from their specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at no less than 100 percent of the equivalent Manitoba rate for similar services. Hospital services are paid at up to 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds.

Manitoba Health made payments totalling approximately $3,500,862[1] for hospital care provided in hospitals outside Canada in the 2000-2001 fiscal year. In addition, Manitoba Health made payments totalling approximately $500,757[2] for medical care.

In instances where Manitoba Health has given prior approval for services provided outside Canada and payment is less than 100 percent of the amount billed for insured services, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for services provided in other provinces or territories. Prior approval is required for elective hospital and medical care provided outside Canada. An appropriate medical specialist must apply to Manitoba Health to receive approval.

5.0 Accessibility

5.1 Access to Insured Health Services

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

5.2 Access to Insured Hospital Services

As of March 31, 2001, Manitoba had a total of 3,993 acute care set-up beds and 703 other set-up beds (psychiatric extended treatment, palliative, chronic, long term assessment/ rehabilitation and panelled) to serve a population of 1,147,900.

Winnipeg, with 56.6 percent of the population, has 2,271 acute care set-up beds and 420 other set-up beds. In addition, there are two hospitals

[1] This figure does not include the amount paid for exchange on U.S. claims.

[2] This figure does not include the amount paid for exchange on U.S. claims paid under the Critical Shortages Fund.

that provide long term care and one adolescent psychiatric facility.

In rural Manitoba there are 1,722 acute care set-up beds and 283 other set-up beds, plus two federal hospitals and 22 federal nursing stations. In addition, rural Manitoba residents have access to Winnipeg's acute care set-up beds.

As in other provinces, Manitoba Health is experiencing a critical shortage of nurses in all geographic settings. Nursing enrolment for the University of Manitoba baccalaureate degree program has been increased and a two-year nursing diploma course has been reinstated. Manitoba does, however, have one of the higher Registered Nurse-to-population ratios in the country (89.1 Registered Nurses per 10,000 population, CIHI, 2000), but the average age of nurses is slightly higher than the Canadian average.

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields such as radiation therapy, ultrasound technology, MRI technology and lab technicians are also becoming more problematic, with difficulty recruiting for these areas. The nursing shortage is still the most critical.

Manitoba currently has access to three Magnetic Resonance Images (MRI) machines for clinical testing. All units are located in Winnipeg. The first unit was installed in 1990 by the St. Boniface Research Foundation and replaced in October 1998. The second is located at the Health Sciences Centre and became operational in September 1998. This unit was installed in conjunction with the National Research Council (NRC). The third MRI unit, located in Winnipeg, became operational in January 2000.

Manitoba has 12 Computerized Tomography (CT) Scanners – two each at the Health Sciences Centre and St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia, Seven Oaks, Grace and Concordia Hospitals. As well, there are ultrasound scanners located within Winnipeg health facilities and rural and northern regions. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

The Province has implemented a five-point plan to improve access to insured hospital services. This plan includes the provision of funding to open up to 100 new beds in Winnipeg, Brandon and Thompson; improving admission and discharge procedures such as expanded emergency fast track, increased emergency psychiatric nurse coverage, and additional geriatric program assessment teams; expanding community based services like the Community Intravenous Therapy Program, strengthening prevention programs like the flu immunization program, and increasing the capacity of the home care program and the adult day program.

Funding has been made available for the purchase of two linear accelerators to be installed in the newly redeveloped building at the McCharles site that became operational in December 2000 and June 2001. These additional machines will ensure the delivery of high quality radiation therapy. The Oncology Day/Evening Hospital was established as part of a larger effort to improve access to treatment in an appropriate care setting. This program allows cancer patients to have long and complex chemotherapy regimens in an out-patient setting.

The Breast Health Centre offers a full range of diagnostic and assessment services in one location, including diagnostic mammography and ultrasound – dedicated to breast service, stereotactic core biopsy as well as open biopsy, and surgical consultation. This centre provides individual and family education, risk assessment, screening recommendations, genetic counselling and facilitation of laboratory gene testing of women who are deemed at high risk for breast cancer, as well as referral services. Also pre- and post-operative exercises and Lymphodema treatment are provided. The interdisciplinary model of care includes the services of social workers, spiritual advisors and clinical dietitians.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2000-2001, Manitoba Health undertook several initiatives to improve access to physicians. Physician shortage in rural and remote areas of the Province is a chronic problem. Manitoba has initiated a Rural Physician Action Plan that will see improved recruitment of rural students into medicine, increased training opportunities for medical students and residents in rural communities, and strong infrastructure support for continuing medical education.

Manitoba continues to experience small increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province introduced a financial assistance grant for students and residents. In return for financial assistance during their training, the student/resident agrees to work in Manitoba for a specific period of time after graduating. The program was introduced in May 2001. The Province also introduced a new program to assist Manitoba foreign-trained physicians to achieve licensure. In return for this assistance, the physician agrees to work in an under-serviced area of the Province for a specified period of time.

5.4 Physician/Dentist Compensation

In 1998, Manitoba and the Manitoba Dental Association (MDA) entered into an Interest Arbitration Agreement. This arbitration process culminated in August 1999 when the Arbitration Board awarded an overall increase to fee-for-service remuneration of 13.4 percent, at a cost of $33.5 million, and instructed the parties to reach agreement on the specific allocation of the overall award. The allocation agreement was finalized in February 2000. The current fee-for-service agreement is effective from April 1, 1998 to March 31, 2002. The arbitration agreement continues to operate as a dispute resolution mechanism in Manitoba.

Physicians are remunerated through a combination of fee-for-service payments, alternative service arrangements, independent contracts, etc. In 2000-2001, Manitoba had no capitation arrangements in place. Dentists are compensated on a fee-for-service basis.

A memorandum of agreement is the most formal documented agreement between Manitoba Health and the MDA. Concluded in the aftermath of the above-noted major arbitration decision, the MDA memorandum ratified 13.4 percent increases for specified oral/dental/maxillofacial surgical procedures carried out in hospital facilities only. This agreement is effective for four years from April 1, 1998 to March 31, 2002.

5.5 Payments to Hospitals

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

Pursuant to the provisions of this division, authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that provides for the health services to be provided by the health corporation, the funding to be provided by the authority for the health services, the term of the agreement, and a dispute resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request the Minister of Health to appoint a mediator to assist them in resolving outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute and the Minister's resolution is binding on the parties.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire March 31, 2006. The operating agreements enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other regional health

authorities that continue to have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or the federal government. The agreements in place between the Authorities and the health corporations do not have expiry dates and the Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by regional health authorities for the provision of hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health and Social Transfer in public documents. Manitoba does not advertise or produce promotional material concerning insured or extended health services.

7.0 Extended Health Care Services

Manitoba has established community based service programs as an appropriate alternative to hospital services. These service programs are provided by Manitoba Health through the Regional Health Authorities. These services include the following.

Personal Care Home Services

The Personal Care Services Insurance and Administration Regulation under the *Health Services Insurance Act* authorizes the provision of services to personal care home residents. Both proprietary and non-proprietary homes are licensed in the Province of Manitoba by Manitoba Health. Residents of personal care homes also pay a residential charge. The total Manitoba Health operating expenditures for personal care services during fiscal year 2000-2001 amounted to $347,695,900, supporting a total of 9,791 licensed set-up personal care beds. In addition, there were estimated capital and equipment expenditures of $40,135,900.

Home Care Services

Manitoba Home Care is a province-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs.

Ambulatory Health Care Services

The *Health Services Insurance Act* includes a provision authorizing the designation of non-profit publicly administered ambulatory health (primary care) centres as institutions within the meaning of the Act. There are approximately 10 such institutions receiving funding from Manitoba Health.

Adult Residential Care Services

Residential care facilities are community based facilities that provide board and room, 24-hour on-site care and supervision, and assistance with activities to ensure that the needs of individual residents are met. These facilities are classified by size: approved homes have up to three adults, and licensed facilities have occupancies of four or more adults.

Residential care facilities are required to be licensed under the *Social Services Administration Act* and Manitoba Regulation 484/88R and to meet standards established by the Residential Care Licensing Branch of the Department of Family Services and Housing. The regulations mandate the licensing of facilities for three adult disability categories (mentally ill, mentally disabled, and infirm aged).

There are currently 98 licensed and approved residential care facilities for individuals with mental illness in Manitoba, for a total of 472 bed spaces. There are also 71 mixed facilities for a total of 208 bed spaces. There are 20 licensed and approved facilities for individuals with infirmities of aging, for a total of 217 bed spaces. The majority of residential care facilities are located in Winnipeg and Brandon.

Saskatchewan

Introduction

The health system in Saskatchewan, as elsewhere in Canada, exists within an intricate relationship of federal, provincial and local government initiatives, private and public funding and provision of service, and with the support and leadership of a large and diverse number of dedicated health professionals.

Saskatchewan is the birthplace of Medicare. Insured hospital services were first provided in Saskatchewan in 1947 and insured physician services were first provided in Saskatchewan in 1962. The primary principle underlying Medicare is that health services should be provided to individuals based on health need rather than on the ability to pay.

Today, the public health system provides a wide range of hospital, physician, public health, mental health, rehabilitation and addiction services to residents in Saskatchewan without any direct service charge. The provincial government also contributes to a range of home care, ambulance, pharmaceutical, special care homes and other specialized services with some level of patient co-payment. These services are delivered through district health boards, affiliated agencies, fee-for-service physicians, pharmacists, and other health care providers. The provincial government, as the major funder of Saskatchewan's health care system, is a major driver in this sector.

In Saskatchewan, District Health Boards have been established to assess needs and to plan and deliver a specific range of integrated health services within designated regions, including hospital services, home care, public health, long-term care, and promotion, protection and prevention services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and dental-surgical services in Saskatchewan.

Section 6.1 of *The Department of Health Act* (1978) authorizes the Minister of Health to:

- pay part of or the whole of the cost of providing health services for any persons or classes of person that may be designated by the Lieutenant Governor in Council;
- pay part of or the whole of the cost of providing health services in any health district or part of a health district in which those services are considered by the Minister to be required; and
- make grants or provide subsidies to any health agency as the Minister considers necessary.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998), also known as *The Medical Care Insurance Act,* provide authority for the Minister of Health to establish and administer a plan of medical care insurance for residents.

The Health Districts Act (1993) provides authority for the Lieutenant Governor in Council to establish District Health Boards (section 3) and for District Health Boards to provide services (section 26). Thirty-two District Health Boards have been established to provide insured hospital services and a range of other health services.

Sections 5 and 11 of *The Cancer Foundation Act* (1997) provide for the establishment of a Saskatchewan Cancer Foundation and for it to coordinate a program for the diagnosis, prevention and treatment of cancer.

The mandates of the Department of Health, District Health Boards, and the Saskatchewan Cancer Foundation are outlined in *The Department of Health Act*, *The Health Districts Act* and *The Cancer Foundation Act* as described above.

1.2 Reporting Relationship

The Department of Health is directly accountable to and reports to the Minister of Health on an ongoing basis with regard to the funding and administration of funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report of the medical care insurance plan to the Legislative Assembly.

The Health Districts Act prescribes that a District Health Board shall, within three months after the end of each fiscal year, submit to the Minister of Health:

- a report of the District Health Board's service activities and costs;
- a detailed audited set of financial statements;
- a report on the health status of the residents of the health district; and
- a report on the effectiveness of the District Health Board's programs.

All District Health Boards are required to annually submit three-year strategic plans and annual budget plans to Saskatchewan Health.

District Health Boards also consult with staff from Saskatchewan Health on an ongoing basis about matters of concern to either the District Health Board or the Minister of Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report to the Minister of Health for the immediately preceding fiscal year, about its business and a financial statement.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government departments and agencies, including Saskatchewan Health. It includes an audit of departmental payments to District Health Boards, the Saskatchewan Cancer Foundation and to physicians and dental surgeons for insured physician and dental-surgical services. The Provincial Auditor may also carry out audits of District Health Boards. The Provincial Auditor independently determines the scope and frequency of its audits based on accepted professional standards.

Section 36 of *The Health Districts Act* prescribes that the accounts of a District Health Board shall be audited at least once in every fiscal year by an independent auditor who possesses the prescribed qualification and is appointed for that purpose by the District Health Board. A detailed audited set of financial statements must be submitted annually by each District Health Board to the Minister of Health.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Foundation shall be audited at least once a year by the Provincial Auditor or by a designated person.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Department of Health Act (1978) provides for the Department of Health to administer health-related acts (section 5) and outlines the powers and duties of the Minister of Health (section 6), including the powers to pay the costs of health services and to fund organizations providing health services.

The Health Districts Act (1993), provides for the establishment of District Health Boards to plan and manage the provision of health services and authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act, and to enter into agreements with District Health Boards respecting grants made pursuant to the Act or, any other matter related to the activities or affairs of a District Health Board.

The Saskatchewan Hospitalization Regulations were repealed in 2000-2001, as they were no longer applicable after the enactment of *The Health Districts Act.* The Regulations concerned the taxation of residents for hospital services and payments to hospitals. Funding for hospitals is now included in funding provided to the health districts.

As of March 31, 2001, the following numbers and types of facilities were providing insured hospital services to in-patients and out-patients:

- sixty-eight acute care hospitals provided in-patient and out-patient services; and
- one rehabilitation hospital provided treatment, recovery and rehabilitation care for patients disabled by injury or illness. Rehabilitation services are also provided in a geriatric rehabilitation unit in one other hospital and in two special-care facilities.

The Hospital Standards Act and *The Hospital Standards Regulations* (1980), establish minimum standards for care and certain administrative requirements for hospitals. All hospitals must provide facilities for the provision of treatment services to in-patients and out-patients, and must have diagnostic services, x-ray and darkroom space, and a pharmacy to facilitate adequate and accurate dispensing of drugs. At least one member of the medical staff must reside in the community in which the hospital is located. Every hospital must employ at least three full-time Registered Nurses, one of whom shall be the Director of Nursing, and shall ensure that there is at least one Registered Nurse on duty on each shift.

The Hospital Standards Act also provides for appointment by the Minister of one or more inspectors to inspect and report on facilities approved under the Act (section 12). *The Hospital Standards Regulations* (section 103) include the provision that “every hospital may be visited at any time by the Minister, an inspector or any person authorized by the Minister to ensure compliance with the Act and these regulations.”

The Department encourages and supports health districts to obtain district-wide accreditation from the Canadian Council on Health Services Accreditation (CCHSA). CCHSA is the major national accrediting body for organizations across all health sectors in Canada. The accreditation process evaluates all aspects of health services delivery from a client-centred perspective. Participating health districts assess and compare their organization against national quality standards so that they may achieve coordinated, responsive and appropriate programs for all residents. There are currently 30 health districts that participate in the CCHSA accreditation process.

A comprehensive range of insured services is provided by hospitals, which may include:

- public ward accommodation;
- necessary nursing services,
- the use of operating room and case room facilities;
- required medical and surgical materials and appliances;
- x-ray, laboratory, radiological and other diagnostic procedures;
- radiotherapy facilities;
- anaesthetic agents and the use of anaesthesia equipment;
- physiotherapeutic procedures;
- all drugs, biological and related preparations administered in hospital; and
- services rendered by individuals who receive remuneration from the hospital.

No registry or central listing is maintained of the full range of services provided by Saskatchewan hospitals (e.g., no listing is maintained of all nursing services, laboratory, radiological and diagnostic procedures).

District Health Boards have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available funding resources.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* (1998) provide for the Minister of Health to establish and administer a plan of medical care insurance for provincial residents.

Amendments were made in April 1999 and January 1, 2001, to the Physician Payment Schedule of *The Saskatchewan Medical Care Insurance Payment Regulations* in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services and changes in payment levels for selected services.

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra-billing for insured services.

As of March 31, 2001 there were 1,609 physicians licensed to practise in the Province and eligible to participate in the medical care insurance plan. This increase over previous years is partly the result of including locum registrations previously excluded from the active physician counts.

Physicians can opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2001 there were no “opted out” physicians in Saskatchewan.

Insured physician services are those services that are medically necessary, are covered by the Medical Services Plan of the Department of Health and are listed in the Physician Payment Schedule of *The Saskatchewan Medical Care Insurance Regulations* of *The Saskatchewan Medical Care Insurance Act*.

There were approximately 3,000 different insured physician services as of March 31, 2001.

Insured physician services are added to the Medical Services Plan through a process of formal discussion with the Saskatchewan Medical Association. The Executive Director of the Medical Services Branch manages the process of adding a new service. When a new insured physician service is covered by the Medical Services Plan, a regulatory amendment is made to the Physician Payment Schedule. No new services were added in 2000-2001.

Formal public consultations are not held about adding an insured physician service, although any member of the public may make recommendations about physician services to be added to the Plan.

2.3 Insured Surgical-Dental Services

Dentists registered with the College of Dental Surgeons of Saskatchewan and designated by the College as specialists able to perform dental surgery may provide insured surgical-dental services under the Medical Services Plan.

Ninety-two dental specialists were providing such services as of March 31, 2001.

Dentists are able to opt out or not participate in the Medical Services Plan, but if doing so, must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required.

As of March 31, 2001 there were no “opted out” dentists in Saskatchewan.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- oral surgery required in hospital as a result of trauma;
- treatment for infants with cleft palate;

- hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
- surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with the dental surgeons of the Province. The Executive Director of the Medical Services Branch manages the process of adding a new service. Formal public consultations are not held about adding an insured surgical-dental service although any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include:

- in-patient and out-patient hospital services provided for reasons other than medical necessity;
- the extra cost of private and semi-private hospital accommodation not ordered by a physician;
- physiotherapy and occupational therapy services not provided by or under contract with a District Health Board;
- services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health;
- non-emergency cataract and non-emergency Magnetic Resonance Imaging services provided outside Saskatchewan without prior written approval;
- non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- non-medically required elective physician services;
- surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
- services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with District Health Boards, physicians and dentists.

There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with District Health Boards, physicians and dentists.

Insured hospital services could be de-insured by the Government if determined no longer medically necessary. The process is based on discussions among District Health Boards, clinicians and officials from the Department of Health.

Insured surgical-dental services could be de-insured if determined not medically necessary or not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the Province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if determined not medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2000-2001.

3.0 Universality

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and *The Medical Care Insurance Beneficiary and Administration Regulations* define eligibility for insured health services in Saskatchewan.

Eligibility is limited to residents. "Resident" means a person who is legally entitled to remain in Canada, makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor in Council to be a resident.

Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following their establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for coverage for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police, federal inmates; refugee claimants; and Kosovar Refugees who are covered under the Interim Federal Health Program;
- visitors to the Province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the Royal Canadian Mounted Police, if stationed in or resident in Saskatchewan on discharge date;
- released federal inmates;
- refugee claimants, on receipt of Convention Refugee status (immigration documentation is required); and
- Kosovar Refugees, on expiration of their coverage under the Interim Federal Health Program (immigration documentation is required).

3.2 Registration Requirements

The following registration process is used to issue a health services card and to document that a person is eligible for insured health services:

- every resident other than a dependent child under 18 years of age is required to register;
- registration should take place immediately following the establishment of residency in Saskatchewan;
- registration can be carried out either in person in Regina or Saskatoon or by mail;
- each eligible registrant is issued a plastic health services card bearing the registrant's unique lifetime nine-digit health services number; and
- cards are renewed every three years. (Current cards expire December 2002.)

All registrations are family-based. Parents and guardians can register dependent children in their family units if they are under 18 years of age. Children 18 years of age and over living in the parental home or on their own must self-register.

The number of persons registered in Saskatchewan on June 30, 2000 was 1,021,762.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of either an Employment Authorization, Student Authorization or Minister's Permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

Refugees are eligible on confirmation of Convention status combined with either an employment/student authorization, Minister's permit or permanent resident, i.e., landed immigrant record.

As of March 31, 2001, there were 3,604 such temporary residents in Saskatchewan.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency in Saskatchewan. However, where one spouse arrives in advance of the other, the eligibility for the first arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the third month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* of *The Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents when temporarily absent within Canada.

Continued coverage for a resident during such a period of temporary absence from Saskatchewan is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized education facility (written confirmation by Registrar of the full-time student status is required annually);
- employment: up to 12 months (no documentation required); and
- vacation and travel: up to 12 months.

Section 6.6 of *The Department of Health Act* replaces the previously noted section 14 of *The Saskatchewan Hospitalization Regulations* as providing the authority for payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the Province.

Section 10 of *The Saskatchewan Medical Care Insurance Payment Regulations* provides for the payment of physician services to Saskatchewan beneficiaries temporarily residing outside the Province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates.

In 2000-2001 expenditures for insured out-of-province physician services were $13.77 million and insured out-of-province hospital services were $28.68 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of *The Medical Care Insurance Beneficiary and Administration Regulations* of *The Medical Care Insurance Act* describe the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on expiration of the approved period as follows:

- students: for the duration of studies at a recognized education facility (written

confirmation by a Registrar of full-time student status is required annually);

- employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day. Section 6.6 of *The Department of Health Act* replaces the previously noted section 15 of *The Saskatchewan Hospitalization Regulations* regarding provision of health coverage to Saskatchewan beneficiaries temporarily residing outside the Province.

In 2000-2001, $1,022,000 was paid for in-patient hospital services and $377,600 was spent on out-patient hospital services.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

The reciprocal arrangement for physician services applies to every province except Quebec. Physician bills are submitted and Saskatchewan Health pays for insured services provided in Quebec at Saskatchewan rates. However, the physician fees will be paid at Quebec rates with prior approval.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health and problem gambling services;
- cataract surgery services, bone densitometry, and Magnetic Resonance Imaging (MRI), since Saskatchewan Health doesn't normally cover these services out-of-province.

Before the Department of Health funds services received by a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada.

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring physician must ask for prior approval from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.
- Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric, and chiropractic services; therefore, prior approval is required.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in the provision of public services, which include insured health services, on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2001, Saskatchewan had 3,307 staffed hospital beds in 68 acute care hospitals, including 2,802 acute care beds, 203 psychiatric beds and 302 other beds.

The Wascana Rehabilitation Hospital had 118 rehabilitation beds, 109 extended care beds and 80 other long-term care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

The Department does not collect information on acute care beds used for out-patient services.

Province-wide data from the Provincial Health Employer Survey shows that throughout the 1990s, there was small but steady growth in the numbers of health professionals employed in the provincial health system. In almost all cases, the number of practising health professionals in the Province increased throughout the last decade. There were, however, decreases in the number of Registered Nurses (about 6.5 percent) and Licensed Practical Nurses (about 19 percent) over this period. Saskatchewan's population has not changed substantially over this period, although the proportion of the population aged 75-plus increased from 5.9 percent to 7.3 percent of the covered population.

The Canadian Institute for Health Information's Registered Nurses Database indicates that in 2000, the ratio of Registered Nurses to population in Saskatchewan (835/100,000) was similar to other provinces and higher than the rate for Canada as a whole (754/100,000).

In the past two years, hospitals have experienced shortages of nursing staff, particularly nurses with specialized training to work in areas such as operating rooms, intensive care and dialysis.

Listed below are some of the initiatives implemented to improve the recruitment and retention of nurses.

- In fall 2000, 280 students enrolled in the first year of the Nursing Education Program of Saskatchewan (RNs and RPNs), an increase of 100 over the previous year.
- In April 2000, the Province announced a bursary program for RNs, LPNs and RPNs who wished to re-enter their respective professions.
- In July 2000, a principal nursing advisor for Saskatchewan was appointed to provide advice and expertise to the Minister and Deputy Minister on policy and program issues pertaining to nursing, as well as working with health professionals, employers, professional regulatory bodies and unions to address nursing issues.
- Other initiatives include pilot projects to create "magnet" work environments, address issues of casual workforce in specific nursing units (e.g. sick time, hiring practices and overtime costs), and mentoring nursing students during clinical assignments.

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

- Magnetic Resonance Imaging (MRI) machines are located in Saskatoon (2) and Regina (1);
- Computed Tomography (CT) scanners are available in Saskatoon (3), Regina (3), Prince Albert (1) and Swift Current/Moose Jaw (1);
- renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton and Swift Current;
- cancer treatment is provided at clinics in Saskatoon and Regina. More than 46,000 cancer treatments are given to an average of 4,500 patients at the Saskatoon and Regina Cancer Clinics every year;
- nineteen health districts are involved in a Community Oncology program that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon;
- approximately 70 percent of surgery services are provided in Saskatoon and Regina where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 22 percent is provided in five mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current and North Battleford, with the remaining surgery performed in smaller hospitals across the Province; and

- telehealth links have been established to provide residents in a number of rural and remote areas with access to specialist, family physician and other health provider services without having to travel long distances.

A number of measures were taken in 2000-2001 to improve access to insured hospital services.

- Access and use of specialized medical imaging services including MRI, CT and bone mineral density testing has grown steadily in Saskatchewan during 2000-2001. In that year, approximately 12,000 MRI tests were performed, representing a 30 percent increase from the previous year; approximately 62,000 CT tests were performed, representing a 15 percent increase from last year and double the volume of 1992-93.
- In October 2000 the Regina district began providing a bone mineral density testing service in order to serve residents in southern Saskatchewan. Previously, the Saskatoon district was the sole provider of this service in the Province.
- On June 30, 2000 the 12-month Northern Telehealth Network (NTN) pilot project was completed. The NTN is a partnership between Saskatchewan Health and six health districts. An external evaluation concluded that the network improved access to services for patients and clients, particularly for child psychiatry and dermatology patients. The number of specialist clinics held in the north has remained stable, which means that the NTN has increased access to specialists without increasing their travel.
- The NTN has proved to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health will continue to support the network, and in the 2000-2001 fiscal year applied to Health Canada for funding under the Canadian Health Infostructure Partnership Program (CHIPP) to further develop this program in the rest of the Province.
- The Saskatchewan Cancer Agency continued to expand the Community Oncology Program, and 19 health districts now participate. This Program allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon. An evaluation of the Program was expected to be finalized in the fall of 2001.
- Saskatchewan Health contributed $4.2 million toward the purchase of a new linear accelerator and treatment planning system for the Allan Blair Cancer Centre in 2000-2001. Construction of a bunker to house the new treatment equipment began in April 2001 and the new linear accelerator is scheduled to be installed and operational by Spring, 2002.
- Increased funding was provided to expand the peripheral blood stem-cell transplant program for cancer patients to include myeloma and leukemia patients, following the Program's success in the treatment of Hodgkin's Lymphoma and Non-Hodgkin's Lymphoma. The expansion of this specialized service ensures that more cancer patients can be effectively treated closer to home, reducing the financial and emotional burden of travelling long distances to receive treatment. Since the inception of the program in 1998, 112 patients have been referred to the Stem Cell Program.
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven stationary sites around the Province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program has the highest participation rate in Canada, with approximately 36,400 women screened annually.

Saskatchewan Health has dedicated considerable time and resources to resolving the wait-list issue. Guided by the recommendations of the Task Team on Surgical Waiting Lists (March 1999), the Department has continued to work with all health sector partners to improve access to surgical services in the Province.

The provincial government established a $12 million wait-list fund in August 1999 to address wait-list issues and reduce waiting times for insured services. In 2000-2001, this fund was expanded to include Prince Albert and Moose Jaw, while investments continued in Saskatoon

and Regina. The funds were used by the four largest health districts to:

- purchase additional capital equipment for surgery;
- increase available operating room time through staff scheduling changes and moving some procedures out of operating rooms to ambulatory care;
- fund staff recruitment, retention and training initiatives; and
- implement a series of coordination and utilization management initiatives.

In 2000-2001, Saskatchewan Health continued to take part in the Western Canada Waiting List Project along with 19 partner organizations from the four western provinces. The Project worked closely with physicians, the public, regional health authorities and governments to develop and test clinical assessment tools. These tools will help physicians consistently prioritise patients waiting for total hip or knee replacement, cataract surgery, general surgery, children's mental health services, and diagnostic MRI scans.

5.3 Access to Insured Physician and Dental-Surgical Services

As of March 31, 2001 there were 1,609 active physicians (defined as earning at least $10,000 per quarter in fee-for-service earnings) in Saskatchewan. Of these, 1,016 (63.1 percent) were family practitioners and 593 (36.9 percent) were specialists.

As of March 31, 2001 there were approximately 398 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety-two provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2000-2001 to enhance access to insured physician services and reduce waiting times.

- A new Long-term Service Retention Program will reward physicians who work in the Province for 10 or more years.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- New Specialist Recruitment and Retention Funding provides funding for new initiatives in addition to the existing funding of the Regina and Saskatoon Health Districts.
- A Physician Recruitment Coordinator is assisting rural districts and physicians in recruiting physicians.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program through which $6.8 million in annual funding is used to compensate physicians providing emergency room coverage in rural areas, and to assist those communities with fewer than three physicians to gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Program makes grants of $18,000 available to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Medical Resident Bursary Program provides bursaries of $18,000 to three family medicine residents to assist them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $18,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training provides income replacement to practising rural physicians and assistance to medical residents wishing to take specialized training in an area of need in rural Saskatchewan. A return service commitment is required.
- The Rural Emergency Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are

required to provide service in rural Saskatchewan after completing an educational program.

- The Resident Weekend Relief Program matches second-year family medicine residents with physicians in larger rural communities who are seeking weekend relief.
- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program, while they take vacation, education or other leave.
- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to assist in stabilizing the supply of physicians in northern Saskatchewan.
- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by *The Saskatchewan Medical Care Insurance Act* as follows:

- a Medical Compensation Review Committee is established within 15 days of either the Saskatchewan Medical Association or the Government providing notice to commence discussion on a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn selects a third member; and
- the Board has the authority to make a binding decision on the parties.

In December 2000 a new three-year agreement (retroactive to April 1, 2000) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of three percent in each year of the contract. Similar increases were applied to non fee-for-service physicians. Increased funding was also provided for new items and modernization of the payment schedule.

Section 6 of *The Saskatchewan Medical Care Insurance Payment Regulations* outlines the obligation of the Minister of Health to make payment for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services.

5.5 Payments to Hospitals

Saskatchewan adopted a population needs-based funding approach in 1994 and 1995. Through this approach, funding is allocated to each District Health Board on the basis of population characteristics determining service needs. Each District Health Board is given a global budget defined by broad service sector (e.g., institutional acute care hospitals;

institutional supportive care; home-based services), and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes. Districts may receive additional funds for the provision of specialized hospital programs, (e.g., renal dialysis, specialized medical imaging services and specialized respiratory services) or for the provision of services to residents from other health districts.

Payments to health districts for delivering services are made pursuant to *The Health Districts Act* (1993). The legislation provides authority for the Minister of Health to make grants to District Health Boards for the purposes of the Act and to enter into agreements with District Health Boards respecting grants made pursuant to the Act or any other matter related to the activities or affairs of a District Health Board.

District funding, including the bulk of funding for insured hospital services, is provided through the needs-based funding approach described above.

Districts may be given additional funds for providing specialized hospital programs, such as renal dialysis, specialized medical imaging services and specialized respiratory services.

Designated funds to address surgical waiting list issues were provided to the four largest health districts in 2000-2001. Each district was asked to outline a maximum expenditure on capital equipment and a plan for allocating equipment, with the remainder of the allocated funds to be spent on operational initiatives to increase surgical capacity and throughput. Districts were required to report all expenditures and changes in service volumes resulting from the additional funding.

District Health Boards provide an annual report on the aggregate financial results for their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in the Department of Health 2000-2001 Annual Report, the 2000-2001 Annual Budget and related budget documents, its 2000-2001 Public Accounts, and the Mid-Year Financial Report. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums (see Additional Materials section).

7.0 Extended Health Care Services

As of March 31, 2001, the range of extended health care services provided by the provincial government included a prescription drug plan, the Saskatchewan Aids to Independent Living Program, which provides medical equipment and appliances to disabled persons; the Supplementary Health Program, which provides non-insured health services to people nominated by Saskatchewan Social Services; the Family Health Benefits Program, which provides non-insured health services primarily to children of low-income working families; a children's dental education program; a hearing aid program; partial coverage for services provided by chiropractors, optometrists and chiropodists; home care services; long-term care services; air and road ambulance services; community clinic and community health centre services; addiction services; mental health services; occupational and physical therapy.

Nursing Home Intermediate Care Services

- Special-care homes provide institutional long-term care services to meet the needs of individuals with heavy care needs. Services offered include care and accommodation, respite care, day programs, night care, palliative care, and in some instances convalescent care. These facilities are publicly funded through the District Health Boards and are governed by *The Housing and Special-care Homes Act.*
- Public Health Services of District Health Boards provide immunization to residents in long-term care facilities and other similar residential facilities under the provincial immunization program. Saskatchewan Health purchases the vaccines and provides them free of charge to Public Health Services of District Health Boards who then provide them to local long-term care and other similar residential facilities. This applies to influenza and pneumococcal vaccines.

Adult Residential Care Services

Mental Health Services

- Group homes provide 24-hour living assistance to individuals with long-term mental illnesses and are governed by *The Mental Health Services Act* and *The Residential Services Act.*
- Saskatchewan Health, in partnership with the Midwest Health District, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and is currently governed by *The Non-profit Corporations Act* and *The Co-operatives Act.*

Alcohol and Drug Services

- Alcohol and drug services generally fall under *The Health Districts Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the Health Districts contract with community based and non-profit organizations to provide services governed by *The Non-profit Corporations Act*.
- Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days. *The Housing and Special-care Homes Act* governs detoxification services.
- In-patient services are provided to individuals who are concerned about their own or others' use of alcohol or drugs. Services offered include assessments, counselling, education and support for up to four weeks or longer depending on individual needs. In-patient services are governed by *The Housing and Special-care Homes Act.*
- Long-term residential services provide services for an extended period to individuals recovering from chemical dependency and addiction. These facilities offer counselling, education and relapse prevention in a safe and supportive environment. *The Housing and Special-care Homes Act* governs long-term residential services.

Home Care Services

- The Home Care Program provides an option for those individuals with varying degrees of short and long-term illness or disabilities to remain in their own homes rather than in a care facility. The Program is designed to provide care and services for individuals that have palliative, acute and supportive care needs. Services include assessment/care coordination, nursing, personal care, respite, homemaking, meals, home maintenance, therapy and volunteer services. This program is governed by *The Home Care Act* (in the process of being repealed) and *The Health Districts Act.*

Ambulatory Health Care Services

- Saskatchewan Health Districts provide a full range of mental health and alcohol and drug services in the community. Mental health services are governed by *The Mental Health Services Act.*
- Most Saskatchewan Health Districts offer chiropody services. Services include assessment, consultation and treatment. This program is governed by *The Health Districts Act.*
- Saskatchewan Health Districts also offer a Hearing Aid Program. Services include hearing screenings, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Health Districts Act* and *The Speech-Language Pathologists and Audiologists Act* govern these programs.
- Community therapies, including occupational and physical therapies, are offered by the Saskatchewan Health Districts and help individuals of all ages to improve their functional independence. Services are provided in facilities, schools, hospitals, and private homes and include assessment, consultation and treatment. *The Health Districts Act* governs this program.

Additional Materials Submitted to Health Canada

- Saskatchewan Health Annual Report, 1999-2000
- Medical Services and Health Registration Branch Annual Report, 1999-2000
- Saskatchewan Finance Backgrounder – 2001-2002 CHST
- Partners in Health – Our Other Partners
- Health Services Opportunities Conference – November 25, 2000, Speaking Notes for the Minister of Health
- *The Non-profit Corporations Act*, 1995
- *The Speech-Language Pathologists and Audiologists Act*
- The *Home Care Act*
- *The Co-operatives Act*, 1996
- *The Cancer Foundation Act*
- *The Housing and Special-care Homes Act*
- *The Mental Health Services Act*
- *The Residential Services Act*
- *The Housing and Special-care Homes Regulations*
- *General Regulations under The Cancer Control Act*
- *The Dental Care Beneficiary Regulations, 1987*
- *The Dental Care Act*
- *The Hospital Standards Act*
- *The Hospital Standards Regulations, 1980*
- *The Department of Health Act*
- *The Saskatchewan Medical Association Dues Check-off Regulations, 1996*
- *The Saskatchewan Medical Care Insurance Act*
- *The Optometric Services Payment Negotiation Regulations, 1988*
- *The Medical Care Insurance Peer Review Regulations*
- *The Chiropractic Services Payment Negotiation Regulations*
- *The Insured Services (Physicians) Payment Schedule Review Regulations, 1989*
- *The Insured Services (Physicians) Access Regulations, 1987*
- *The Saskatchewan Medical Care Insurance Payment Regulations, 1994*
- *The Medical Care Insurance Beneficiary and Administration Regulations*
- *The District Health Boards Election Regulations*
- *The Health Districts Act*
- Saskatchewan Budget 2000-2001 and 2001-2002 at www.gov.sk.ca/finance/budget
- Public Accounts 2000-2001 at www.gov.sk.ca/finance/paccts/default.htm

Alberta

Introduction

The Ministry of Alberta Health and Wellness (AHW) includes the Department of Health and Wellness (the Department) and the Alberta Alcohol and Drug Abuse Commission (AADAC). The Department consists of six divisions and 28 branches.

Mission:

The mission of the Ministry is to lead and support a system for the delivery of quality health services and to encourage and support healthy living. The vision of the Department is "Citizens of a Healthy Alberta Achieving Optimal Health and Wellness".

In addition to the principles described in the *Canada Health Act*, the Department is committed to providing a health system that:

- demonstrates excellence. High standards and best practices are achieved through research, education and information;
- provides for equal access by all Albertans to a comprehensive range of integrated health services;
- provides quality services and effective outcomes;
- builds on shared responsibility and decision-making among users and providers;
- ensures accountability, at all levels, for outcomes; and
- is cost-effective and sustainable in the long term.

In addition to meeting the requirements specified in the *Canada Health Act*, the Department also provides full and/or partial coverage for a number of other health care services, such as:

- home care and long-term care;
- mental health services;
- Extended Health Benefits for senior citizens, recipients of the Alberta Widows' Pension (and the eligible dependants of both);
- palliative care;
- immunization programs for children; and
- some allied health services such as optometry (for residents under 19 and over 65 years), chiropractic, podiatry, etc.

Regional Health Authorities and Provincial Health Authorities

In Alberta, 17 regional health authorities and two provincial health authorities deliver health services. The regional health authorities are responsible for hospitals, continuing care facilities, community health services and public health programs in the province. They deliver health services in the regions and work with communities to provide health services locally.

The two provincial health authorities (the Alberta Cancer Board and the Alberta Mental Health Board) provide health services on a province-wide basis.

Regional Health Authority Funding

Beginning with the 1997-1998 fiscal year, Alberta adopted a new method of funding regional health authorities to ensure that each region received its fair share of available health dollars. This funding method is referred to as "Population-Based Funding". Under this method, funds are allocated to each regional health authority according to the population in each region and their estimated relative health care expenditure requirements.

The population's health care expenditure requirements are measured by taking into account:

- the total population base of each region;
- the age and gender of the population base;
- the socio-economic composition of the population base; and

- services provided by regions to residents of other regions.

Province-wide Services Funding

Province-wide services funding is targeted to provide a range of high-cost, high-tech, life-sustaining services that are funded separately from the basic health services covered under population-based funding. Province-wide services planning, delivery and standards setting are collaborative efforts between the Department and the Calgary Health Region and Capital Health Authority. These services are only delivered in Edmonton and/or Calgary. Therefore availability of centrally funded services to all Alberta residents, regardless of where they live, is ensured.

Alberta Health Care Insurance Plan Statistics

In the 2000-2001 fiscal year there were 4,856[1] physicians and 2,910[1] allied health practitioners registered with the Alberta Health Care Insurance Plan. There were 3,007,582[1] residents registered with the Alberta Health Care Insurance Plan.

In 2000-2001, the Alberta Health Care Insurance Plan issued a total of $959,073,855[1] in fee-for-service payments to Alberta physicians and a total of $57,804,028[1] to Alberta allied health practitioners, (dental surgeons, dentists, chiropractors, optometrists, podiatrists), for basic health services.

Key Alberta activities in 2000-2001 were:

- proclamation of the *Health Care Protection Act* and Regulations on September 28, 2000;
- negotiations/amending agreement entered into with the Alberta Medical Association;
- continuation of the development of the Relative Value Guide (RVG);
- four additional Magnetic Resonance Imaging (MRIs) machines added to the health system: two in Calgary and two in Edmonton;
- a pilot project to cover special high-cost dental treatment for Albertans with congenital conditions, cancer or other trauma who require certain orthodontic services that are needed before insured oral and maxillofacial surgical services can be performed was introduced in Alberta;
- meningitis immunization programs were launched in “high-risk” areas of the province;
- eight postgraduate training positions were opened to international medical graduates at the University of Alberta and University of Calgary;
- the Department approved a new drug treatment (Ocular Photodynamic Therapy) for macular degeneration; and
- effective April 1, 2000, commenced paying for accommodation and subsistence costs (for those persons approved by the Out of Country Health Services Committee under Section 26.1 of the Alberta Health Care Insurance Regulation), to travel outside of Canada to receive insured services or insured hospital services on an out-patient basis.

Some of the major challenges facing the Department are:

- drug costs;
- technology and the change in demographics;
- public expectations and demands for services; and
- sustainability of health care in Alberta.

The Premier’s Advisory Council on Health has been established to identify strategies to maintain an effective, high-quality health care system for Albertans.

Additional information on Alberta Health and Wellness can be obtained on our website at www.health.gov.ab.ca

[1] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness’ *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Alberta Health Care Insurance Plan is operated on a non-profit basis and is administered by the Minister of Health and Wellness.

The Alberta Health Care Insurance Plan is governed by the *Alberta Health Care Insurance Act* and Regulations. The *Alberta Health Care Insurance Act* was proclaimed in 1969. It provides benefits for basic health services to all Alberta residents, as defined in the *Alberta Health Care Insurance Act*, and extended health services to residents 65 years of age or older, or those who are receiving the Alberta Widows' Pension and their eligible dependants.

- Part 1, Section 3 of the *Alberta Health Care Insurance Act* authorizes the operation of the Alberta Health Care Insurance Plan.
- Section 4 describes "coverage under the Alberta Health Care Insurance Plan".
- Section 5 describes payment of benefits and emergency services. Section 5 also prohibits extra-billing and identifies "other prohibited fees".

There were no legislative amendments that changed the name or public authority of the Alberta Health Care Insurance Plan in 2000-2001.

The role and mandate of the Department is:

- to preserve, protect and improve the health of Albertans and the quality of the health system;
- to develop health policy and standards and identify resources required to sustain the health system and meet Albertans' health needs on an ongoing basis; and
- to ensure that health services are appropriate, well managed and accessible to all Albertans.

1.2 Reporting Relationship

The Alberta Health Care Insurance Plan is administered through the Program Services Division of the Department. The Assistant Deputy Minister of the Program Services Division reports to the Deputy Minister of the Department, who in turn reports to the Minister of Health and Wellness. The Minister is accountable to the Legislative Assembly and the Government of Alberta. In turn, the Government of Alberta is accountable to all Albertans.

The Department issues an Annual Report that contains the Ministry's Accountability Statement, Management Responsibility for Reporting and the consolidated financial statements of the Ministry of Health and Wellness. In addition, the Annual Report provides information about the actions, key achievements and results for all key performance measures included in the 2000-2001 business plan for each of the Department's four goals that support the two core businesses of the Department.

The two core businesses of the Department are:

- to lead and support a system for the delivery of quality health services, and
- to encourage and support healthy living.

The Department's Annual Report for the year ended March 31, 2001 was prepared under the direction of the Minister of Alberta Health and Wellness in accordance with the Departments *Government Accountability Act* and the Government's accounting policies.

- Section I of the Annual Report contains the audited consolidated financial statements of the Department and a comparison of actual performance results to desired results set out in the Ministry's Business Plan.
- Section II provides financial statements of the regional health authorities and provincial boards, which are accountable to the Minister of Alberta Health and Wellness.

The Department also issues an annual statistical supplement report on data related to the Alberta Health Care Insurance Plan, primarily the number of people registered and the fee-for-service payments made to Alberta physicians and allied practitioners, i.e., oral and dental surgeons, chiropractors, optometrists

and podiatrists. Statistics regarding the Extended Health Benefits (EHB) Program and the Alberta Blue Cross Non-Group coverage offered through the Alberta Health Care Insurance Plan are also provided in this statistical supplement report.

1.3 Audit of Accounts

The financial statements of the Alberta Health Care Insurance Plan are now included as part of Alberta Health and Wellness audited financial statements. The Ministry's financial statements are audited by the Auditor General of Alberta.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospitals Act* (Revised Statutes of Alberta 1980, Chapter H-11 with amendments in force as of December 1, 1997), the Hospitalization Benefits Regulation (AR244/90), the *Health Care Protection Act*, proclaimed September 28, 2000, and Health Care Protection Regulation, are the legislative authorities that provide for insured services provided in hospitals or designated surgical facilities in Alberta.

There were no amendments made to the *Hospitals Act* or the Hospitalization Benefits Regulation in 2000-2001.

The Minister of Alberta Health and Wellness administers the *Hospitals Act*. Regional health authorities are accountable for ensuring the overall management and delivery of all hospital services within their regions. In accordance with the *Hospitals Act* and Regulations, they are required to provide specifically identified "Insured Hospital Services". Services provided beyond "Insured Hospital Services" are at the discretion of the individual regional health authority.

The *Hospitals Act* defines insured services as "the hospital services the operating costs of which will be provided for under this Part" and goes on to define Standard Ward Hospitalization and where insured services shall be furnished. These services are set out in the Hospitalization Benefits Regulation (AR244/90).

The Hospitalization Benefits Regulation describes "insured services" as follows:

"(a) to in-patients:

(i) a semi-private or private room, where a patient's medical condition makes it necessary;

(ii) private nursing care for a patient when ordered by the attending physician and approved in accordance with the hospital's by-laws;

(iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital;

(iv) pacemakers, steel plates, pins, joint prostheses, valve implants and any other goods approved by the Minister;

(v) transportation in Alberta, whether by ambulance or other commercial vehicle to transport a patient in the circumstances described in section 6, [i.e. transfer from one hospital to another].

(vi) goods and services included in an approved hospital program or a specific program, but not included in subclauses (i) to (v).

(vii) enhanced goods or services provided under section 5.2(2); [must be a medical necessity as determined by an attending physician]

(b) to out-patients: any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility."

Effective April 12, 2000, monofocal rigid or foldable lens implants were provided to patients, without charge, as part of the insured hospital service, when provided in conjunction with an insured physician service.

Effective September 28, 2000, both plaster and fibreglass casts were provided to patients, without charge, as part of the insured hospital service, when provided in conjunction with an insured physician service.

In June 2000 coverage was provided for ocular photodynamic therapy using Visudyne to treat wet macular degeneration.

Table 1 identifies the number and types of facilities operating in Alberta in fiscal 2000-2001.[2]

Table 1: Health Care Facilities by Type*	
Acute Care Facilities (facilities that offer health services that are provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation)	102
Chronic Care Facilities (facilities that offer health services to in-patients who need assistance on a continuing basis due to chronic impairment lasting at least several months)	105
Rehabilitative Facilities (facilities that offer health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury)	1
Other (Community Care Facilities)	3
Total	**211**

*excludes psychiatric hospitals and nursing homes

Non-hospital surgical facilities (facilities that offer health care services involving medical operative procedures that do not require an overnight stay in the facility for post-operative recovery or observation – including private cataract/abortion/dental/optometry clinics) and non-hospital diagnostic facilities (facilities that offer health care services for procedures that do not require an overnight stay and that detect and/or determine various diseases or health conditions) also operate in the province. These facilities operate under agreements and/or contracts with the regional health authorities. Alberta Health and Wellness collects data only on the insured fee-for-service procedures performed in these facilities and does not collect data on insured hospital services provided within the facilities. According to the College of Physicians and Surgeons of Alberta, there are currently 52 non-hospital day surgical facilities accredited under the College by-laws. These provide both insured and uninsured day surgery.

Currently there are 36 contracts for insured surgical services with 33 facility operators. The Minister approved 34 of the 36 contracts after the *Health Care Protection Act* was proclaimed. Two existing contracts, which expired after the Act's proclamation, were deemed to be approved. Any amendments or renewal of these two contracts requires ministerial approval. The types of insured surgical services provided by these 36 facilities are ophthalmology; dermatology; ear, nose and throat treatment; oral surgery; orthopaedics; pregnancy termination and plastic surgery.

Copies of the 35 contracts with the Capital Health Authority and the Calgary Health Region are posted on their websites. The contract with the Headwaters Health Region is not available on its website; however, a hard copy is available by calling its corporate office at (403) 601-8330. Information about the contracts approved by the Minister is available on the Alberta Health and Wellness website at www.health.gov.ab.ca.

On September 28, 2000, the Government proclaimed the *Health Care Protection Act* and enacted the Alberta Health Care Protection Regulation under which accredited surgical facilities must operate.

The *Health Care Protection Act* sets out the strongest rules in the country for protecting the publicly funded health system by filling gaps in current legislation, providing protection for the publicly funded and administered health care system, preventing a two-tier system, and providing health authorities with a further option to improve access to services.

Under this Act:

- private hospitals are prohibited from operating;
- surgical facilities are allowed to provide insured surgeries only when they have contracts with a health authority and only when the health authority can demonstrate that there is a net benefit to the public system;

[2] The Alberta section of the 1999-2000 Canada Health Act Annual Report did not reflect Chronic Care or Rehabilitative Care Facilities. This year, based on the definitions provided for the various facilities, as provided by Health Canada, and agreed to by the Provinces and Territories, we have changed this portion of the Narrative to reflect the same facility categories as listed in Annex A of this report (see Provincial and Territorial Health Care Insurance Plan Statistics).

- facility fees for insured surgical services are illegal;
- it is illegal to jump the queue for insured surgeries by paying or receiving money or by purchasing an uninsured surgical service or an enhanced product or service;
- charges for extra medical products and services that are not medically necessary have been limited; and
- patients and the health system are protected from unethical behaviour or conflict-of-interest situations.

Under the *Health Care Protection Act,* non-hospital surgical facilities must:

1. be accredited by the College of Physicians and Surgeons to provide the insured surgical services;
2. have an agreement for the provision of these insured surgical services with a health authority that has been approved by the Minister; and
3. be designated by the Minister to provide these insured surgical services.

The Act also specifies the conditions that must be satisfied for the Minister to approve an agreement between a health authority and a non-hospital surgical facility. The provision of insured surgical services, as contemplated under the Agreement, is assessed in relation to factors such as consistency with the *Canada Health Act,* current and ongoing need in the geographical area for the service, potential for adverse impact on the publicly funded and publicly administered health system in Alberta, expected public benefit such as better access, improved quality, flexibility, improved efficiency, and improved cost effectiveness.

Once the Minister approves the proposed agreement between a health authority and non-hospital surgical facility and is satisfied that the facility is accredited to provide insured surgical services, the Minister is required to designate the facility. Designation includes describing the insured surgical services that the surgical facility is authorized to provide, any terms and conditions that the designation is subject to, and the Minister's publishing or otherwise making public his or her reasons for designating a facility or amending a designation.

The current process for establishing an approved hospital status (acute care hospitals and auxiliary hospitals) involves departmental review and ministerial approval. For a new hospital this process includes a regional needs assessment; a program and service plan; a hospital functional programming study; identification of functional centres; facility registration and inclusion in the Ministerial Order - "Schedule of Approved Hospitals". Updates to approved hospital status that include amendment to or consolidation of the Ministerial Order – "Schedule of Approved Hospitals" requires certification by the health region that all relevant approved hospital data and current common names are accurate and that the approved hospitals are operating in accordance with applicable federal, provincial and departmental legislation and standards.

Publicly owned nursing homes are operated by regional health authorities. Regional health authorities negotiate and approve contracts for the operation of private or voluntary owned and operated nursing homes. Under the *Nursing Homes Act*, Part II, Section 6, regional health authorities are responsible for providing the Minister with copies of all nursing home contracts.

Continuing Care Facilities

In Alberta, long-term care facilities are classified as either nursing homes or auxiliary hospitals under current legislation. Collectively these are now referred to as continuing care facilities.

Auxiliary Hospital

Under Section 1(1)(c) of the *Hospitals Act,* "auxiliary hospital" means a hospital for the treatment of long term or chronic illnesses, diseases or infirmities. Auxiliary hospitals are owned by regional health authorities or voluntary, non-profit societies and are operated under the *Hospitals Act* and its Regulations.

Nursing Home

Under Section 1(m) of the *Nursing Homes Act,* "nursing home" means a facility for the provision of nursing home care.

Nursing homes are owned by regional health authorities, voluntary societies or private

corporations and are operated under the *Nursing Homes Act* and its regulations. Where a nursing home or auxiliary hospital is owned by a voluntary, non-profit society or private corporation it is operated under a service contract or agreement with the regional health authority.

Continuing care facility operators are responsible for providing all services required under the *Nursing Homes Act* and Regulations and the *Hospitals Act* and Regulations.

These include:

- services provided by auxiliary hospitals and nursing homes such as professional and ancillary nursing care, pharmacy, nutrition, physical therapy services and accommodation services (e.g. laundry, housekeeping, maintenance and administration);
- trust account services;
- supplies for recreation programs;
- medications or drugs and related preparations as prescribed by the attending physician, including oxygen;
- all dressing and wound-care supplies;
- incontinence products and bladder care equipment;
- transportation, including ambulance transport, for prescribed services;
- nutritional supplements as prescribed by the attending physician;
- basic room furniture; and
- special care items such as handrails, sheepskin pads, elbow and ankle protectors, pressure mattresses, side-rail pads, etc.

Section 25(1)(h) of the *Health Care Protection Act* gives the Lieutenant Governor in Council the authority to prescribe whether a particular medical good or service is or is not a standard or an enhanced good or service. The Health Care Protection Regulation sets out major surgical services, minor surgical procedures and standard and enhanced medical goods and services. Adding or removing an item from the Health Care Protection Regulation requires an amendment to the Regulation and the requirements of the Government's regulatory review process must be followed. Routine decisions regarding equipment and supplies used in procedures are the purview of the health authorities and practitioners and are excluded from this process.

The Department is developing a process to define standard and enhanced medical goods and services that will be used on an exception basis to examine medical goods and services that cannot be dealt with by a single health authority, or where an inconsistency in benefits has been identified across regions.

2.2 Insured Physician Services

The Medical Benefits Regulation governs the services for which benefits are payable, as well as the requirements for submission of fee-for-service claims to the Alberta Health Care Insurance Plan. This regulation sets the rates for benefits as those "set out in the Schedule of Medical Benefits prepared and published by the Department and approved by the Minister".

There were no amendments to the Legislation or Regulations in 2000-2001 with regard to insured physician services.

The *Alberta Health Care Insurance Act* defines "physician" as:

- "With reference to medical services provided in Alberta, a person registered as a medical practitioner or as an osteopathic practitioner under the *Medical Profession Act,* and
- With reference to medical services provided in a place outside Alberta, a person lawfully entitled to practise medicine or osteopathy in that place."

The *Alberta Health Care Insurance Act* defines "practitioner" as:

- "A chiropractor, dental mechanic, dental surgeon, optician, optometrist, physician or podiatrist or other person who provides a basic health service or an extended health service."

The *Medical Profession Act* defines "registered practitioner" as:

- "A person registered in the Alberta Medical Register or who is temporarily registered under Section 28."

Requirements for Physicians and Practitioners

Only those who meet the above requirements are allowed to provide insured physician services under the Alberta Health Care Insurance Plan.

Medical practitioners' offices must be registered by the Department. Practitioners must see patients at the location, book appointments from the location and maintain patient files at the location in order to be registered by the Department.

Prior to being registered with the Department, a practitioner must complete the appropriate registration forms and include a copy of his/her licence (issued by the appropriate governing body/association – e.g. the College of Physicians and Surgeons of Alberta, the Alberta Dental Association, etc.).

The number of practitioners registered with the Alberta Health Care Insurance Plan as of March 31, 2001, is as follows[3]:

Physicians	4,856
Oral Surgeons/Dentists	1,484
Chiropractors	689
Optometrists	243
Podiatrists	44
Denturists	191
Opticians	259
TOTAL	7,766

Physicians Opting out of the Alberta Health Care Insurance Plan

In accordance with section 5.11(1) of the *Alberta Health Care Insurance Act,* every physician is deemed to have opted into the Alberta Health Care Insurance Plan.

A physician may practise and bill patients for services outside of the Alberta Health Care Insurance Plan. A physician who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions, at least 180 days prior to the effective date of the opting out.

These conditions include:

- notifying the Minister, in writing, of his/her intention to opt out, indicating the effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practises; and
- posting a notice of the proposed opting out in a part of the physician's office to which patients have access.

As of March 31, 2001 there was one medical practitioner in the Province who had opted out of the Alberta Health Care Insurance Plan.

Schedule of Medical Benefits

The Medical Benefits Regulation (AR 173/93) describes the services for which benefits are payable. These services are set out in the Schedule of Medical Benefits prepared and published by the Department and approved by the Minister. Specifically, these are:

- general medical services;
- general medical and surgical procedures;
- anaesthesia;
- laboratory medicine and pathology;
- obstetrics;
- gynaecology;
- cardio-thoracic and vascular surgery;
- general surgery;
- orthopaedic surgery;
- neurosurgery;
- urologic surgery;
- otolaryngology;
- ophthalmology;
- reconstructive plastic surgery;
- medicine;
- psychiatry;

[3] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

- paediatrics;
- dermatology;
- physical medicine and rehabilitation;
- emergency medicine;
- diagnostic radiology;
- therapeutic radiology; and
- neurology.

Alberta also covers unlisted services that are deemed medically required and are not experimental or applied research.

Insured physician services and any subsequent additions, deletions or amendments to the Schedule of Medical Benefits are discussed between the Department and the Alberta Medical Association through a subcommittee composed of Alberta Health and Wellness and Alberta Medical Association members. Changes to the Schedule of Medical Benefits require ministerial approval.

During the period April 1, 2000 to March 31, 2001, the following services were added to the list of insured physician services covered by the Alberta Health Care Insurance Plan.

- rotation duty – off-hours benefits;
- pre-lung transplant, assessment;
- post-lung transplant, in-patient care;
- balloon dilation of lower gastrointestinal (ileum or colonic) stricture in association with colonoscopy;
- balloon dilation of lower gastrointestinal stricture (ileum or colonic) stricture in association with sigmoidoscopy;
- balloon dilation of upper gastrointestinal stricture (stomach, duodenum or jejunum);
- removal of double “J” stent;
- management of shoulder dystocia;
- selective fetal reduction;
- reconstruction of collateral ligament and/or the volar plate of the MP or IP joint;
- intravaginal trigger point injection(s);
- effective June 1, 2000 consultation benefits may be paid to physicians when a midwife refers a patient to them for a consultation;
- hyperbaric oxygen therapy detention time – over 15 minutes;
- debridement of mastoid cavities and/or repair of small perforation – under microscopy;
- application of fibreglass cast, lower limb;
- application of fibreglass cast, upper limb, excluding finger;
- ilioplasty, bone graft to iliac crest following harvesting of bone for neurospinal surgery;
- prolonged psychiatry consultations per additional 15 minutes, when the consultation exceeds 60 minutes;
- assessment of an unrelated condition in association with a Workers’ Compensation service;
- second and subsequent physician attendance at a formal, scheduled, professional interview/case conference on behalf of a specific patient 18 years of age and under, per 15 minutes;
- peripheral embolectomy or endarterectomy (note: may only be claimed in association with other vascular surgery through the same arteriotomy);
- endoscopic ultrasound of esophagael or gastric lesions; and
- endoscopic ultrasound of rectal lesions.

2.3 Insured Surgical-Dental Services

Under the Alberta Health Care Insurance Plan, the Province insures a number of medically necessary oral surgical procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits. A dentist or dental surgeon may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan only when performed by an Oral and Maxillofacial Surgeon.

Dentists (or dental surgeons) must be registered as members of the Alberta Dental Association or must be entitled to practise dental surgery in any place outside Alberta. Oral and Maxillofacial Surgeons must be dental specialists in oral and maxillofacial surgery,

registered as members of the Alberta Dental Association, or be lawfully entitled to practise oral and maxillofacial surgery in any place outside Alberta.

As of March 31, 2001, there were 1484[4] oral surgeons and dentists registered with the Alberta Health Care Insurance Plan, providing services under both the Extended Health Benefits Program for seniors and the insured surgical dental services program. However, during the 2000-2001 fiscal year, only 232[4] dentists and oral surgeons billed the Alberta Health Care Insurance Plan for insured oral surgery procedures.

Provisions of opting in and out of the Alberta Health Care Insurance Plan by dentists are set out in section 5.1(1) of the *Alberta Health Care Insurance Act.* Subject to this section, every dentist is deemed to have opted into the Alberta Health Care Insurance Plan.

A dentist may practise and bill patients for services outside the Alberta Health Care Insurance Plan. A dentist who decides to opt out of the Alberta Health Care Insurance Plan must meet certain conditions, at least 180 days prior to the effective date of the opting out. These conditions include:

- notifying the Minister, in writing, of his/her intention to "opt out", indicating the effective date of the opting out;
- publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the dentist practises; and
- posting a notice of the proposed opting out in a part of the dentist's office to which patients have access.

As of March 31, 2001, no dentists or oral surgeons had opted out of the Alberta Health Care Insurance Plan.

The following procedures are insured under the Alberta Health Care Insurance Plan and are listed in the Oral and Facial Surgery Benefits Regulation: (note: decisions as to (a) whether the procedure is medically necessary, and (b) where it should be performed; are left to the surgeon and depend on the medical needs of the patient):

- diagnostic interview and evaluation or consultation;
- arthroscopy temporo-mandibular joint;
- injection or infusion of other therapeutic or prophylactic substance;
- cranioplasty;
- operations on cranial peripheral nerves;
- submucous resection of nasal septum;
- reduction of nasal fracture; intransal antrotomy;
- repair and plastic operation of nasal sinus;
- excision of dental lesion of jaw; other orthodontic operation;
- repair and plastic operations on tongue;
- other operations on tongue;
- incision of salivary gland or duct;
- excision of lesion of salivary gland;
- other operations on salivary gland or duct;
- drainage of face or floor of mouth;
- incision of palate;
- excision of lesion or tissue of palate; plastic repair of mouth (internal);
- palatoplasty;
- invasive diagnostic procedures on oral cavity;
- other operations on mouth and face;
- plastic operation on pharynx;
- control of hemorrhage, not otherwise specified;
- reduction of facial fractures;
- incision of facial bone without division;
- temporomandibular arthroplasty;
- other facial bone repair and osteoplasty;

[4] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

- invasive diagnostic procedures on facial bones;
- other operations on facial bones and joints;
- sequestrectomy;
- synovectomy;
- repair and plastic operations on joint structures;
- incision of muscle, tendon, fiscia and bursa;
- relaxation of scar or contracture of skin;
- flap or pedicle graft; and
- oral and burn appliances.

The Claims Branch in the Program Services Division of the Department manages any addition of new surgical-dental items to the list of insured services. Changes to the schedule require ministerial approval. All changes (both addition and deletion of items) are done through extensive consultation with the Department, the Alberta Dental Association and the Oral Maxillofacial Surgery section of the Alberta Dental Association, and are supported by impact assessment studies. Depending on the changes, the regional health authorities may also be consulted.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 4(2) of the Hospitalization Benefits Regulation provides a listing of uninsured hospital services. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Services required for the use of third parties, services covered under another provincial/territorial/federal statute, services that have been deemed unnecessary for the patient (i.e., enhanced goods and services), laboratory and x-ray services, drugs, biologicals and related preparations (in some circumstances), and services provided by a facility outside of Canada without the prior approval of the Minister, are the types of uninsured services listed in the Hospitalization Benefits Regulations.

The *Health Care Protection Act* (Section 5) and Regulations specify the conditions that apply when patients are charged for enhanced medical goods and services related to the provision of an insured surgical service. These provisions of the legislation apply to both public hospitals and non-hospital surgical facilities. The legislation limits charges to those enhanced medical goods or services that are listed in Schedule 2 of the Regulation. Currently, there is only one enhanced medical good listed: multi-focal intraocular lens implants. It also specifies the method for determining the amount that may be charged for an enhanced medical good or service. As well, the legislation includes disclosure provisions that apply when an enhanced medical good or service is offered to a patient, i.e., patients must be advised that the standard medical good or service meets generally accepted medical practise and is available at no charge. These are only some of the key provisions relating to the sale of goods and services.

Section 21 of the Alberta Health Care Insurance Regulations, sets out the services that are not basic health services or extended health services and therefore are not considered insured services. The Regulation is detailed in the section entitled Additional Materials Submitted to Health Canada, which appears at the end of this narrative. Briefly, some of the services that are not considered insured services under this regulation are services provided for third parties, (insurance companies, medico-legal services, etc.); advice by telephone or other means of telecommunication (including toll charges for same); transportation costs (includes costs of both patients and practitioners as well as ambulance costs, unless otherwise directed by the Minister); services covered under another provincial/territorial/federal statute; group immunizations; services provided by a practitioner to his children, siblings, parents and/or spouse, except where the Minister rules otherwise, etc.

The Schedule of Oral and Maxillofacial Surgery Benefits details the services that are not insured benefits under that Schedule. The Schedule is detailed in the section entitled Additional Materials Submitted to Health Canada that appears at the end of this narrative. Some of these items are: services that are cosmetic in nature; drugs/medication; advice by telephone; ambulance services; services that are not medically required; travel time; and services provided by a practitioner to his or her children,

siblings, parents and/or spouse, except where the Minister rules otherwise; etc.

Regional Health Authority Responsibilities

Section 5 (Responsibilities of Authority) of the *Regional Health Authorities Act* states "Subject to this Act and the Regulations, a Regional Health Authority: shall (i) promote and protect the health of the population in the health region and work towards the prevention of disease and injury, (ii) assess, on an ongoing basis, the health needs of the health region, (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly, (iv) ensure that reasonable access to quality health services is provided in and through the health region, and (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region". Regional health authorities are responsible for ensuring that decisions related to access to insured hospital and other community health services are based on need.

Billing Outside the Alberta Health Care Insurance Plan

In accordance with Section 31.1(1) of the Alberta Health Care Insurance Regulations, no person may charge a fee (a) the payment of which is a condition of receiving an insured service provided by a physician who is enrolled in the Alberta Health Care Insurance Plan or a dental surgeon who is opted into the Alberta Health Care Insurance Plan, and (b) that is in addition to the benefit payable by the Minister for the insured service.

In accordance with the *Canada Health Act,* the Alberta Health Care Insurance Plan covers the medically required services physicians provide to patients. When a service is not medically required, physicians may bill a patient for that service. The Department does not regulate physicians' billings for uninsured services. The College of Physicians and Surgeons of Alberta has developed and enforces a policy on this issue entitled *Charging for Uninsured Services*, and the Alberta Medical Association provides the *Guide to Direct Billing for Uninsured Services* to physicians.

The Alberta Health and Wellness/Alberta Medical Association agreement defines de-insurance as "...in respect of an insured service, the decision of the Minister that such insured service is no longer an insured service and no longer payable under the Plan." According to this agreement, Alberta Health and Wellness must notify the Alberta Medical Association of any proposal to de-insure, and the proposal must be discussed by the Finance Committee, the joint Alberta Health and Wellness/Alberta Medical Association body that manages the Agreement. If the Alberta Medical Association does not agree to de-insure the service, Alberta Health and Wellness must wait three months from the notification date to remove the service from the Schedule of Medical Benefits.

Before items are de-insured (deleted) from the Schedule of Oral and Maxillofacial Surgery Benefits, Alberta Health and Wellness consults with the Alberta Dental Association.

In reviewing whether new medical products, services or devices should be publicly funded, the Department's process is to first review the scientific literature and seek expert advice as to the safety and effectiveness of the product, and next to issue the policy, funding, training and other implications of providing public coverage. Issues requiring immediate attention are addressed on an issue management basis with the most appropriate branch taking the lead.

3.0 Universality

3.1 Eligibility

Sections 3(1) and 4(3) of the *Alberta Health Care Insurance Act;* Sections 4(1), 4(2), 4.1 and 4.2 of the Alberta Health Care Insurance Regulations**,** Section 18.2 of the *Health Insurance Premiums Act*, and Section 21 of the Health Insurance Premiums Regulation define eligibility for the Alberta Health Care Insurance Plan.

All Alberta residents are eligible to receive services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada who makes his or her home and is ordinarily present in Alberta and any other

person deemed by the Regulations to be a resident, but does not include a tourist, transient or visitor to Alberta.

Persons from outside Canada who move to Alberta to establish permanent residence are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. All new landed immigrants must provide a copy of their Record of Landing. Temporary residents arriving from outside Canada, who may be deemed residents, include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits.

In each of these cases, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that in Alberta to be eligible.

Refugee claimants who entered Canada before January 1, 1989, and who intended to reside in Alberta for 12 months were also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989 are not eligible for coverage until they are deemed to be Convention Refugees.

Persons moving permanently to Alberta from another country are eligible for coverage on their date of arrival, provided all Canada entry documents are in order and they register within three months of arrival. Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

There were no amendments made to this legislation, or the Regulations, in 2000-2001.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan are:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
- persons serving a term in a federal penitentiary.

However, their family members are eligible for coverage.

Alberta residents who cease to be members of the Canadian Forces, the RCMP, or inmates federal penitentiaries and are released in Alberta are eligible for coverage on the day of their release.

3.2 Registration Requirements

All new Alberta residents, except those specifically exempt, are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan by completing an application. New residents to Alberta should apply for coverage within three months of arrival. If the application is not received within the required time, the effective date is determined at the time of registration. Following registration, the account holder and dependants, if any, are each given a personal health number and card, which is used to obtain health services.

Family members are registered on the same account for billing purposes and to ensure that benefits (e.g., extended health benefits, non-group Blue Cross) can be provided to all members of the family unit.

In most cases, dependants are defined as a husband and wife and children under 21 years of age who are single and wholly dependent on the parent(s). Dependants can also be:

- adopted children, foster children and wards for whom the resident is entitled to claim income tax deductions;
- single children over 21 who are wholly dependant because of physical or mental disabilities;
- single children under 25 who are full-time students at an accredited educational institution; and
- separated or common-law spouses, who may also choose to pay premiums independently.

As of March 31, 2001, the estimated number of residents registered with the Alberta Health Care Insurance Plan was 3,007,582[5].

Residents who object to the Alberta Health Care Insurance Plan may opt out of the Alberta Health Care Insurance Plan. Residents can opt-out at the beginning of each benefit period. A benefit period begins July 1 of one year and ends June 30 of the following year. A Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year and premiums must be fully paid to June 30 of the current year. New account holders can opt out at the time of registration or reinstatement. The opt out period begins the day coverage would have become effective. To remain opted out, a Declaration of Election to Opt Out must be completed and filed with the Alberta Health Care Insurance Plan by June 30 of each year.

233 individuals had opted out of the Alberta Health care Insurance Plan for the benefit period July 1, 2000 to June 30, 2001.

3.3 Other Categories of Individual

Temporary residents arriving from outside Canada who may be deemed residents include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits. In each of these cases, copies of the individual's Canada entry document must be reviewed before eligibility for coverage can be determined. A person must have permission to stay in Canada for at least 12 months and intend to spend that time in Alberta to be eligible. Refugee claimants who entered Canada before January 1, 1989 and who intend to reside in Alberta for 12 months, are also eligible for coverage. Refugee claimants who entered Canada after January 1, 1989 are not eligible for coverage until they are deemed to be Convention Refugees.

The following figures show the estimated number of individuals residing in Alberta who were covered under the above conditions on March 31, 2001:

Minister's Permit	158
Student Authorization	5,038
Visitor's Record	3,058
Employment Authorization	5,110

3.4 Premiums

All residents of Alberta, except dependants and individuals excluded from registration, are required to pay premiums. Individuals enrolled in special groups, such as Alberta Widows' Pension and Support for Independence, are exempt from paying premiums. The current monthly premium rates are $34 for single coverage and $68 for family coverage (two or more people). There are two programs available to assist low-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program. Seniors are required to pay premiums at the same rates as non-seniors. Seniors' eligibility for premium assistance is determined through the Alberta Seniors Benefit Program.

Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to do so.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival, provided they register within three months of arrival.

4.2 Coverage During Temporary Absences in Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and Section 1(2) of the Alberta Health Care Insurance Regulations define portability of health insurance during temporary absences in Canada.

[5] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

Residents leaving Alberta for another part of Canada for 12 months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than 12 months, coverage may be cancelled or residents have the option of applying for extensions. These extensions are:

- extended visits or vacations, to a maximum of 24 consecutive months from date of departure. Extensions must be requested in person, by phone or in writing;
- employment or business engagements, to a maximum of 48 consecutive months from date of departure. A letter from the employer confirming the length of the business contract is required;
- a full-time student at an accredited educational institute are provided coverage until their educational training is completed. After the first year, verification of full-time student status must be submitted yearly to maintain coverage;
- sabbatical leave or educational leave from employment for advanced training, to a maximum of 24 consecutive months from date of departure. A letter from the employer confirming their training and length of absence is required;
- missionary work for an approved registered organization, to a maximum of 48 consecutive months from the date of departure. A letter from the religious organization confirming date of departure, destination and length of absence is required. Missionaries may return to Alberta on furlough (leave of absence or vacation) from their duties. The period of time they are in Alberta is counted as part of their temporary absence and does not indicate they have re-established permanent residence.

Effective November 15, 2000, the Alberta Health Care Insurance Regulation was amended to: define temporary absences as those that will not exceed six months outside Canada or 12 months within Canada; eliminate the provision that made coverage mandatory for the first 12 months, even if the absence is for longer than 12 months; and remove the reasons for absences and the timelines so they can be established in policy. This will better accommodate those who want to maintain coverage for longer periods of temporary absence as well as those who want to cancel coverage during an extended absence.

Hospital Reciprocal Agreement

Alberta participates in the Hospital Reciprocal Agreement with the provinces and territories, which allows for the processing of hospital costs provided to Albertans and non-Albertans by the host province. Claims are paid at the standard ward rate for in-province insured services approved by each provincial/territorial jurisdiction and at the out-patient rates for insured services approved by the Co-ordinating Committee on Reciprocal Billing. Exchange of claims data between each jurisdiction takes place on a monthly basis.

Medical Reciprocal Agreement

Alberta also participates in the Medical Reciprocal Billing Agreement with the provinces and territories (except Quebec). The Agreement allows for the processing of medical costs provided to Albertans and non-Albertans by the host province. Claims are paid in accordance with the rates, rules and regulations of the host provinces' physician's fee schedule for insured medical services. Exchange of claims data between the provincial/territorial jurisdictions takes place on a monthly basis.

Services excluded from this billing process, such as abortions, must be billed directly by the physician to the patient's home province/ territory for payment consideration.

The Capital Health Authority has also entered into an agreement with the Northwest Territories that allows for Northwest Territories patients to be treated within the region's hospitals and be paid at an agreed in-patient rate. The billing process for these claims is similar to the in-patient hospital reciprocal billing arrangement between the provinces and territories. Services that are excluded from reciprocal billing are also excluded from this bilateral agreement with the Northwest Territories.

Payment for insured hospital and medical services provided to eligible Albertans elsewhere in Canada is at the rate approved by the hospital insurance plan of the province or territory in which the goods or services are

provided, unless the Minister has entered into an agreement with the government of a province or territory to apportion the costs in a different manner.

Payments for insured medical services provided to eligible Albertans elsewhere in Canada are at the host provincial or territorial rates, including Quebec.

In 2000-2001, the total amount paid for in-patient and out-patient insured hospital services provided out-of-province (within Canada) was $19,602,875[6].

4.3 Coverage During Temporary Absences Outside Canada

Sections 5(1) and 5(3) of the *Alberta Health Care Insurance Act* and Section 1(2) of the Alberta Health Care Insurance Regulation define portability of health insurance during temporary absences outside Canada.

Alberta residents leaving Canada for six months or less must maintain their Alberta Health Care Insurance Plan coverage during their absence. If the absence will be longer than six months, coverage can be cancelled or residents have the option of applying for extensions. These extensions are the same as for those temporarily absent within Canada (please see details in section 4.2 for a description of the extensions).

For a description of amendments made in 2000-2001 to the Legislation or Regulations with regard to out-of-Canada portability, please refer to details in section 4.2, paragraph 3. Effective November 15, 2000, amendments were made to the Alberta Health Care Insurance Regulation that affected temporary absences both within and outside of Canada.

Hospital benefits are payable only when services are provided in acute care facilities that provide standard services such as intensive care units or emergency ward, or auxiliary hospitals that provide standard acute care services to long-term or chronically ill patients. If services are not insured in the Province, they are not insured when provided outside the country. The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day, (not including day of discharge). The maximum hospital out-patient per visit rate is $50 (Canadian). Some specialists' out-patient services, such as CAT scans, are paid at higher rates.

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

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

1. the Out-of-Country Health Services (OOCHS) Program, which may apply where the required service is not available in Canada, and
2. the Emergency Financial Assistance Program, which may apply where the treatment expense could not have been guarded against.

4.4 Prior Approval Requirement

Prior approval is required for elective services received outside Alberta. Treatment of alcohol and substance abuse, eating disorders and similar addictive or behavioural disorders, whether received out-of-province or out-of-country, must be approved by the Minister prior to being received.

Requests for prior approval for "hospitalisation" and "medical" treatment outside Alberta but within Canada must be submitted to the Department, by the physician responsible for the ongoing care of the patient in Alberta, or by the physician of the applicable provincial jurisdiction. Applications for prior approval of out-of-country health services are submitted to the Out-of-Country Health Services Committee by the Alberta physician or by the patient.

[6] NOTE: This figure will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

5.0 Accessibility

5.1 Access to Insured Health Services

Access to insured health services in Alberta is available to all residents on uniform terms and conditions, without barriers.

Those who are unable to pay premiums are not prevented from receiving insured health services. Registrations are not cancelled because of non-payment of accounts. Also, Alberta has two programs in place to assist low-income persons with payment of premiums.

These programs are:

- the Premium Subsidy Program, and
- the Waiver of Premiums Program.

Since 1986 “extra-billing” by physicians and “user charges” to patients for insured services have been prohibited.

Alberta’s Good Faith policy allows practitioners to submit claims for services provided to patients who are unable to provide an Alberta health care number at the time of service. This can be done one time only per patient and the practitioner must first satisfy him/herself that the patient is an Alberta resident.

5.2 Access to Insured Hospital Services

Since 1994, the delivery of hospital services in Alberta has been the responsibility of the regional health authorities.

In February 2000, the Government of Alberta announced its 2000-2001 to 2001-2003 business plan outlining increases to the provincial health system.

Under this business plan, Alberta’s health system expense increased by $482 million, an increase of 9.3 percent over the 1999-2000 base budget.

The increased spending improved access to publicly funded services and enabled regional health authorities to hire up to 2,400 more nurses and other front-line staff over the next three years. The budget also provided for an additional 90 physicians in 2000-2001 and an increase in the number of postgraduate residency positions in Alberta medical schools in the next two years. Funding increases also addressed waiting times for some procedures by increasing the number of life-saving surgeries performed, including major heart surgery, organ transplants, major cancer surgery and neurosurgeries. The new health care funding also increased home care services ($20 million), medical equipment purchases ($49 million), drugs and medical supplies ($29 million) and blood and blood products ($17 million).

The health authorities received an increase of $218 million or 7.7 percent in 2000-2001. Regional health authorities also received an increase of $47 million or 18.2 percent for province-wide services for key life-saving procedures primarily done in Edmonton and Calgary.

In May 2000 additional funding also provided:

- $54.4 million to reduce wait times for open-heart surgeries, joint replacements, MRIs and cancer treatments;
- $64 million to replace aging medical equipment. This brought the total for equipment to $112 million; and
- $20 million to expand long-term care and home care services.

The Ministry also provided $39 million to help pay for the costs of health authorities’ negotiated salary settlements.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2000-2001 there were 4,856[7] physicians and 2,910[7] allied health practitioners registered with the AHCIP.

In 2000-2001, new funding initiatives for physician services included:

[7] NOTE: These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness’ *Alberta Health Care Insurance Plan, Statistical Supplement 2000-2001.*

- an increase of $42.8 million (4.7 percent) for physician services;
- an increase of 2.2 million (16.7 percent) for rural initiatives to continue to enhance efforts to recruit and retain physicians for rural Alberta;
- a $6.6 million increase for post-graduate medical education training; and
- eight entry-level seats will be reserved for international medical graduates who are Alberta residents.

In 2000-2001, $260 million in funding was identified to add new long-term care beds and replace or renovate existing health facilities in the Province.

5.4 Physician Compensation

On April 20, 1998 Alberta Health and Wellness and the Alberta Medical Association signed a five-year master agreement governing the provision of physician services to Albertans for the period 1998 to 2004. All prior agreements were terminated and superseded by this new agreement. The Agreement covers three years of financial arrangements, 1998-1999 to 2001-2002, under which Alberta Health and Wellness provides an adjustable hard cap to pay for the fee-for-service billings by physicians and a number of physician benefit programs. The agreement was ratified by a majority of the Alberta Medical Association membership.

In January 2001, Alberta Health and Wellness and the Alberta Medical Association entered into an "amending agreement" to the April 20, 1998 Master Agreement. The terms of this amending agreement are in effect from April 1, 2001 to March 31, 2003, unless another effective date is expressed in any term of the Amending Agreement. Among other things, the Amending Agreement sets the Medical Service Budget for the 2001-2002 and 2002-2003 fiscal years, as well as the percentage to be used for estimating increases in population, when making adjustments to the adjustable hard-cap portion of the Medical Service Budget.

A Medical Services Delivery Innovation Fund to support the development of Alternate Payment Plans was also established by the Amending Agreement, as well as a Specialist On-Call Program to compensate specialist physicians for being on call and to enable to meet their responsibility of ensuring patients have the required access to specialist physicians. Under the terms of the Amending Agreement, Alberta Health and Wellness also committed to establishing an "On-Call Contingency Fund" to become effective April 1, 2002, for the purposes of funding changes that may arise from the review and evaluation of the effectiveness of Alberta physician on-call programs.

Section 4(1) of the *Alberta Health Care Insurance Act,* provides the authority for the Minister to pay benefits in respect of health services provided to residents of Alberta. There were no changes made to this legislation in 2000-2001.

Fee Structures

Most physicians in Alberta are paid on a fee-for-service basis for providing insured services. Some physicians find the fee-for-service funding and payment model to be restrictive. The Department and the Alberta Medical Association are working with health authorities, facilities and physicians to develop a number of Alternate Payment Plan (APP) projects as alternatives to fee-for-service. To date, the joint AMA/AHW APP Subcommittee has developed four new funding models. As with fee-for-service, APPs are funded from the Department's Medical Services Budget and **are not reflected in Annex A of this report** (see *Provincial and Territorial Health Care Insurance Plan Statistics*). In some circumstances, APP funding and fee-for-service may be blended in order to compensate physicians for services that are not part of the arrangement. APP projects may also be eligible for grant funding to help offset certain project-related expenses.

Four funding models have been developed by the APP Subcommittee.

- **Capitation** funding is generally associated with the delivery of primary medical care. Per capita funding is provided for the comprehensive care of each patient over a set period of time. The capitation rate is calculated by taking a number of factors into account, including patient age and gender and the pre-determined range of services to be offered by the practice.

- **Sessional** funding is based on units of time (e.g. hourly or daily) spent in the provision of defined insured medical services within an organized structure of program. Sessional funding arrangements must be part of a regional health authority program, and must adhere to a set service delivery model.
- **Contractual** funding is provided as a lump sum for the provision of a pre-determined volume of insured medical services over a specified period of time, such as a year (e.g. X dollars paid for 100 patient encounters or for performing 500 procedures of a certain type).
- **Block Funding** is a negotiated amount paid to a group of physicians to provide all insured services in a specific area of medical practice over a significant period of time (e.g. X dollars for the provision of all neurosurgical services in Northern Alberta over a three-year period).

5.5 Payments to Hospitals

The *Regional Health Authorities Act* sets out the requirements for the establishment and governance of Alberta regional health authorities.

In accordance with Section 8 of the *Regional Health Authorities Act*, the authority must submit a proposal for a health plan for the region to the Minister. This proposal must contain a statement as to how the authority proposes to carry out its responsibilities and measure its performance in the carrying out of those responsibilities, as well as information respecting health services to be provided and the anticipated cost of providing those services.

Regional health authorities are funded by the provincial government using a population-based funding formula. Additional funding is also provided to Edmonton and Calgary health authorities for the provision of specialised tertiary services (Province Wide Services) to all Albertans. In 2000-2001, $3.1 billion dollars in population-based block funding including Province Wide Services was provided to the regional health authorities.

Regional health authorities are accountable and report to the Minister of Health and Wellness. The Minister has the authority to request records, reports and returns from the regions, as well as an annual report on its activities. The annual reports are subsequently presented to the Legislative Assembly by the Minister and are included in the *Alberta Ministry of Health and Wellness Annual Report.*

There were no changes made to this legislation in 2000-2001.

6.0 Recognition given to Federal Transfers

The Alberta government publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2000-2001 Income Statement, the three-year business plan and on a schedule of revenues in the Department's financial statements. These transfers are also listed in the Ministry's Annual Report and Statistical Supplement. All of these documents are available to the public, either through the Queen's Printers, on our website at www.health.gov.ab.ca, or at some public libraries throughout the Province.

7.0 Extended Health Care Services

Alberta's Long Term Care Centres provide room and board and a range of care services, from personal care with nursing supervision to skilled medical and therapeutic services. In most instances, these auxiliary hospitals and nursing homes are referred to as Continuing Care Centres and meet the needs of residents with similar care requirements. Funding for Continuing Care Centres has been transferred to the 17 regional health authorities. Regional health authorities either operate the Continuing Care Centres or sign contracts with voluntary or private operators to deliver these services.

The Home Care Program is also delivered through the regional health authorities and provides a variety of professional health support services to assist individuals of all ages to return or remain at home. All Home Care

Programs provide assessment, case co-ordination and nursing and support services such as personal care and home support. Other services may include occupational, physical and respiratory therapy, speech-language pathology, social work and nutrition services.

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

Alberta Aids to Daily Living

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

Alberta Mental Health Board, Mental Health Services

Mental health services delivered by the Alberta Mental Health Board (AMHB) include community clinics, two mental health hospitals, two care centres, 67 community mental health clinics and three satellite offices, as well as various non-profit community agencies. Services provided by the clinics include assessment and treatment of individuals and families and consultation to physicians, health facilities, health units, schools and community agencies. Two mental health hospitals provide assessment, treatment and rehabilitation for adults with mental illnesses, including mentally ill offenders, and for adults with brain injuries.

Two residential care centres provide long-term rehabilitation programs for people with severe mental illness. The AMHB also provides the governance function for four mental health provincial programs: Forensic Psychiatry, Geriatric Psychiatry, Adult Tertiary Care and Brain Injury.

Other mental health services provided by regional health authorities include specialized psychiatric services located in 17 hospitals throughout the Province. Family physicians, Home Care Programs and Continuing Care Centres also provide services to people with mental illness.

Alberta Cancer Board

In 2000-2001, the Department provided $123.8 million to the Alberta Cancer Board to support its operating and various research programs.

Additional Materials Submitted to Health Canada

Lists of uninsured hospital, physician and surgical-dental services:

- *Schedule of Medical Benefits, 2001*;
- *Schedule of Oral and Maxillofacial Surgery Benefits, 2001*;
- Reports of the Auditor General of Alberta for 1999-2000 and 2000-2001.

Office consolidations of all health care insurance legislation, as identified under the public administration section of our narrative, together with all relevant regulations:

- *Alberta Health Care Insurance Act*;
- Alberta Health Care Insurance Regulation;
- *Government Accountability Act*;
- *Health Care Protection Act*;
- Health Care Protection Regulation;
- *Health Insurance Premiums Act*;
- Health Insurance Premiums Regulation;
- Hospitalization Benefits Regulation;

- *Hospitals Act*;
- Hospital Foundation Regulation;
- Medical Benefits Regulation;
- *Medical Profession Act*;
- *Nursing Homes Act*;
- Nursing Homes General Regulation;
- *Regional Health Authorities Act;*
- Regional Health Authorities Regulation;

Reports giving recognition to federal contributions provided under the Canada Health and Social Transfer (CHST):

- *Alberta Health Care Insurance Plan Statistical Supplement, 1999-2000*;
- *Alberta Ministry of Health and Wellness Annual Report, 1999-2000*;
- *Ministry of Health and Wellness Three-Year Business Plan, 2001-2004*;
- Alberta Budget, 2000-2001.

British Columbia

Introduction

British Columbia has a progressive and integrated health care system. The British Columbia health system includes insured services under the *Canada Health Act* as well as services funded wholly by the Government of British Columbia. It is based on regional delivery and self-regulating professional colleges providing quality, accessible and affordable health care. Health authorities are responsible for the delivery and management of health services in each community of British Columbia. As of March 31, 2001, the health authorities included 11 Regional Health Boards, 34 Community Health Councils and 7 Community Health Services Societies across the Province. Health care is a top priority for the Government and people of British Columbia. The delivery of health care in the Province includes wholly and partially funded health services, as well as services regulated but not funded by the Government.

Activities for 2000-2001

During 2000-2001, the Ministry of Health focussed on ensuring the delivery of timely, quality health services in British Columbia. A critical issue in this regard was keeping the health system supplied with doctors, nurses and other care providers where they were needed. The provincial health system also focussed on meeting the needs of an aging population and developing innovative ways of meeting the increasing requirements for a system that is responsive to, and respectful of, seniors. The need to meet these challenges led the Government to build stronger partnerships among the Ministry of Health, health authorities and key stakeholders and to find new and effective ways of delivering the high quality, accessible care that people need.

A number of measures were undertaken in 2000-2001 to improve access and to reduce waiting times for insured hospital services. Utilizing in part monies received from the federal government, British Columbia acquired 15 CT scanners and 11 MRI scanners. This brings the total number of MRI scanners from 7 to 16, more than doubling the Province's capacity.

A wide range of capital projects were funded to provide new and improved health care facilities.

Changes in 2001-2002

On June 5, 2001, the Ministry of Health and Ministry Responsible for Seniors was reorganized into two new ministries to meet health challenges and to enhance health care in British Columbia. The Ministry of Health Services provides funding, strategic direction and leadership to support the delivery of health care, preventive health and health promotion services in British Columbia. The Ministry of Health Planning supports the development of long-term planning necessary to sustain British Columbia's public health care system in the years ahead.

Information on health and health care in British Columbia is available from the following websites:

www.gov.bc.ca/healthservices/

www.gov.bc.ca/healthplanning/

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, by the Regional Programs Division of the Ministry of Health. This program is responsible to the provincial

government for the ongoing funding of the Province's public hospitals, delivered via funding and transfer agreements with regionalized health authorities, under the terms of the *Hospital Act,* the *Hospital Insurance Act*, and the *Hospital District Act*. This entails expenditures and commitment controls for the operation of hospitals (amalgamated and non-amalgamated) and designated facility societies, provision of funds for hospital construction and equipment, and payment of out-of-province hospital costs for qualified British Columbia residents.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health Services and facilitates, in the manner provided for under the *Medicare Protection Act* (1996), reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is carried out by the employees of the Medical Services Plan program of the Ministry of Health Services.

The Commission's powers include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, negotiating agreements with practitioners and their associations, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing or investigating practitioner billings and patterns of practise concerning claims submitted, and hearing appeals from practitioners and beneficiaries.

1.2 Reporting Relationship

Health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health in accordance with provincial policy. Non-amalgamated hospitals are required to report health information data to the Ministry of Health in accordance with provincial policy, and to their health authority as requested by the health authority. The Regional Programs Division reports to government through the *Ministry of Health Annual Report*.

The Medical Services Commission reports annually to the Minister in a separate Financial Statement. The statement is included in the *Ministry of Health Annual Report* to government. The 1999-2000 Annual Report was tabled February 9, 2001.

In its annual performance report, the Ministry of Health provides extensive information on the performance of B.C.'s publicly-funded health care system. Tracking and reporting this information is consistent with the Ministry's increasingly strategic approach and its responsibilities for performance planning and reporting, under the *Budget Transparency and Accountability Act*.

1.3 Audit of Accounts

The Regional Programs Division and the Medical Services Commission are subject to audit of their accounts and financial transactions through three types of auditor. Internally, the Ministry of Health Financial Policy and Monitoring Branch reviews Ministry operations.

The Office of the Comptroller General's Internal Audit Branch is the provincial government's internal auditor and the Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the findings. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry of Health. The Ministry's Senior Financial Officer determines the scope and timing of reviews conducted by the Financial Policy and Monitoring Branch.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided in facilities specified in the *Hospital Insurance Act*. In 2000-2001 there were 94 acute care hospitals, 3 rehabilitation hospitals, 18 free-standing extended care hospitals and 25 diagnostic and treatment and other health centres.

Insured in-patient services provided by hospitals are:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister;
- clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the Hospital Insurance Act;
- routine surgical supplies;
- use of operating room and case room facilities;
- anaesthetic equipment and supplies;
- use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- other services approved by the Minister that are rendered by persons who receive remuneration from the hospital.

Qualified persons not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Hospital out-patient benefits include:

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

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

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

In 2000-2001, no new services were added to the list of insured hospital services covered by the *Hospital Insurance Act.*

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act (1996)*. The Medical Services Plan provides for all medically required services of medical practitioners. The broad category of services covered includes consultations; complete examinations; home visits; major and minor surgery; obstetric services; surgical assistance; anaesthesia; diagnostic/therapeutic procedures; special and miscellaneous services; other office procedures; and other hospital procedures performed by a physician.

To practise in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the Medical Services Plan. There were 7,658 physicians

enrolled and billing fee-for-service in the fiscal year 2000-2001 as of March 2001. In addition, some physicians practice solely on salary or receive sessional payments under alternative payments. Most physicians paid by alternative mechanisms also practise on a fee-for-service basis.

A physician can choose not to enroll or to de-enroll with the Commission. An enrolled physician can cancel their enrolment by giving 30 days' written notice to the Commission. Services provided by un-enrolled physicians are not benefits and patients are responsible for the full cost of the service.

There was one previously enrolled physician who had de-enrolled as of March 31, 2000.

Enrolled physicians can elect to be paid directly by beneficiaries by giving written notice to Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries can apply to the Medical Services Plan for reimbursement of the fee for insured services rendered. Only eight physicians have opted out as of March 2001.

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental or oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Any dental or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan who is providing one or more of the limited insured dental surgical services in a hospital may provide an insured dental-surgical service. There were 283 dental surgeons and three oral surgeons enrolled in 2000-2001. None have de-enrolled and none have opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are:

- diagnostic out-patient services not associated with emergency services;
- the services of medical personnel not employed by the hospital;
- treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
- services solely for the alteration of appearance; and
- reversal of sterilization procedures.

Uninsured hospital services also include:

- preferred accommodation at the patient's request;
- televisions, telephones and private nursing services;
- preferred medical/surgical supplies;
- dental care that could be provided in a dental office including prosthetic and orthodontic services; and
- preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan are:

- those covered by the *Workers' Compensation Act* or by other federal or provincial legislation;
- provision of non-implanted prostheses;
- orthotic devices;
- proprietary or patent medicines;
- any third-party request for a medical examination or certificate;
- oral surgery rendered in a dentist's office;
- acupuncture;
- group immunizations;
- telephone advice;
- reversal of sterilization procedures;
- *in-vitro* fertilization;
- medico-legal services;

- cosmetic services; and
- preventive medical counselling, for example, smoking withdrawal programs.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services. The status of the patient as a beneficiary of a third-party payer should not affect this determination. In this way, third parties are not given priority access to insured services over insured persons.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the Act prohibits persons from charging a beneficiary "for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry of Health responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the Ministry.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee.

3.0 Universality

3.1 Eligibility

For insured hospital services the eligibility terms and requirements are set out in the *Hospital Insurance Act*, sections 2, 3, 4, 6, and 7 and the Hospital Insurance Act Regulations sections 1, 3, 4 and 9.3. Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry's Acute Care Policy Manual.

The *Medicare Protection Act* defines the eligibility and enrolment of beneficiaries of insured physician services. The Act's regulations (Medical and Health Care Services Regulations) detail residency requirements in Part 2. A person must be a resident of British Columbia in order to qualify for provincial health care benefits. The *Medicare Protection Act* defines a resident as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under the Regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage.

The Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

As of April 1, 1998, residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enroll. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the Province. Each person who enrolls with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrolment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries may cover their dependants, provided the dependants are residents of the Province. Dependants include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward under the age of 19 supported by the beneficiary, or a child under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2000 was 4.02 million. Enrolment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2001, 150 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible. Individuals who are approved for refugee status and who are, therefore entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits**.** Holders of Minister's Permits are eligible for benefits where deemed to be residents under the Medical and Health Care Services Regulation. A waiting period applies.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for the Medical Services Plan are $36 for one person, $64 for a family of two, and $72 for a family of three or more. Residents with limited means may be eligible for premium assistance. There are five levels of assistance, ranging from 20 percent to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have been resident in Canada and a Canadian citizen or holder of permanent resident status (landed immigrant).

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2001 the maximum non-subsidized rate was $50 a day. Residents with limited means are eligible for assistance, on a sliding scale, being 85 percent of the Old Age Security and Guaranteed Income Supplement. In certain circumstances there is a provision to waive a portion of the $25.90 fee. Client rates of less than $50 per day are reviewed quarterly and patients are advised one month before any changes are made.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

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

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions during temporary absences from British Columbia but still residing within Canada with regard to insured physician services. Section 17 of the *Hospital Insurance Act* empowers the Minister of Health to enter into an agreement with any other province or territory to

bring about a high degree of liaison and cooperation between the provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the Province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their home in British Columbia. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

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

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

The Financial Administration section of the Acute Care Policy Manual sets out the specific details of the current inter-provincial or territorial reciprocal billing agreement for insured hospital services. Each provincial hospital insurance plan will process hospital in-patient and out-patient accounts on behalf of the residents of the other provinces and territories, with the exception of Quebec, which is not a signatory to the Agreement. The Agreement covers benefits rendered within provincial or territorial boundaries and makes provision for the periodic settling of accounts between provinces and territories.

4.3 Coverage During Temporary Absences Outside Canada

The *Hospital Insurance Act* Regulations and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until the last day of the month in which the person ceased full-time attendance at that educational institution, or if studying outside Canada, the last day of the sixtieth month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence, if this person obtains prior approval from the Commission, does not establish residency outside BC and has not been granted approval for a similar absence during the preceding 60 months.

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

Out-of-country medical services are covered for emergency or sudden illness during temporary absences from the Province. These are paid up to the same fee payable for that service, had it been performed in British Columbia. Cases

pre-authorized because of extenuating circumstances, however, are paid at the rate applicable where the service is rendered. With prior authorization, payment for non-emergency medical services outside the country may be made at usual and customary rates, when the appropriate treatment is not available in the Province or elsewhere in Canada.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the inter-provincial reciprocal agreements with other provinces. Prior approval from the Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of Regional Programs (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require approval from the Commission prior to the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes that all residents have reasonable access to hospital and medical care services. Beneficiaries, as defined in the *Medicare Protection Act* and the Ministry's Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act,* section 17, prohibits extra-billing for medical services provided by enrolled physicians.

5.2 Access to Insured Hospital Services

In 2000-2001, there were 8,994 acute care beds in 94 acute care facilities, and 474 rehabilitation beds, of which 176 were located in three specialized rehabilitation care facilities. In addition, there were 25 diagnostic and treatment centres and six Red Cross Outposts.

The Province also provides access to care services for extended care patients. In 2000-2001, there were 17 free-standing extended care facilities. These care units and the associated beds in acute/rehabilitation hospitals provided a total of 9,102 extended care beds.

The number of practising Registered Nurses as of December 2000 was 28,616. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2000 there were 2,203 RPNs and 4,496 LPNs.

The "Capital Planning Requirements for Health Authorities" document defines the Ministry of Health's expectations of health authority capital planning. This document outlines the processes, policies, timelines, and roles and responsibilities related to health capital projects. The requirements apply to all types of health care facilities, community health centres, ambulance stations, and mental health facilities.

Capital planning needs to be consistent with the health authorities' visions, missions, needs assessment, priority issues, goals and strategies as outlined in their three-year health service plans. The health service plan, combined with the age and condition of the components of a health authority's physical inventory, will determine the direction for capital planning in a health authority area. Health Authorities submitted Capital Plans in June 2000 for the three-year period 2001-2004. The Capital Plans include the anticipated capital requirements for the three-year period within the context of the strategic direction of each health authority.

Government responsibility for health capital projects is shared between the Ministry of Health and the Ministry of Finance and Corporate Relations. The Ministry of Health is responsible for needs assessment and planning, while the Implementation Branch of the Ministry of Finance and Corporate Relations is responsible for project management, financial administration, and project delivery.

Regional hospital districts cost-share with the provincial government for a portion of the capital costs associated with health facilities that operate under the authority of the *Hospital*

Act. This contribution comes from taxpayers via property taxes levied by regional hospital district boards composed of municipal and electoral area directors under the authority of the *Regional Hospital District Act*.

A number of measures were undertaken in 2000-2001 to improve access and to reduce waiting times for insured hospital services. Utilizing in part monies received from the federal government, British Columbia acquired 15 CT scanners and 11 MRI scanners. This brings the total number of MRI scanners from 7 to 16, more than doubling the Province's capacity.

A wide range of capital projects were funded to provide new and improved health care facilities for British Columbians. Major projects undertaken by the Ministry of Health in the 2000-2001 fiscal year include the following:

- The B.C. Cancer Agency's new Vancouver Island Cancer Centre opened in March 2001. The new centre adds 20 percent more treatment capacity for Island residents and reduces service pressures in other cancer centres in the Province. The Ministry of Health contributed $39.3 million to build and equip the new centre. The Ministry also provided $1.9 million in start-up costs and $400,000 in one-time operational funding to enable the centre to open early, upon completion of construction.
- A new wing and children's health centre opened at Surrey Memorial Hospital. The new wing increases the number of operating rooms, in-patient beds and special-care basinettes in the nursery. The Ministry of Health provided total funding of $76.5 million required to complete the hospital addition.
- The new Ambulatory Care Building at B.C. Children's Hospital was under construction during the 2000-2001 fiscal year.
- Construction began to expand and redevelop the Prince George Regional Hospital. This project includes building a four-story medical surgical tower, adding more out-patient services, expanding the haemodialysis and paediatric units, and upgrading the emergency department.
- Work began at Trail Regional Hospital to expand ambulatory care facilities. The new $6.7 million unit will enable the hospital to deliver a wide range of out-patient services, including surgical day care, a surgical suite and an expanded emergency area.
- Work began on the $3.5 million renovation and expansion project at Golden and District General Hospital. Improvements to the hospital will include expanding and redeveloping emergency and main entry areas, as well as major mechanical and electrical upgrades.
- Eagle Ridge Manor, a new multi-level care addition to the Port Hardy Hospital, opened in July 2000. The manor will provide 24-hour care to residents in a home-like setting.
- Construction started on the new $5.6 million Cormorant Island Health Centre that will replace St. George's Hospital in Alert Bay. The centre will provide acute care and multi-level-care beds, diagnostic and treatment facilities, community health programs and support services.

Additionally, the Province has introduced the HealthGuide program. Initially, the Health Guide manual has been distributed to every household in British Columbia. Supporting this health user manual is an online knowledge base available to all persons with a BC personal health number, and a nurse line is available 24 hours a day, 7 days a week, toll-free throughout British Columbia.

5.3 Access to Insured Physician and Dental-Surgical Services

There were 4,360 General Practitioners, 3,298 Specialists and 283 Dentists who provided insured fee-for-service physician and dental-surgical services in 2000-2001.

The Ministry of Health initiated a Physician Recruitment and Retention Program to address workload and practice issues of doctors working in rural and remote areas of BC. Changes made to the Physician Recruitment and Retention Program included developing a new payment program for rural physicians. Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an

estimated 1,728 visits by family doctors and specialists to 61 rural communities. The Northern and Rural Locum Program assisted physicians practising in small communities to secure subsidized continuing medical education and vacation relief.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medial Association to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including salaried physicians. Other health care practitioners offering insured services have individual fee schedules approved by the appropriate special committees.

The Master Agreement between the Medical Services Commission, the Government of British Columbia and the British Columbia Medical Association, signed in December 1993, was extended until March 31, 2001. Key elements include a binding dispute resolution mechanism and participation by the Association and the Commission.

During 2000-2001, the Medical Services Plan's payments to physicians, supplementary benefit practitioners and program management in the Province totaled approximately $1.62 billion. For physician services provided out-of-province, including those within Canada and outside the country, the Plan paid approximately $35.8 million, of which approximately $4.5 million was for reciprocal payments to other provinces or territories.

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

The Medical Services Commission also funds certain medical services through alternative payment arrangements. An Alternative Payments Branch provides funding to some 360 health care agencies that retain physicians to deliver approved programs. Approximately 1,900 physicians have voluntarily entered into alternative payment arrangements with these agencies, and receive part or all of their income through salaries, sessions or service agreements. A variety of alternative payment arrangements are currently being explored, including population-based funding for family practice.

5.5 Payments to Hospitals

In 2000-2001, the total funding provided to Health Authorities was $4.8 billion, including funds for hospital, continuing care, health promotion and preventive health, and adult mental health programs. Payments to out-of-province hospitals, including those within Canada and outside the country, for insured services provided to British Columbia residents, totalled $4.5 million in 2000-2001.

6.0 Recognition

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of British Columbia through a various government websites and provincial government documents. For the fiscal year 2000-2001, these documents included the following:

- Public Accounts for 1999-2000 (Tabled August 14, 2000);
- Public Accounts for 2000-2001 (Tabled July 31, 2001);
- Budget 2001 (Tabled March 15, 2001);
- Ministry of Health and Ministry Responsible for Seniors Performance Plan 2000-2001 (Tabled April, 2000);
- *Ministry of Health and Ministry Responsible for Seniors Annual Report 2000-2001* (Tabled June, 2001).

7.0 Extended Health Care Services (EHCS)

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

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

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

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

Yukon

Overview

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director of Insured Health Services. References in this text to the "Plan" refer to either the YHCIP or the Yukon Hospital Insurance Services Plan.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services in accordance with the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. Coverage is provided to all eligible residents of the Yukon Territory. The Minister, Department of Health and Social Services, is responsible for the delivery of all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services, Insured Health Services and Community Health Programs. There are no regional health authorities. There were 31,133 eligible persons registered with the Yukon health care plan on March 31, 2001.

Other legislated insured services provided to eligible Yukon residents include the Travel for Medical Treatment Program, Chronic Disease and Disability Benefits Program; Pharmacare and Extended Benefits Programs; and the Children's Drug and Optical Program. Other non-insured programs include Public Health, Ambulance Services, Hearing Services, Health Promotion, Dental Health and Mental Health Services.

One of the major challenges facing the delivery of insured health care services in the Territory is the recruitment and retention of health care professionals such as general practitioners, specialists and nurses. The increasing cost of retaining health care professionals, operating hospitals and acquiring and maintaining new and advanced high-technology diagnostic and communication services has a direct impact on the ability of the Government of the Yukon to maintain or improve the existing level of services available to eligible residents.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, adopted April 1, 1972, sets out the legislative framework for the payment of insured physician services to eligible Yukon residents. The *Hospital Insurance Services Act*, adopted April 9, 1960, sets out the legislative framework for payment to hospitals i.e., amounts in respect of the cost of insured services provided by hospitals to insured persons.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate and function of the Director, Insured Health Services is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in the operation of the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of the

Yukon's right of subrogation under this Act to the rights of insured persons;

- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

Subject to the *Hospital Insurance Services Act* (section 6) and Regulations, the mandate and function of the Director, Insured Health Services is to:

- develop and administer the hospital insurance plan;
- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research programmes and obtain statistics for such purposes;
- appoint inspectors and auditors to examine and obtain information from hospital records, reports and accounts;
- prescribe the forms and records necessary to carry out the provisions of this Act; and
- perform such other functions and discharge such other duties as may be assigned by the Regulations.

There were no amendments made to the Legislation in 2000-2001.

1.2 Reporting Relationship

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health Services make an annual report to the Executive Council Member respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and is subject to discussion at that level.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report tabled in December 2001 covered the fiscal years 1998-1999, 1999-2000 and 2000-2001.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Auditor General's office. The Auditor General of Canada is the auditor of the Government of the Yukon in accordance with section 30 of the *Yukon Act* (Canada) and section 8(4)(e) of the *Financial Administration Act* (Yukon). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit was for the year ended March 31, 2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9 and sections 2, 4, 5, 9 and 11 of the Hospital Insurance Services Regulations, provide for insured hospital services. There were no amendments made to the Legislation in 2000-2001.

In 2000-2001, insured hospital services to in-patients and out-patients were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital[1] and twelve health centres[2]. Visiting nursing services are provided in one health station[3].

All services provided in a hospital by hospital employees are insured. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services.

Pursuant to the Hospital Insurance Services Regulations, section 2(e) and (f), services provided in an approved hospital are insured services. Section 2(e), defines "in-patient insured services" as all of the following services to in-patients, namely:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability;
- drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- use of radiotherapy facilities where available;
- use of physiotherapy facilities where available; and
- services rendered by persons who receive remuneration therefor from the hospital.

Section 2(f) of the same regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator provided the service could not be obtained within 24 hours of the accident, namely:

- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations of the purpose of assisting in the diagnosis and treatment of an injury;
- drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital;
- use of operating room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- services rendered by persons who receive remuneration therefor from the hospital;
- use of radiotherapy facilities where available; and
- use of physiotherapy facilities where available.

2.2 Insured Physician Services

Adopted on April 1, 1972, sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 4, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to the Legislation in 2000-2001.

The Yukon Health Care Insurance Plan covers physicians who provide medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are that they must:

- register for licensure pursuant to the *Medical Professions Act,* and

1 A facility that provides 24-hour emergency treatment, short-term admissions and respite care.

2 Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

3 A facility that serves as a clinic from which Community Nurse Practitioners provide services on a regularly scheduled basis.

- maintain licensure pursuant to the *Medical Professions Act*.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations states that "A medical practitioner may elect to collect his fees under the Plan for insured services rendered to insured persons otherwise than from the Plan without loss of benefit to insured persons by giving notice in writing of his election". In 2000-2001, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in the Yukon are defined as medically required services rendered by a medical practitioner. Services not insured by the Plan are listed in section 3 of the Regulations (see section 2.4). Services not covered by the Plan include advice by telephone, medical-legal services, preparation of records and reports, services required by a third party, cosmetic services, and services determined to be not medically required.

During the period April 1, 2000 to March 31, 2001 the following services were added to the list of insured physician services covered by the Yukon Health Care Insurance Plan:

- management of prolonged second stage of labour (fee code 4199);
- repair of complete separation of external sphincter (fee code 4022);
- repair of extensive cervical and/or vaginal lacerations (fee code 4023);
- rheumatology consultation (fee code 3101);
- rheumatology repeat limited consultation (fee code 3102); and
- rheumatology office visit (fee code 3103).

The process used to add a physician service to the list of insured services covered by the Yukon Health Care Insurance Plan requires that physicians submit in writing a request to have a fee code added to the Relative Value Guide to Fees[4]. The request is then reviewed by the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee. Following review, a decision is made on whether to include or exclude the service. The costs or fees are normally set in accordance with costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. No public consultation is required in this process.

[4] Physician's fee guide manual.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the territory must be licensed pursuant to the *Dental Professions Act* and are provided billing numbers for the purpose of billing the Yukon Health Care Insurance Plan for the provision of insured dental services. In 2000-2001, six dentists, three oral surgeons and two orthodontists billed the Plan for insured dental services. No dentists opted out of the Yukon Health Care Insurance Plan in 2000-2001.

Insured dental services are limited to those surgical-dental procedures scheduled in the Regulations and requiring the unique capabilities of a hospital for their performance (e.g., surgical correction of prognathism or micrognathia). Insured surgical-dental services include:

- surgical removal of unerupted teeth;
- alveoloplasty and gingivolplasty;
- sulcus deepening and ridge construction;
- exposure of tooth for orthodontic treatment;
- treatment of traumatic injuries to soft tissues within the mouth;
- root resection;
- phrenectomy;
- excision of intra-oral cysts;
- excision of benign intra-oral tumours;
- sialolithotomy;
- excision of ranula;
- condylectomy;
- intra-oral biopsy;
- incision and drainage of abscess of dental origin;

- closed reduction of fractures of mandible and maxilla;
- open reductions of fractures of the mandible and maxilla;
- closed reduction of temporo-mandibular dislocation;
- open reduction of temporo-mandibular dislocation;
- removal of root or foreign body from maxillary antrum;
- repair and closure of antro-oral fistula;
- surgical correction of prognathism or micrognathia;
- therapeutic or diagnostic alcohol nerve block; and
- avulsion of nerve (mental, infra-orbital or interior dental).

In the case of children aged 16 years or under, the following surgical-dental services are also insured:

- oral surgery and orthodontia necessitated by, or consequent to the repair of, cleft palate or cleft lip deformity, only where that service arises as part of or following plastic surgical repair;
- surgical removal of erupted, unerupted or impacted teeth; and
- such other dental care procedures as determined to be medically necessary by the Director of Insured Health Services.

The addition of new surgical-dental services to the list of insured services requires amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured. See "Additional Materials" for a complete listing.

Uninsured physician services include:

- services that are not medically necessary;
- charges for long-distance telephone calls;
- preparing or providing a drug;
- case conference;
- advice by telephone at the request of the insured person;
- medico-legal services including examinations and reports;
- cosmetic services;
- acupuncture;
- experimental procedures.

Section 3 of the Yukon Health Care Insurance Plan Regulations contains a non-exhaustive list of services that are prescribed as non-insured.

Uninsured hospital services include non-resident hospital stays; additional charges for preferred accommodation unless prescribed by a physician; private nursing charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services are services considered to be restorative.

All Yukon residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Health and Safety Board are not given priority access to services. The Territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health Services to monitor usage and service concerns.

The purchase of non-insured services such as fibreglass casts does not delay or prevent access to insured services at any time. Insured persons are provided treatment options at the time of service. The territory has no formal process in place to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health Services to monitor usage and service concerns.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows.

- **Physician services** - the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Relative Value Guide to Fees, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service all physicians are provided notification in writing. The Director, Insured Health Services manages this process.
- **Hospital services** - an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2001, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. The Director, Insured Health Services is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- **Dental-surgical services** - an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required.

No services were removed from the Relative Value Guide to Fees in fiscal year 2000-2001.

3.0 Universality

3.1 Eligibility

For insured hospital services the eligibility terms and requirements are set out in the *Health Care Insurance Plan Act*, section 2; the *Health Care Insurance Plan Act* and Regulations, section 4; the *Hospital Insurance Services Act*, section 2; and the *Hospital Insurance Services Act* and Regulations, section 4. Subject to the provisions of these Acts and their regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and "means a person lawfully entitled to be or to remain in Canada, who makes his home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon."

Under section 4.(1) of both health care insurance regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory."

Residents ineligible for coverage are those residents who are entitled to or eligible for benefits under any other act, under any law of a province or under any act of the Canadian Parliament other than the *Canada Health Act*, are not entitled to benefits. This includes but is not limited to members of the Canadian Forces; members of the Royal Canadian Mounted Police (RCMP); and inmates in federal penitentiaries.

Persons who provide documentation indicating the date of discharge or release from the RCMP, armed forces or a federal penitentiary become eligible for coverage under the Yukon Health Care Insurance Plan on the day following the documented date.

3.2 Registration Requirements

Persons moving to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form, which is available from the Insured Health Services office or community Territorial Agents. Once approved, a health care card is mailed to the applicant. Family members receive separate health care cards and numbers. Coverage expires every year on the resident's birthday and an updated label, with the new expiry date is mailed out each year.

If other family members move to the Yukon in advance of a remaining spouse residing elsewhere in Canada, the originating province or territory will cover all family members to a maximum of 12 months, in accordance with the Interprovincial Agreement on Eligibility and Portability.

As of March 31, 2001, there were 31,133 residents registered with the Yukon Health Care Insurance Plan.

Section 16 of the *Health Care Insurance Plan Act* states: "Every resident other than a dependant or a person exempted by the regulations from so doing, shall register himself and his dependants with the Director, Insured Health Services, at the place and in the manner and form and at the times prescribed by the regulations."

3.3 Other Categories of Individual

Conditions regarding eligibility for coverage applying to special categories of individuals are as follows:

- returning Canadians and landed immigrants: no waiting period (section 4(3) Yukon Health Care Insurance Plan Regulations and section 4(3) Yukon Hospital Insurance Services Regulations);
- authorized Minister's Permit: no waiting period if eligible;
- Convention Refugees: eligible if the individual has an Employment Authorization for one year; and
- authorized Temporary Residents (e.g., Employment Authorizations and permits other than Minister's permits: no waiting period).

There were four individuals residing in the Yukon with work visas as of March 31, 2001.

3.4 Premiums

Yukon residents pay no premiums.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to the Yukon from another province or territory are entitled to coverage pursuant to section 4.(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations. Section 4.(1) states that "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

4.2 Coverage During Temporary Absences In Canada

The provisions relating to portability of health care insurance during temporary absences in Canada are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies (confirmation of registration is required yearly). The Director, Insured Health Services may approve other absences in excess of 12 continuous months upon receipt of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director. For temporary workers, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. For missionaries, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt

of a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health Services.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability effective January 1, 1998. Definitions have been rendered consistent in regulations, policies and procedures.

Yukon participates fully with the Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories (Quebec does not participate in the medical reciprocal billing arrangement). Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals for the fiscal year 2000-2001.

In-patient services	Out-patient services
$4,220,525	$857,580

Note: figures are by date of service and are not final[5]

In 2000-2001 payments to out-of-territory physicians totalled $1,660,572. (Includes out-of-Canada costs and is by payment date.)

The Hospital Reciprocal Billing Agreements provide payment of in-patient and out-patient hospital services to eligible Yukon residents receiving insured services outside the territory. High-cost procedure rates, newborn rates and out-patient rates are derived by the Federal/ Provincial/Territorial Coordinating Committee on Reciprocal Billing. These rates are established by Order-in-Council under the Charges for Out-Patient Procedures Regulation, Standard Ward Rates Regulation and Charges for In-Patient High-Cost Procedures Regulation.

The Medical Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Yukon residents receiving insured services outside the Territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

Sections 5 and 6 state that "Where an insured person is absent from the territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

The provisions for portability of health insurance during out-of-country absences are similar to those in effect for absences within Canada as described under section 4.2. Similar provisions also apply for out-of-country students, temporary workers and missionaries.

Students attending educational institutions outside the territory remain eligible for the duration of their academic studies (confirmation of registration is required yearly). With regard to temporary workers, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. For missionaries, the Director, Insured Health Services may approve absences in excess of 12 continuous months upon receipt of a written request from the insured person. All requests for extensions must be renewed yearly and are subject to approval by the Director, Insured Health Services.

[5] Out-of-country costs are reported under lines 22 and 23 in the Yukon section of Annex A – Provincial and Territorial Health Care Insurance Plan Statistics.

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in the Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital. Reimbursement is made for elective and emergency services. Exceptions may be made where the services received are not available in Canada. Remuneration is based on the standard ward rate of the nearest approved facility in Canada providing similar services. Prior approval is required. The standard ward rate for the Whitehorse General Hospital as of March 31, 2001 was $989. The rate is established through Order-in-Council and is derived as follows:

- Standard Ward Rate = (total operating expenses - non-related in-patient costs - related newborn costs - associated out-patient costs) / (total patient days - patient days for other services, ex. non-Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $110 and is established through Order-in-Council and is derived by the Canadian Coordinating Committee on Reciprocal Billing (CCRB).

The following amounts were paid for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient services	Out-patient services
$20,597	$8,368

Note: 2000-2001 figures are by service date and are not final.

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency services outside Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. Access to specialists and services not available locally are available through a visiting medical specialist program and a publicly funded travel for medical treatment program. There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Hospital beds are readily available and no wait-list for admission exists. The Yukon's main acute-care facility, the Whitehorse General Hospital, is located in Whitehorse. Beds staffed and in operation as of March 31, 2001 totaled 49. Eight additional acute care beds can be made available, should future occupancy trends indicate a need. The Yukon has no rehabilitative beds. Patients are referred out-of-territory for these services – usually to Vancouver or Edmonton.

The Whitehorse General Hospital currently employs 103 nurses, representing 72¾ full-time equivalent (FTE) positions. A full complement requires 75¾ FTE positions.

The Whitehorse General Hospital provides in-patient, out-patient, and 24-hour emergency services. Emergency services are provided on rotation by local physicians. Medical services provided include:

- intensive care services (surgical and cardiac);
- respiratory services (chronic obstructive pulmonary diseases, asthma etc.);
- cardio vascular accidents;
- maternity;
- gastro-intestinal bleeds;
- cellulitis;

- chemotherapy;
- hypertension, and
- general failure to thrive/weakness.

Surgical services provided include:

- minor orthopaedics;
- gynaecology;
- paediatrics;
- general abdominal;
- mastectomy;
- emergency trauma;
- ear/nose/throat/otolaryngology;
- ophthalmology including cataracts.

Patients requiring specialized surgeries are sent to outside centres.

Diagnostic services include:

- radiology;
- laboratory;
- mammography, and
- electrocardiogram.

Rehabilitative services are limited.

There is no wait-list for admission to the Whitehorse General Hospital. Emergency day surgery patients are normally seen within 24 hours. Non-emergency day and routine surgery patients are normally seen within one to two weeks. Visiting specialist clinics are routinely increased to reduce wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3). For services not available locally, the Visiting Specialist Program provides services and the Travel for Medical Treatment Program is available to assist eligible persons with the cost of medically necessary transportation for emergency and non-emergency insured services.

A second acute care facility is located in Watson Lake — the Watson Lake Cottage Hospital. There are 12 beds and there is no wait-list for admission.

Other than the Whitehorse General Hospital and the Watson Lake Cottage Hospital, only the Dawson Health Centre provides limited in-patient services. Out-patient and 24-hour emergency services are provided by all 12 community health centres. Health centres are staffed by one or more Community Nurse Practitioners and auxiliary staff. The communities of Whitehorse, Faro, Mayo, Watson Lake and Dawson City have resident physicians.

In April 1998 the Yukon departments of Health and Social Services and Government Services, together with NorthwesTel, successfully applied to the Canadian Network for the Advancement of Research, Industry and Education (CANARIE) for funding to pilot a telemedicine project in Dawson City, Ross River and Teslin. The purpose was to enable the departments to test the use of telemedicine in improving accessibility to medical services and thereby improving quality of care. The pilot began in July 1998 and was completed on June 30, 1999.

Based on the success of the 1998 telemedicine project, application for funding has been made to the Canada Health Infostructure Partnerships Program (CHIPP), to implement real-time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta. CHIPP recently approved $1 million in funding for this project, which will run from September 1, 2001 to March 31, 2003.

5.3 Access to Insured Physician and Dental-Surgical Services

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2001:

General Practitioners/Family Practitioners	43
Specialists	6
Dentists	11

The following specialists provide services under the Visiting Specialist Program:

Ophthalmology	1
Oncology	3
Orthopaedics	4
Internal Medicine	1
Otolaryngology	2
Neurology	1
Rheumatology	1
Dermatology	1
Dental Surgery	1
Infectious Disease	1
Child Psychiatrist	1

Visiting specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2001, the wait-list for non-emergency specialist services was estimated at:

Ophthalmology	0-6 months
Orthopaedics	6-12 months
Otolaryngology	8-10 months
Dental Surgery	2-3 months

Most physicians in the Yukon are located in Whitehorse. Outside Whitehorse only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two contracted physicians have been placed in the communities of Faro and Mayo.

A visiting physician program provides access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians who provide visiting services are compensated for lost practice time, mileage, meals and accommodation.

The Travel for Medical Treatment Program assists eligible residents with the cost of medically necessary transportation from rural areas to access physician and hospital services that are not available locally.

The Department of Health and Social Services and the Yukon Medical Association (YMA) are in discussion on strategies that will address the current need for physicians and locums in Yukon. Several options are under consideration.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, prior to entering negotiations with the YMA. The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department of Health and Social Services seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent negotiations were concluded on December 14, 1999. The resulting Memorandum of Understanding is effective from April 1, 1999 through March 31, 2002.

The Legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. Currently, two full-time rural physicians are compensated on a contractual basis and one physician providing visiting clinics in an outlying community is paid a flat sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital), through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated based on operational requirements and utilization projections for prior years. The current one-year contribution agreement is in effect to March 31, 2002.

In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded through a contribution agreement. The cottage hospital and all health centres are funded through the Yukon Government's budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and Hospital Insurance Services Plan Regulations. The legislation and regulations set out the legislative framework for payment to hospitals of amounts in respect of the cost of insured services provided by that hospital to insured persons.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon Territory has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2000-2001 annual Main Estimates and Public Accounts publications, which are available publicly to Yukon residents.

7.0 Extended Health Care Services

Extended Health Care Services are available to eligible Yukon residents. In 2000-2001, the Yukon provided the following range of extended health care services:

- nursing home intermediate care services;
- adult residential care services;
- home care services; and
- ambulatory health care services.

The following details the types of services provided by facility and program:

MacDonald Lodge
- adult residential care
- home care

Macaulay Lodge
- nursing home intermediate care
- home care

Thompson Centre
- nursing home intermediate care
- ambulatory health care
- home care

Yukon Home Care Program
- home care
- ambulatory health care

No major changes were made in the administration of these services in 2000-2001.

In addition to the services described above, the following are also available to eligible Yukon residents:

The Chronic Disease and Disability Benefits Program: provides benefits for Yukon residents who have specific chronic diseases or serious functional disabilities: coverage of related prescription drugs and medical-surgical supplies and equipment. (Chronic Disease and Disability Benefits Regulation)

The Pharmacare Program and Extended Benefits Programs are designed to assist registered senior citizens with the cost of prescription drugs, dental care, eye care, hearing services, and medical-surgical supplies and equipment. (Pharmacare Plan Regulation and Extended Health Care Plan Regulation)

The Travel for Medical Treatment Program assists eligible Yukon residents with the cost of emergency and non-emergency medically necessary air and ground transportation. (*Travel for Medical Treatment Act* and Travel for Medical Treatment Regulation)

The Children's Drug and Optical Program is designed to assist low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 years of age and younger. (Children's Drug and Optical Program Regulation)

Public Health is designed to promote health and well-being throughout the territory through a variety of preventive and education programs. This is a non-legislated program.

The Ambulance Services Program is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the nearest health care facility capable of providing the required level of care. This is a non-legislated program.

Hearing Services provides services designed to help people of all ages with a variety of hearing disorders, through the provision of routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.

Dental Services provides a comprehensive diagnostic, preventative and restorative dental service to children from pre-school age to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for pre-school age to grade 12. This is a non-legislated program.

Mental Health Services provides assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. This is a non-legislated program.

Additional Materials Submitted to Health Canada

Lists of uninsured hospital, physician and surgical-dental services

- *Health Care Insurance Plan Act* and Regulations
- *Hospital Insurance Services Act* and Regulations
- Statement of Revenue and Expenditures: Health Care Insurance Programs
- Yukon Public Accounts – Excerpt of the Auditor General's Report, 1998-1999
- Yukon Public Accounts – Excerpt of consolidated Financial Statements, 1998-1999
- Yukon Budget, 2000-2001

Northwest Territories

Overview

The Northwest Territories Department of Health and Social Services, together with nine health and social services boards, offer a broad range of programs and services in family support, child protection, public health, home care, independent living, community wellness, environmental health, vital statistics insured services and supplementary health benefits. While insured services include medical care and hospital care, there are a number of other supplementary benefits such as pharmacare, medical travel and extended medical benefits for seniors. The NWT Department of Health and Social Services takes a community-based approach to service delivery. Health and Social Services boards deliver a full spectrum of community and institutional health services. Nurses are the largest group of health care practitioners in the Northwest Territories (NWT). In most communities, community health nurses are the access point to health care at community health centres. Health centres provide regular and emergency outpatient treatment services, a full public health program and consult with physicians as needed. Social workers provide community-based social services, including counselling, crisis intervention and child welfare programs.

In larger communities such as Yellowknife and Inuvik, physicians are often the public's first point of contact with the health care system. Other communities are visited regularly by a general practitioner and at times by a specialist.

Specialists are based at Stanton Regional Hospital in Yellowknife, or at hospitals in southern Canada. Stanton resident specialties include obstetrics/gynaecology, internal medicine, paediatrics, orthopaedics, ophthalmology, ear, nose and throat, radiology, general surgery and psychiatry. Special visiting clinics, such as urology and cardiology, offer additional consultant services for patients referred from outlying communities.

Changing Demographics

As of July 1, 2000, there were an estimated 42,083 people in the Northwest Territories, of which 21,320 were aboriginal people. The NWT has a relatively young population and a high birth rate. According to the 2000 census, approximately 27 percent of the NWT population is less than 15 years of age, compared with 19 percent in the overall Canadian population. This population profile points to a need to invest in services that target children, youth and young families.

Although the territorial population is comparatively young, it is nonetheless aging. By 2020, the number of seniors 65 years of age and older is expected to rise from approximately 1,700 to over 4,400, representing an increase of 160 percent. In contrast, the population under 20 years of age is expected to increase by only 15 percent over the same time period. On average, seniors require more health services than any other age group, including newborns. The demand for health resources among seniors is more than five times that of the population under 65. This relates to higher rates of cancer, circulatory diseases, nervous system and sense organ diseases, injuries and respiratory diseases compared with the population as a whole.

Changing Economic Conditions

Changes in the economic situation in the North have an impact on the health and well-being of residents. Income from increased employment opportunities, especially in the areas of mining and oil and gas exploration, has a positive impact on the economy. Increased disposable income can result in improved nutrition, safety, and security for families. However, changing economic conditions can also cause stress that may lead to an increase in social problems such as abuse of alcohol or gambling. Unstable employment is distressing and can affect physical, mental and social well-being. Studies have shown that the unemployed have a reduced life expectancy and suffer more health problems than the employed. In our smaller

communities, low household income levels and reduced employment opportunities combined with poor housing conditions create stress and unhealthy living conditions.

Incidence of Preventable Illness, Injury and Death

Compared with the rest of Canada, the incidence of preventable illness, injury and death is high in the Northwest Territories (*1999 Health Status Report*). Adverse outcomes such as family violence, Fetal Alcohol Syndrome/Effects (FAS/E) and most forms of cancer are linked to poor lifestyle choices made by individuals regarding diet or the use of alcohol, tobacco and drugs. Injuries and deaths are the result of risky behaviour. The underlying causes of many acute or long-term care needs are linked to poverty, low educational achievements, unemployment, and low self-esteem, all of which can lead to poor coping skills.

Tobacco use, in particular, has become an acute public health concern. Smoking rates in the NWT are among the highest in Canada. The implications for health care costs and human costs in terms of death and disability are significant and rising.

Rises in Health Care and Social Services Costs

Factors such as demographics, new technologies and medical practices, increased incidence of chronic and new diseases, use of recently developed and more expensive pharmaceuticals, and changing expectations of citizens have all contributed to an increased demand for resources.

In the Northwest Territories, population growth and inflation have also contributed to an increase in costs to deliver health and social services — in other words, delivery of the same set of core services this year costs more than it did last year. Increasing costs continue to place pressure on the system. The Government of the Northwest Territories can expect to face similar challenges.

Maintaining a Sustainable System

The delivery of health and social programs has been a subject of ongoing discussion in the Northwest Territories for a number of years. Change is required to address a number of significant challenges. These include concerns about the sustainability of the system in the face of limited resources and increasing demands, questions about the capacity of the current system to maintain quality of care, confusion about accountability relationships within the system, and challenges related to the coordination of service delivery. Difficulty in recruiting frontline professionals and the mounting competition from other jurisdictions across Canada and even internationally, places further strains on the system. A priority of the territorial government is to make sure programs and services are affordable and sustainable.

Information Technology

With a relatively small population distributed over a large and isolated area, the Northwest Territories is looking to new information technologies to improve connections between communities. At the same time, the remoteness of these communities makes it costly and difficult to provide adequate and appropriate technological solutions and to support those solutions once they are in place.

Data quality and integrity are a challenge in any jurisdiction, and are even more challenging in the NWT. It has become increasingly important that new information systems created for the Department and the Boards be developed with recognition of issues related to client privacy.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The name of the plan in the NWT is The Northwest Territories Health Care Plan, which includes the Medical Care Plan, and the Hospital Insurance Plan. The public authority responsible for the Medical Care Plan is the Director of Medical Insurance as appointed

under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through boards of management appointed under the *Hospital Insurance and Health and Social Services Administration Act.*

Legislation that enables the plan in the Northwest Territories includes the *Medical Care Act* (revised 1988) and the *Hospital Insurance and Health and Social Services Administration Act* (revised 1988). In January 2001, sections of the *Medical Care Act* Regulations pertaining to fee schedules were amended to reflect the negotiated contract between the NWT Medical Association and the Department of Health and Social Services.

The mandate of the Director of Medical Insurance is to deliver services as described in detail in the *Medical Care Act*. The mandate of the Minister is outlined in the *Health Insurance and Health and Social Services Act.*

1.2 Reporting Relationship

In the Northwest Territories, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for the administration of the *Medical Care Act* and the Regulations.

The Minister also appoints members to the Board of Management for facilities located throughout the Northwest Territories. Boards of Management are established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* or under the *Societies Act*. The Boards are established with the authority to manage, control and operate health and services facilities and, subject to the *Financial Administration Act* (1987), exercise any powers that are necessary and incidental to these duties. The Boards' Chairpersons hold office during the pleasure of the Minister, while the remaining members typically hold office for a term of three years, to a maximum of three consecutive terms. Accounts of the Boards of Management must be audited every year.

An annual audit of accounts is done at each Board of Management. The Chairperson of each Board of Management has regular meetings with the Minister, and uses that forum to provide non-financial reporting.

1.3 Audit of Accounts

The Hospital Insurance Plan and the Medical Care Plan are administered by the Department of Heath and Social Services. The Auditor General of Canada has the mandate to audit the payments made under the Medical Care Plan. Pursuant to the *Financial Administration Act,* an auditor appointed by the Minister must audit the accounts of every Board of Management annually.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and the Regulations. As of March 31, 2001, the Northwest Territories had four hospitals and 28 health centres that delivered insured hospital services to both in- and out-patients.

The Northwest Territories provides a full range of insured hospital services. Boards of Management have the authority to provide services above those considered medically necessary, although those services are not covered by the insurance plans.

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

Out-patient services include laboratory tests, x-rays including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital

services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy and speech therapy services in an approved hospital; and psychiatric and psychology services provided under an approved hospital program. A detailed list of insured in-patient and out-patient services is contained in the Territorial Hospital Insurance Services Regulations.

A detailed list of insured in-patient and out-patient services is contained in the Territorial Hospital Insurance Services Regulations. The Minister makes the determination to add insured hospital services to the Regulations. As such, on the recommendation of the Minister, the Commissioner may make regulations prescribing the in- and out-patient services that insured persons are eligible for and entitled to as insured services. The Minister will also determine if any public consultation will occur prior to making changes to the list of insured services.

Where insured services are not available in the Northwest Territories, residents receive those services from hospitals in other jurisdictions. These services must be medically necessary and they can include hospital-to-hospital transfer as well as referral from physicians. The NWT provides Medical Travel Assistance, a supplementary health benefit program, which ensures that residents of the NWT have accessed to medically required services.

2.2 Insured Physician Services

The *Medical Care Act* and the Medical Care Regulations provide for insured physician services in the Northwest Territories. Medical doctors are the only medical practitioners allowed to deliver insured physician services in the Northwest Territories. The physician must be licensed to practice in the Northwest Territories. Although physicians may opt out or de-enrol in the Northwest Territories, none have chosen to do so.

The Northwest Territories provides a broad range of medically necessary services. If a service has been deemed an insured service, no limitations are applied.

The Medical Care Plan insures all medically required procedures provided by medical practitioners, including approved diagnostic and therapeutic services; necessary surgical services; complete obstetrical care; eye examinations; and visits to specialists, even when there is no referral by a family physician.

In negotiations between the Northwest Territories Medical Association and the Director of Medical Insurance, additional medical services may be added to the fee schedule Regulation. The Director of Medical Insurance manages the process of adding a service and also determines if public consultations are appropriate before changes are made to approved schedules.

2.3 Insured Surgical-Dental Services

If the service is an insured service and related to oral surgery, injury to the jaw, or disease of the mouth/jaw, it is eligible. Only oral surgeons may submit claims for billing.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Some services provided by hospitals, physicians, and dentists that are not covered by the health care insurance plan of the NWT include medical-legal services, third-party examinations, services not medically required, group immunization, *in-vitro* fertilization, services provided by a doctor to his or her own family, telephone advice or prescriptions given over the phone, surgery for cosmetic purposes except where medically required, dental services other than those specifically defined services for oral surgery, dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, and surgical appliances or special bandages; treatments in the course of chiropractics, podiatry, naturopathy, osteopathy or any other practice ordinarily carried out by persons who are not medical practitioners as defined by the *Medical Care Act and Regulations*; physiotherapy and psychology services received from other than an insured

out-patient facility; services covered by the *Workers' Compensation Act* or by other federal or territorial legislation; and routine annual checkups where there is no definable diagnosis.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* is the legislation that defines the eligibility of Northwest Territories residents to the health care insurance plan of the Territory.

The Northwest Territories uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the Northwest Territories Health Care Plan Registration Guidelines to define eligibility. No changes have been implemented to eligibility in 2000-2001.

Ineligible individuals for Northwest Territories health care coverage are members of the Canadian Forces, Royal Canadian Mounted Police, federal inmates, and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form, and supporting documentation as applicable, e.g. visas and immigration papers. The individual must be prepared to provide proof of residency if requested. Registration should optimally occur prior to the actual eligibility date of the client. Renewal of health care cards is done every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of March 31, 2001, there were 41,673 individuals registered with the Northwest Territories Health Care Plan.

No formal provisions are in place for clients to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas, and in some cases visitor visas are covered if they hold valid visas for a period of 12 months or more.

4.0 Portability

4.1 Minimum Waiting Period

Waiting periods are imposed as per the Interprovincial Agreement on Eligibility and Portability for insured persons moving into the Northwest Territories from other jurisdictions, generally until the first day of the third month, or until the first day of the thirteenth month in some cases.

4.2 Coverage During Temporary Absences In Canada

The Interprovincial Agreement on Eligibility and Portability and the Northwest Territories Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the Northwest Territories for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the Northwest Territories for work, vacation, secondments etc. When an individual is approved as being temporarily absent from the Northwest Territories, the full costs for insured services are paid for all services received in other jurisdictions.

The Northwest Territories participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The Northwest Territories Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada. Individuals are granted coverage for up to one year if they are outside the country for any reason.

As per section 11. (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. Reimbursement is determined by applying the Northwest Territories rate for the same service.

4.4 Prior Approval Requirement

With respect to the requirement to obtain approval before receiving elective services in other provinces, territories and outside the country, the NWT requires prior approval if coverage is to be considered for these services. Prior approval is also required if insured services are to be obtained from private facilities.

5.0 Accessibility

5.1 Access to Insured Health Services

The Medical Travel Assistance Supplementary Health Benefit Program ensures that economic barriers are reduced for all Northwest Territories residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Accessibility of beds has not been a problem in the Northwest Territories. If such a case arises, the resident is transported to another facility where appropriate beds exist. As of March 31, 2001, hospitals and health centres in the NWT faced some short-term staffing difficulties that had negative impacts on functions. However, through the use of medical travel arrangements, access to services was maintained.

The Northwest Territories recognizes that our facilities do not have sufficient capacity to offer an extensive range of medical, surgical, rehabilitative and diagnostic services. The Medical Travel Assistance Program is in place to ensure that residents are able to access the required services at facilities where available.

Measures taken in 2000-2001 to improve access to insured hospital services include the expansion of the telehealth program. The expansion originally planned for the 2000-2001 fiscal year was not fully completed as suitable equipment was not available. However, during the reporting period a number of steps were taken to ensure that installation of equipment and the upgrading of the three existing WestNet sites (Inuvik, Fort Smith and Yellowknife) would be completed in 2001-2002.

5.3 Access to Insured Physician and Dental-Surgical Services

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories.

The Medical Travel Assistance Program provides access to physicians for residents and the telehealth program has provided an expansion of specialist services to residents in isolated communities.

5.4 Physician Compensation

The *Medical Care Act* and the Medical Care Regulations are used in the Northwest Territories to govern payments to physicians. The NWT uses two models: fee-for-service and employee contracts, to compensate physicians. In 2000, the majority of fee-for-service family physicians opted out of fee-for-service and agreed to a contractual arrangement with the Northwest Territories.

Fee-for-service physician compensation is determined by negotiations between the Northwest Territories Medical Association and the Department of Health and Social Services. The Director of Medical Insurance and his or

her designates negotiate on behalf of the Department and the Northwest Territories Medical Association chooses a negotiation team from within their membership.

The Government of the Northwest Territories and the Northwest Territories Medical Association have negotiated an agreement, subsequently signed into law, as Regulations of the *Medical Care Act*. These regulations covered the period starting April 1997 through March 31, 2000. The current Agreement runs to March 31, 2002.

5.5 Payments to Hospitals

Payments are made to hospitals based on contribution agreements between the Boards of Management and the Department of Health and Social Services. Amounts allocated in the agreements are based upon the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Act* and the *Financial Administration Act.* No amendments were implemented in 2000-2001. A global budget is used to fund hospitals in the Northwest Territories.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents. For fiscal 2000-2001 these documents included the following:

- 2000 Budget Address
- 2000-2001 Main Estimates and
- 1999-2000 Public Accounts.
- Departmental Business Plans for the Department of Finance and the Department of Health and Social Services.

The Estimates noted above represent the financial plan of the GNWT and is presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Nursing home-level care is supported by the Hospital Insurance Plan and provided in designated beds in facilities located in Inuvik, Yellowknife, Hay River, and Fort Smith.

Health and Social Services Boards are core funded by the Department of Health and Social Services to provide long-term care services to residents of the Northwest Territories. These services include long-term care facilities, group homes, supported living options and home care.

Long-term care facilities provide complex medical and personal care. Group homes and supported living options provide services to the severe mentally and physically disabled population. Home care provides services to people of all ages, based upon an assessed need, to allow them to continue to live independently in the community, in their own home for as long as possible, to prevent or delay institutionalization.

When appropriate services are not available in the NWT, clients are accommodated in facilities in southern Canada.

Provision of Additional Materials

In the NWT, the health and social services system has been extensively reviewed over the past few years by the Legislative Assembly's Special Committee on Health and Social Services (1993) and the Med-Emerg Review (1998). During the reporting period, the report from the Minister's Forum on Health and Social Services was received. The Minister's Forum urged the Government to take action on issues around board structure and financing, but without providing specific suggestions. Copies of the Report and other materials produced by

the NWT Department of Health and Social Services can be found at www.hlthss.gov.nt.ca

In addition, NWT legislation, regulations and other documents such as Main Estimates can be found at [www.gov.nt.ca]. During the reporting period, no audit of the health insurance plan was conducted.

Nunavut

Overview

Nunavut was formed as a territory on April 1, 1999. The Territory covers one-fifth of Canada's total landmass. There are 26 communities situated across three time zones. According to recent statistics, the population of Nunavut is 27,692. Inuit make up the majority at about 85 percent of the total residents. There is a small French-speaking population of about four to six percent residing on Baffin Island, predominantly in the capital city of Iqaluit. As well, Nunavut has a highly transient workforce, particularly skilled labourers and seasonal workers from other provinces and territories.

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories as Nunavut statutes pursuant to the *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness for the Government of Nunavut as set out in the objectives of the Bathurst Mandate. The Bathurst Mandate outlines the Government's agenda to achieve healthy communities, simplicity and unity, self-reliance, and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimanituqangit, in program policy development, service design and delivery, is an expectation placed on all departments.

Health service delivery in Nunavut is based on a primary health care model. There is a local health centre in each of the 25 communities, as well as one regional hospital in Iqaluit. The primary health care providers are nurse practitioners. There are 12 physicians located at the hospital and three physicians in private practice (two in Iqaluit and one in Pond Inlet). Nunavut relies heavily on the Northern Medical Unit of the University of Manitoba, Ottawa Health Services Network Inc., and the Stanton Regional Hospital in Yellowknife for a majority of its physician and specialist services.

The management and delivery of health services in Nunavut is now integrated into the overall operations of the Department of Health and Social Services. The former boards (Baffin, Kitikmeot and Keewatin) were dissolved on March 31, 2000. Former board staff are now employees of the Department. A continued emphasis on support to front-line service delivery has remained an integral part of this amalgamation.

The territorial budget for health care and social services in 2000-2001 was $115.9 million, plus an additional $4.3 million for capital. Only the Department of Education has a higher budget.

In 2000-2001, telehealth services were developed in five communities. In March 2001 the Department was advised that its proposal under the Canada Health Info-structure Partnerships Program (CHIPP) was approved to enable expansion of telehealth services to an additional ten communities over the next two years.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Approximately one fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and a limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent outside the Territory. Plans to build a new regional hospital in Iqaluit and new regional health facilities in Rankin Inlet and Cambridge Bay in the next three years will enable Nunavut to build internal capacity and enhance the range of services provided.

High rates of respiratory diseases such as tuberculosis continue. There is an acute shortage of nurses, despite aggressive national and international recruitment and retention activities.

Health promotion and prevention activities are high on the Department's list of service priorities. These include strategies to reduce tobacco use, public education for healthy lifestyle choices and the importance of traditional foods.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans, including physician and hospital services, are administered by the Department of Health and Social Services on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration* Act (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) enables the establishment of hospital and other health services.

Through the *Dissolution Act* (Nunavut, 1999) the three former Health and Social Services Boards of Baffin, Kitikmeot and Keewatin were dissolved. Their operations were integrated into the Department of Health and Social Services on April 1, 2000. Regional sites were maintained to support front-line workers and community-based delivery of a wide range of health and social services.

1.2 Reporting Relationship

A Director of Medical Care appointed under the *Medical Care Act* is responsible for administering the Territory's medical care insurance plan. The Director reports to the Minister of Health and Social Services and is required to submit an annual report on the operations of the medical insurance plan. The Department plans to table its first reports for 1999-2000 and 2000-2001 in the Legislative Assembly in February 2002. Our annual submissions to the *Canada Health Act Annual Report* serve as the basis for these reports under the *Medical Care Act*.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General has the mandate to audit the activities of the Department of Health and Social Services.

The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government. The most recent audit for the fiscal year ending March 31, 2001 was being conducted as of September 2001.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the authority of the *Hospital and Social Services Administration Act* and Regulations, sections 2 to 4. No amendments were made to Legislation or Regulations in 2000-2001.

In 2000-2001, insured hospital services were delivered in 26 facilities throughout Nunavut, including one general hospital located in Iqaluit and 25 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut that provides a range of in- and out-patient hospital services as defined by the *Canada Health Act*. Community health centres provide public health, emergency-room services and some overnight services (observations). There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre.

The Department is responsible for authorizing, licensing, inspecting and supervising all health and social service facilities in Nunavut.

Insured in-patient hospital services include:

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

Out-patient services include:

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

The Department of Health and Social Services makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Nunavut Financial Management Board. No new insured hospital services were added in 2000-2001.

2.2 Insured Physician Services

The *Medical Care Act,* section 3(1) and the Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to the Legislation or Regulations in 2000-2001.

Medical doctors are the only practitioners permitted to deliver insured physician services in Nunavut. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practise in Nunavut. The Government of the Northwest Territories' Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 15 physicians in Nunavut (three in private practice and twelve at the Baffin Regional Hospital in Iqaluit) providing services to Nunavummiut. Visiting specialists, general practitioners and locums also provide insured physician services through arrangements made by each of the Department's three regions.

Physicians can collect fees other than those listed in the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked on the first day of the following month after a letter to that effect is delivered to the Director. No physicians provided written notice of this election in 2000-2001.

Insured physician services means all medically required services rendered by medical practitioners. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction.

The addition or deletion of insured physician services requires territorial approval. There were no additions or deletions in 2000-2001.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) and are provided billing numbers for the purpose of billing the Plan for the provision of

insured dental services. In 2000-2001, three oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to dental-surgical procedures scheduled in the Regulations that require the unique capabilities of a hospital for their performance, for example, orthognathic surgery.

The addition of new surgical-dental services to the list of insured services requires territorial approval. No new services were added in 2000-2001.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut* Act, 1999) or other Acts of Canada, except the *Canada Health Act,* are excluded.

Services provided by physicians that are not insured include:

- yearly physicals;
- cosmetic surgery;
- services that are considered experimental;
- prescription drugs;
- physical examinations done at the request of a third party;
- optometric services;
- dental services other than specific procedures related to jaw injury or disease;
- the services of chiropractors, naturopaths, podiatrists, osteopaths, and acupuncture treatments; and
- physiotherapy, speech therapy, and psychology services received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include

- hospital charges above the standard ward rate for private or semi-private accommodation;
- services that are not medically required, such as cosmetic surgery;
- services that are considered experimental;
- ambulance charges (except inter-hospital transfers);
- dental services, other than specific procedures related to jaw injury or disease; and
- alcohol and drug rehabilitation, unless previously approved.

The Baffin Regional Hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see 4.2 under Portability). Queries or complaints are handled on individual bases with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton and Yellowknife), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Interprovincial/Territorial Agreement on Eligibility and Portability, and internal guidelines.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Territory, but does not include a tourist, transient or visitor. Applications are accepted for health coverage and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Coverage generally begins on the first day of the third month after arrival, but first-day coverage is provided under a number of circumstances, e.g., newborns whose mothers or fathers are eligible for coverage. Permanent residents, including landed immigrants, returning Canadians, repatriated Canadians, returning permanent residents, and non-Canadians who have been issued employment visas for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Forces, Royal Canadian Mounted Police and inmates of a federal penitentiary are not eligible for coverage. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Interprovincial/ Territorial Agreement on Eligibility and Portability, persons temporarily absent from their home province or territory and who are not establishing residency in Nunavut remain covered by their own provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

These include a completed application form and supporting documentation. A health care card is issued to each resident. Nunavut will be going to a staggered renewal process once a new health claims system is put into place next fiscal year. There are no premiums. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. Non-residents need a valid health care card from their home province or territory in order to access insured health services.

As of March 31, 2001, there were approximately 26,887 residents registered with the Nunavut Health Care Plan. Nunavut's population statistics as published by Statistics Canada include a number of “temporary residents” who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister’s Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis, consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Interprovincial/ Territorial Agreement on Eligibility and Portability, the waiting period for coverage for individuals moving within Canada is three months or the first day of the third month following the establishment of residency in a new province or territory, or the first day of the third month when a person who has been temporarily absent from his or her home province decides to take up permanent residence in Nunavut.

4.2 Coverage During Temporary Absences In Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*,

sections 5(d) and 28(1)(j)(o) provide authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents, and the terms and conditions of payment. No legislative or regulatory changes were made in 2000-2001 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continued coverage. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences of up to one year for work, vacation or other reasons are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months on receipt of a written request from the insured person.

The provisions regarding coverage during temporary absences within Canada fully comply with the terms and conditions of the Interprovincial/Territorial Agreement on Eligibility and Portability, as of January 1, 1998.

Nunavut participates in Physician and Hospital Reciprocal Billing; and agreements are in place with other provinces and territories (Ontario, Manitoba, Alberta and the Northwest Territories).

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents who receive insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents who receive insured services outside the Territory. Payment is made to the host province at the rates established by that province.

The sum of $17,221,307 (of which $3,381,922 was for 1999-2000) was paid to out-of-territory hospitals for the fiscal year 2000-2001.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3) prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o) provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care. No changes were made to these rates in 2000-2001.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made either to the insured person or the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 Accessibility

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra-billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barriers posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients, if required, in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital in Iqaluit, is the only acute care facility in Nunavut. The hospital has 25 beds, but due to a shortages of nurses in 2000-2001, an average of 16 beds was available for acute, rehabilitation and chronic care services. The hospital has a staff of 101, including 12 physicians and 33 nurses. The facility provides in-patient, out-patient, and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services include an ambulatory care/ out-patient clinic, intensive care services, respiratory services, cardiovascular care, maternity, gastrointestinal bleeding and hypertension treatment. Surgical services include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit.

Nunavut has special arrangements with facilities in Ottawa, Toronto, Churchill, Winnipeg, Edmonton and Yellowknife, to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency services are provided by all 25 health centres located in the communities.

Although nurses and other health professionals were not at the desired levels of staffing, all basic services were provided in 2000-2001. Nunavut is seeking to increase resources in all areas.

5.3 Access to Insured Physician and Dental-Surgical Services

In addition to the medical travel assistance and telehealth initiatives, Nunavut has agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. Patients are referred to other jurisdictions for services and equipment unavailable in Nunavut. In 2000-2001, Nunavut had 59 general/family practitioners, 55 physician specialists and 21 general and specialist dental practitioners.

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry, and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There are three fee-for-service physicians residing in Nunavut. Because these physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20 percent greater than the amounts set out in the schedule (*Medical Care Act*, section 4). The fees are negotiated between the NWT Medical Association and Nunavut's Department of Health and Social Services. The remaining physicians work on contract at a per diem rate or are paid a salary. Visiting specialists are paid on a per diem basis under the terms of their contracts.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 25 community health centres is part of the Department's budget for regional operations. No payments are made directly to the hospital or to the community health centres.

6.0 Recognition Given to Federal Transfers

Recognition will be given this year when the Director of Medical Care presents the 1999-2000 and 2000-2001 annual reports to the Minister. These reports will be tabled in the Legislative Assembly in early 2002.

7.0 Extended Health Care Services

A home care program assists Nunavut residents who are not fully able to care for themselves at home. A community-based visiting service encourages self-sufficiency, and supports family members and community involvement to enable individuals to remain safely in their own homes. Services include basic housekeeping, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are provided between 7 a.m. and 7 p.m. After-hours services are for personal care only. The community health centre provides after-hours medical attention.

Nursing home services are available at the Iqaluit and Arviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut, that is, extensive chronic care services up to the point of acute care (levels 4 and 5) services. Acute care cases are transferred to the nearest hospital.

The use of telehealth services has been a significant step in improving access to hospital, medical and other health and social services. Pilot projects are underway in five communities. To date, telehealth has been used for mental health counselling, family visits, and pre- and post-natal visits. The long-term goal is to integrate telehealth into the primary care delivery system, to allow residents and health care providers greater access to a broader range of service options, and to use existing resources more effectively. Our approved Canada Health Infostructure Partnership Program (CHIPP) proposal will allow Nunavut to provide telehealth services to an additional ten communities over the next two years.

Annex A – Provincial and Territorial Health Care Insurance Plan Statistics

Introduction

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

The Annex contains statistical data on the cost and utilization of insured hospital, physician and surgical-dental services for each province and territory for the five consecutive fiscal years ending on March 31 of 1996-1997, 1997-1998, 1998-1999, 1999-2000 and 2000-2001.

New to this year's statistical annex are statistics on registered persons covered by the health care insurance plans, the number of opted-out and non-participating physicians of the health care insurance plans, and statistics on out-of-country physician services.

All information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, provincial/territorial governments were provided with a user's guide outlining what and how to provide the information. The user's guide was prepared in consultation with representatives in each province and territory.

Although efforts were made to capture data on a consistent basis, differences exist in the reporting of health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions should not be made.

The annex is organized in the same order as the provincial/territorial health care insurance plan descriptions. Quebec chose to submit selected statistics in a format different from the one requested.

Organization of the Information

Information for each province and territory is organized according to the eight subcategories described below. In some cases data were not yet available and estimates were provided. In other cases, no information was available or the requested statistic did not apply to the particular province or territory.

For a discussion on some of the data shown in these tables, please refer to Chapter 2 – Provincial and Territorial Health Care Insurance Plans in 2000-2001.

Registered Persons

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

In-Province/Territory Hospital Services

Statistics on the provision of insured hospital services within each jurisdiction to residents of the jurisdiction and to visitors from other provinces or territories are provided in fields 2 through 13.

Details include numbers of facilities by type of care provided; number of beds; number of separations; average length of stay; total payments in the province/territory per category of care; average cost per visit by type of care; and the number and payments to private for-profit facilities.

Out-of-Province/Territory Hospital Services (in Canada)

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 are shown in this subsection. The information reported includes the total number of claims paid for insured hospital services in other provinces or territories, total payments made, and the average payment level.

Out-of-Country Hospital Services

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. Statistics reported in this subsection are of the same type as hospital services provided out-of-province or out-of-territory.

In-Province/Territory Surgical-Dental Services

The information in this subsection describes insured surgical-dental services provided in each province and territory. This includes the number of participating professionals (dentists, dental surgeons, and oral surgeons); the number of services provided; total payments made in the fiscal year; and the average payment per service.

In-Province/Territory Physician Services

Statistics in this subsection 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.

Details include the number of physicians participating in the provincial or territorial health insurance plan; the number of physicians opted-out or not participating in the plan; the number of insured services provided; the total payments made to physicians by category of physician and by category of service; and the average payment level per insured physician service.

Out-of-Province/Territory Physician Services (in Canada)

This subsection reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents. Statistics include the number of services paid, total payments made, and the average payment level per service.

Out-of-Country Physician Services

Physician services provided out-of-country represent a person's medical costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are the same as for physician services provided out-of-province or out-of-territory.

Newfoundland and Labrador

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st.	**(#)**	not available	635,835 [1]	622,744	618,118 [2]	616,944 [3]

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	**(#)**					
a. acute care		33	33	33	33	32
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total facilities		33	33	33	33	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		1,860	1,842	1,814	1,807	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		38	38	62	57	not available
d. out-patient diagnostic care		0	0	0	0	0
e. other		0	0	0	0	0
f. total staffed beds		1,898	1,880	1,876	1,864	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		1,860	1,842	1,814	1,807	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		38	38	62	57	not available
d. out-patient diagnostic care		0	0	0	0	0
e. other		0	0	0	0	0
f. total approved bed complement		1,898	1,880	1,876	1,864	not available

[1] Data are as of December 31, 1997.

[2] Data are as of March 1, 2000.

[3] Data are as of April 11, 2001.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		68,766	67,385	68,729	66,828	not available
b. chronic care		0	0	0	0	0
c. rehabilitative care		108	54	227	272	not available
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care		0	0	0	0	0
f. alternative level of care		0	0	0	0	0
g. newborns		0	0	0	0	0
h. other		0	0	0	0	0
i. total separations		68,874	67,439	68,956	67,100	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		8.0	7.9	7.5	7.4	not available
b. chronic care		0.0	0.0	0.0	0.0	0.0
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		0.0	0.0	0.0	0.0	0.0
e. other		0.0	0.0	0.0	0.0	0.0
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		431,336,662 [4]	441,408,824 [4]	457,065,782 [4]	509,018,766 [4]	537,428,824 [4]
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		0	0	0	0	0
g. total payments to facilities providing insured hospital services		431,336,662 [4]	441,408,824 [4]	457,065,782 [4]	509,018,766 [4]	537,428,824 [4]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		675.0 [5]	675.0 [5]	690.0 [5]	690.0 [5]	705.0 [5]
b. chronic care		0.0	0.0	0.0	0.0	0.0
c. rehabilitative care		0.0	0.0	0.0	0.0	0.0
d. other		0.0	0.0	0.0	0.0	0.0

[4] Operating costs only: does not include capital, deficit or non-government funding. Payments represent the final provincial plan funding provided to regional health care boards for the purposes of delivering insured acute care services.

[5] Insured Canadian resident rate.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	1	1	1	1
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	not available	not available	not available	not available
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		0	53,808	212,990	387,030	270,750
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	53,808	212,990	387,030	270,750

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	1,796	1,970	1,826	1,549	1,699
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	22,187	26,293	28,739	25,546	24,929
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	11,550,785	11,286,130	12,037,091	10,144,354	10,608,368
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	2,048,471	2,656,772	3,316,482	3,138,582	3,047,375
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	6,431.0	5,729.0	6,592.0	6,549.0	6,244.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	92.0	101.0	115.0	123.0	122.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	72	39	42	73	111
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	366	374	363	260	287
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	144,887	161,364	503,043	198,072	1,102,540
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	33,298	38,985	56,614	15,626	36,260
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	2,012.0	4,137.0	4,997.0	2,713.0	9,933.0
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	91.0	104.0	156.0	60.0	126.0

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	29	25	30	35	35
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	11,000	10,000	10,000	9,000	11,000
28. Total payments to dentists for insured surgical-dental services.	**($)**	335,000	309,000	374,000	354,000	389,000
29. Average payment per service for insured surgical-dental services.	**($)**	30.2	32.5	38.3	38.7	35.1

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician: [6]	**(#)**					
a. general practitioners		not available	not available	not available	432 [7]	437 [7]
b. specialists		not available	not available	not available	480 [7]	485 [7]
c. other		not available	not available	not available	not applicable	not applicable
d. total		not available	not available	not available	912 [7]	922 [7]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

6 Excludes inactive physicians.

7 Total Salaried and Fee-for-service.

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		2,783,000	2.,623,000	2,471,000	2,489,000	2,340,000
b. specialists		2,206,000	2,407,000	2,440,000	2,443,000	2,318,000
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		4,989,000	5,030,000	4,911,000	4,932,000	4,657,000
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		3,257,000	3,195,000	3,107,000	3,104,000	2,878,000
b. surgical		447,000	487,000	487,000	468,000	433,000
c. diagnostic		1,285,000	1,348,000	1,317,000	1,361,000	1,346,000
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. total		4,989,000	5,030,000	4,911,000	4,932,000	4,657,000
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		44,392,000	40,956,000	41,521,000	42,429,000	43,251,000
b. specialists		61,611,000	67,314,000	71,640,000	72,780,000	73,239,000
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		106,003,000	108,270,000	113,161,000	115,209,000	116,490,000
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		not available	not available	not available	72,500	71,987
b. surgical		not available	not available	not available	10,923	10,834
c. diagnostic		not available	not available	not available	31,786	33,670
d. other		not available	not available	not available	not applicable	not applicable
e. total		106,003,000	108,270,000	113,161,000	115,209,000	116,490,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		16.0	15.6	16.8	17.1	18.5
b. specialists		27.9	28.0	29.4	29.8	31.6
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		21.3	21.5	23.0	23.4	25.0
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. all services		21.3	21.5	23.0	23.4	25.0

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	155,000	163,000	171,000	161,000	173,000
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	3,920,000	4,346,000	4,241,000	4,327,000	4,562,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	25.4	26.6	24.8	28.4	26.4

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	3,000	4,000	4,000	4,000	6,000
43. Total payments for out-of-country insured physician services.	**($)**	76,000	94,000	65,000	107,000	424,000
44. Average payment per service for out-of-country insured physician services.	**($)**	23.5	22.4	17.3	19.6	70.2

Prince Edward Island

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st.	**(#)**	122,867	126,124	130,004	134,006	138,205

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	**(#)**					
a. acute care		7	7	7	7	7
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities		7	7	7	7	7
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		470	470	470	470	470
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		566	566	566	566	566
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		470	470	470	470	470
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		566	566	566	566	566

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		18,047	18,626	18,644	17,796	18,280
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		336	347	377	360	329
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		6,295	5,911	6,250	6,186	not available
f. alternative level of care		not available	not available	not available	not available	267
g. newborns		not available	not available	not available	not available	1,363
h. other		not applicable	not applicable	not applicable	not applicable	not applicable
i. total separations		24,678	24,884	25,271	24,342	20,239
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		8.2	8.1	7.9	8.4	8.2
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		18.0	19.0	19.0	18.0	20.0
d. newborns		not available	not available	not available	not available	not available
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		95,100,000	94,800,000	101,600,000	104,000,000	106,774,200
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		95,100,000	94,800,000	101,600,000	104,000,000	106,774,200
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		642.6	628.4	689.8	695.7	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	1,893	1,904	2,279	1,812	not available [1]
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	11,478	13,341	16,457	14,428	not available [1]
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	11,900,000	11,300,000	12,300,000	10,600,000	not available [1]
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	1,400,000	1,700,000	2,600,000	2,300,000	not available [1]
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	6,286.0	5,935.0	5,397.0	5,850.0	not available [1]
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	122.0	127.0	158.0	160.0	not available [1]

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	35	48	27	21	not available [1]
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	157	211	102	106	not available [1]
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	121,000	119,400	50,100	53,800	not available [1]
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	41,500	76,600	11,700	21,700	not available [1]
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	3,457.0	2,488.0	1,856.0	2,561.0	not available [1]
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	264.0	363.0	115.0	205.0	not available [1]

[1] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	1	1	2	2	2
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	418	411	400	176	145
28. Total payments to dentists for insured surgical-dental services.	**($)**	49,900	50,200	52,700	37,600	53,100
29. Average payment per service for insured surgical-dental services.	**($)**	119.0	122.0	132.0	214.0	366.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		92	97	98	99	101
b. specialists		80	75	72	74	75
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		172	172	170	173	176
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		838,527	834,740	869,320	848,816	861,112
b. specialists		386,714	394,912	422,483	415,130	409,917
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		1,225,241	1,229,652	1,291,803	1,263,946	1,271,029
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		132,979	141,594	158,836	154,930	152,796
b. surgical		139,338	138,667	146,186	144,947	143,940
c. diagnostic		114,397	114,651	117,461	115,253	113,181
d. other		838,527	834,740	869,320	848,816	861,112
e. total		1,225,241	1,229,652	1,291,803	1,263,946	1,271,029
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		14,400,000	14,800,000	15,000,000	15,700,000	15,800,000
b. specialists		15,300,000	15,600,000	16,200,000	17,100,000	17,200,000
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		29,700,000	30,400,000	31,200,000	32,800,000	33,000,000
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		5,600,000	5,900,000	6,200,000	6,600,000	6,500,000
b. surgical		8,000,000	8,000,000	8,300,000	8,800,000	8,900,000
c. diagnostic		1,700,000	1,700,000	1,700,000	1,700,000	1,800,000
d. other		not applicable	not applicable	not applicable	not applicable	15,800,000
e. total		29,700,000	30,400,000	31,200,000	32,800,000	33,000,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		17.0	18.0	17.0	18.0	18.0
b. specialists		40.0	40.0	38.0	41.0	42.0
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		24.0	25.0	24.0	26.0	26.0
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		42.0	42.0	39.0	43.0	43.0
b. surgical		57.0	58.0	57.0	61.0	62.0
c. diagnostic		15.0	15.0	15.0	15.0	15.0
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
e. all services		24.0	25.0	24.0	26.0	26.0

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	57,904	58,667	56,192	56,084	not available [1]
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	2,650,000	2,780,000	3,090,000	3,080,000	not available [1]
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	46.0	47.0	55.0	55.0	not available [1]

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	907	1,242	807	666	not available [1]
43. Total payments for out-of-country insured physician services.	**($)**	35,805	52,874	25,495	38,274	not available [1]
44. Average payment per service for out-of-country insured physician services.	**($)**	39.0	42.0	31.0	57.0	not available [1]

[1] New Brunswick and Nova Scotia have changed their systems. Out-of-province and out-of-country data not available.

Nova Scotia

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	930,805	933,324	937,587	944,487	947,963

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	36	36	36	36	36
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities	36	36	36	36	36
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	3,375 [1]	3,226 [1]	3,233 [1]	3,135 [1]	3,044 [1]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds	3,375	3,226	3,233	3,135	3,044
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

[1] Includes rehabilitative care.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		109,722	108,536	106,954	104,509	94,745
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		897 [2]	944 [2]	855 [2]	792 [2]	800 [2]
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		77,432	86,014	89,046	93,700	96,832
f. alternative level of care		916	1,422	1,690	2,002	2,064
g. newborns		10,474	9,951	9,675	9,607	9,038
h. other		not available	not available	133	135	150
i. total separations		198,525 [3]	205,445 [3]	206,530 [3]	208,608 [3]	201,415 [3]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		7.7	8.2	7.9	8.3	8.6
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		36.7	45.6	44.8	45.0	48.6
d. newborns		3.5	3.7	3.7	3.7	3.8
e. other		not available	not available	124.8	159.4	147.1
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [4]	**($)**					
a. acute care		645,026,000	701,208,000	795,946,000	812,776,800	877,019,426
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		645,026,000	701,208,000	795,946,000	812,776,800	877,019,426
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		435.9	435.9	391.6	391.6	391.6
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[2] Type 4 level of care.

[3] Excludes separations with alternative level of care days.

[4] $'s are paid to acute care facilities/DHAs only.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		89.0 [5]	89.0 [5]	110.0 [5]	110.0 [5]	110.0 [5]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		3,249.1	3,413.1	3,853.9	3,896.2	4,354.3
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		1	1	1	1	1
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

[5] Standard National Rate for Out-Patient Services.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	2,173	2,331	2,395	2,380	2,357
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	24,521	29,165	29,927	30,078	32,174
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	9,141,843	8,864,423	10,395,116	10,502,390	9,559,303
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	2,506,490	3,038,860	3,770,060	3,771,435	4,083,677
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	4,207.0	3,802.8	4,340.3	4,412.8	4,055.7
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	102.2	104.2	126.0	125.4	126.9

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	not available	not available	not available	not available	not available
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	not available	not available	not available	not available	not available
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	1,003,664	851,689	859,642	1,053,577	736,104
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	not available	not available	not available	not available	not available
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	not available	not available	not available	not available	not available
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	not available	not available	not available	not available	not available

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	55	53	54	55	39
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	14,525	15,549	16,909	17,525	6,853
28. Total payments to dentists for insured surgical-dental services.	**($)**	1,439,885	1,515,311	1,726,646	1,467,485	988,692
29. Average payment per service for insured surgical-dental services.	**($)**	99.1	97.5	102.1	83.7	144.3

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not available	not available	not available	829	741 [6]
b. specialists		not available	not available	not available	1,095	1,016 [6]
c. other		0	0	0	0	0
d. total		1,826	1,836	1,853	1,924	1,757 [6]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

[6] Figures adjusted to show only those physicians within each subcategory.

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		not available	4,443,772	4,334,359	4,619,083	4,571,239
b. specialists		not available	1,854,669	1,794,146	1,606,842	1,576,479
c. other		not available	0	0	0	0
d. total		6,298,935	6,298,441	6,128,505	6,225,925	6,147,718
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		not available	5,980,487	5,809,644	5,908,054	4,637,320 [7]
b. surgical		not available	317,854	320,861	317,871	331,316 [7]
c. diagnostic		not available	1,545,203	1,544,529	1,514,011	604,275 [7]
d. other		not available	0	0	0	574,778 [7]
e. total		6,854,885	7,843,544	7,675,034	7,739,936	6,147,689 [7]
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		94,476,324	91,782,118	91,620,190	104,587,110	105,480,167
b. specialists		108,424,409	115,725,195	118,656,216	112,250,617	114,919,756
c. other		0	0	0	0	0
d. total		202,900,733	207,507,313	210,276,406	216,837,727	220,399,923
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		not available	not available	not available	not available	142,110,171 [7]
b. surgical		not available	not available	not available	not available	52,737,469 [7]
c. diagnostic		not available	not available	not available	not available	19,583,421 [7]
d. other		not available	not available	not available	not available	5,967,370 [7]
e. total		267,449,785	296,138,155	317,320,281	350,091,235	220,398,370 [7]
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		not available	20.7	21.1	22.6	23.1
b. specialists		not available	62.4	66.1	69.9	72.9
c. other		0.0	0.0	0.0	0.0	0.0
d. all physicians		32.2	32.9	34.3	34.8	35.9
38. Average payment per service for insured physician services, by category of service: [7]	**($)**					
a. medical		not available	not available	not available	not available	30.6
b. surgical		not available	not available	not available	not available	183.7
c. diagnostic		not available	not available	not available	not available	32.4
d. other		not available	not available	not available	not available	10.4
e. all services		39.0	37.8	41.3	45.2	35.9

[7] Fee-for-service only.

Out-of-Province/Territory Physician Services (In Canada) [8]						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	not available	not available	not available	not available	180,299
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	not available	not available	not available	not available	4,766,189
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	not available	not available	not available	not available	26.4

Out-of-Country Physician Services [8]						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	not available	not available	not available	not available	2,541
43. Total payments for out-of-country insured physician services.	**($)**	not available	not available	not available	not available	98,461
44. Average payment per service for out-of-country insured physician services.	**($)**	not available	not available	not available	not available	38.7

[8] Payments totalling $123,448 are not included in questions 39 - 44 as the distribution between out-of-province/territory and out-of-country for amount paid is unknown. As well, the number of services are not known.

New Brunswick

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	747,173	742,218	735,510	739,336	738,598

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	31	31	31	31	31
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	32	32	32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	3,036	3,036	3,036	3,036	3,036
b. chronic care	397	397	397	397	397
c. rehabilitative care	20	20	20	20	20
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total approved bed complement	3,453	3,453	3,453	3,453	3,453

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		110,549	110,865	109,542	108,353	102,465
b. chronic care		2,423	2,280	2,398	2,281	1,887
c. rehabilitative care		406	457	411	444	465
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		45,175	44,597	42,962	46,287	46,345
f. alternative level of care		231	246	307	308	342
g. newborns		8,347	8,050	7,939	7,778	7,455
h. other		0	0	0	0	0
i. total separations		167,131	160,495	163,559	165,451	158,959
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		6.3	6.6	6.8	6.8	7.1
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		41.9	39.1	47.3	41.3	41.2
d. newborns		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		596,141,800	629,964,593	639,764,216	674,487,768	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	3,827 pts / 28,086 days	3,566 pts / 24,993 days	3,768 pts / 24,915 days	3,900 pts / 25,655 days	4,130 pts / 26,572 days
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	31,229	31,684	36,081	32,796	35,834
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	24,836,405	21,515,090	21,863,730	22,473,974	21,561,907
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	3,108,218	3,295,272	4,374,860	4,235,429	4,702,219
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	884.3	860.8	877.5	876.0	811.5
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	99.5	104.0	121.3	129.1	131.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	231 pts / 1,110 days	190 pts / 788 days	145 pts / 661 days	212 pts / 1,691 days	166 pts / 1,096 days
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	1,318	881	395	524	639
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	1,106,445	385,548	150,403	487,760	458,759
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	159,197	101,585	85,443	105,783	180,712
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	996.8	489.3	227.5	288.4	418.6
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	120.8	115.3	216.3	201.9	282.8

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	12	14	17	12	16
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	602	632	790	751	1,004
28. Total payments to dentists for insured surgical-dental services.	**($)**	96,683	119,524	132,577	136,491	189,777
29. Average payment per service for insured surgical-dental services.	**($)**	160.6	189.1	167.8	181.7	189.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		575	581	619	629	645
b. specialists		678	682	709	721	710
c. other		not available	not available	not available	not available	not available
d. total		1,253	1,263	1,328	1,350	1,355
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		3,626,061	3,625,877	3,692,566	3,721,782	3,668,781
b. specialists		2,423,736	2,479,186	2,551,663	2,612,744	1,568,927 [1]
c. other		not available	not available	not available	not available	not available
d. total		6,049,797	6,105,063	6,244,229	6,334,526	5,237,708
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		684,943	686,896	729,803	739,911	728,947
b. surgical		805,335	827,458	828,626	852,725	839,980
c. diagnostic		933,458 [2]	964,832 [2]	993,234 [2]	1,020,108 [2]	not available
d. other		3,626,061	3,625,877	3,692,566	3,721,782	3,668,781
e. total		6,049,797	6,105,063	6,244,229	6,334,526	5,237,708
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		73,575,982	74,575,504	77,851,628	77,958,130	78,139,070
b. specialists		96,165,584	100,834,441	104,752,866	111,554,173	88,908,789 [1]
c. other		not available	not available	not available	not available	not available
d. total		169,741,566	175,409,945	182,604,494	189,512,303	167,047,859
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		36,116,218	37,548,393	40,384,442	41,795,791	41,068,744
b. surgical		44,697,549	46,574,724	46,871,179	48,732,272	47,840,045
c. diagnostic		15,351,817 [2]	16,711,324 [2]	17,497,245 [2]	21,026,109 [2]	not available
d. other		73,575,982 [3]	74,575,504 [3]	77,851,628 [3]	77,958,130 [3]	78,139,070 [3]
e. total		169,741,566	175,409,945	182,604,494	189,512,302	167,047,859
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		20.3	20.6	21.1	20.9	21.3
b. specialists		39.7	40.7	41.1	42.7	56.7
c. other		not available	not available	not available	not available	not available
d. all physicians		28.1	28.7	29.2	29.9	31.9
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		52.7	54.7	55.3	56.5	56.3
b. surgical		55.5	56.3	56.6	57.1	57.0
c. diagnostic		16.4 [2]	17.3 [2]	17.6 [2]	20.6 [2]	not available
d. other		20.3 [3]	20.6 [3]	21.1 [3]	20.9 [3]	21.3 [3]
e. all services		28.1	28.7	29.2	29.9	31.9

1 Radiology data are incomplete for fiscal year 2000-2001.

2 Radiology only.

3 Includes General Practitioners.

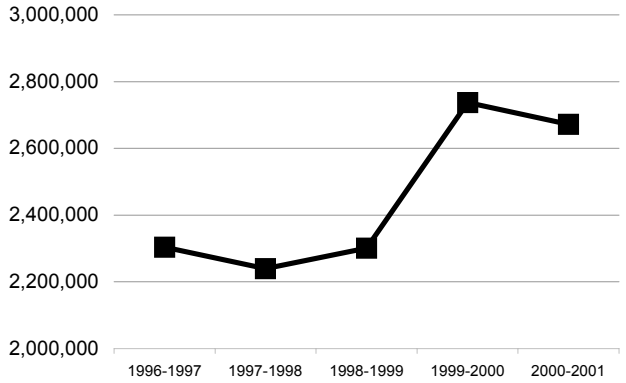
Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	132,873	153,230	140,375	137,950	160,119
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	4,665,617	6,186,476	5,684,969	6,050,729	7,697,923
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	35.1	40.4	40.5	43.9	48.1

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	6,675	7,283	3,835	4,554	4,200
43. Total payments for out-of-country insured physician services.	**($)**	321,754	366,996	223,066	356,128	362,709
44. Average payment per service for out-of-country insured physician services.	**($)**	48.2	50.4	58.2	78.2	86.4

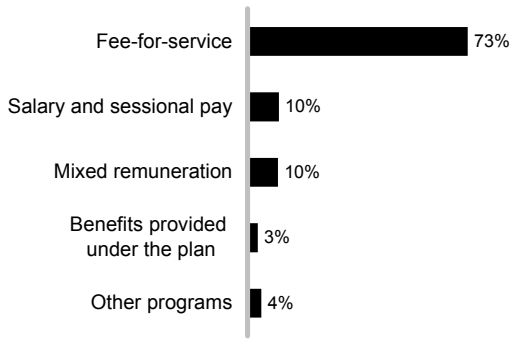
Quebec[1]

Medical Services	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001
	(in thousands of dollars)				
Health insurance plan	2,209,354	2,145,535	2,203,461	2,634,945	2,562,034
Fee-for-service	1,870,783	1,789,854	1,820,968	2,173,993	1,957,201
Specialists	1,131,647	1,081,637	1,090,532	1,257,148	1,105,463
General practitioners	672,547	636,807	657,450	841,128	774,215
Commission of Health and Occupational Safety	43,461	47,533	49,935	54,249	52,822
Payments made to insured persons	13,992	14,790	14,135	12,473	15,826
Health professionals outside Quebec	9,136	9,087	8,916	8,995	8,875
Salary and sessional pay	291,039	294,761	300,447	289,919	267,658
Sessional and lump-sum fees	192,028	200,312	212,843	208,119	183,217
Salary and fixed fees	91,833	87,852	81,226	75,520	78,043
Commission of Health and Occupational Safety	7,178	6,597	6,378	6,280	6,398
Mixed remuneration	-	-	-	72,856	258,949
Health insurance plan	-	-	-	72,234	256,732
Commission of Health and Occupational Safety	-	-	-	622	2,217
Benefits provided under the plan	47,532	60,920	82,046	98,177	78,226
Special measures	34,516	49,010	56,735	57,699	48,229
Professional liability insurance	13,016	11,910	25,311	40,478	29,997
Other programs	94,673	93,967	97,230	102,809	109,755
Remuneration to medical residents	93,351	92,670	95,964	101,247	108,100
Other	1,322	1,297	1,266	1,562	1,655
Total	**2,304,027**	**2,239,502**	**2,300,691**	**2,737,754**	**2,671,789**

Changes in Costs



Distribution of Costs for 2000-2001



[1] Quebec chose to not submit information in the type or in the manner requested by Health Canada. The table and charts have been reproduced directly from Quebec's submission to Health Canada.

Ontario

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	10.9 M [1]	11.2 M [1]	11.3 M [1]	11.4 M [1]	11.7 M [1]

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	not available [2]	179	157	154	150
b. chronic care	not available [2]	20	22	12	11
c. rehabilitative care	not available [2]	6	5	4	4
d. out-patient diagnostic care	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
e. surgical day care (out-patient)	not available [4]	not available [4]	not available [4]	not available [4]	not available [4]
f. other	not available [2]	4	4	3	3
g. total facilities	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	26,267	24,505	23,872	24,254	25,008
b. chronic care	8,678	8,149	7,787	7,505	7,455
c. rehabilitative care	1,875	1,815	1,822	1,975	2,137
d. out-patient diagnostic care	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
f. total staffed beds	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
b. chronic care	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
c. rehabilitative care	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
d. out-patient diagnostic care	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
e. other	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]
f. total approved bed complement	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]

1 M = Millions.

2 Historical data no longer available.

3 Ontario does not have facilities in these categories. These types of facilities are privately owned and any insured services provided are covered by the province.

4 Day surgery only reports cases and the stretchers are not reported whereas acute, chronic and rehabilitative units report beds and have separations.

5 Total is not available since some of the items in the list are not available.

6 Details for other types of beds are not kept separately, they are included as part of the acute, chronic and rehabilitation beds reporting.

7 Not available - there is no central repository for this information.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		1,074,967	1,041,004	1,131,333	1,007,464	1,004,042
b. chronic care		17,321	18,426	17,165	18,943	19,777
c. rehabilitative care		17,399	18,513	188,865	20,837	20,236
d. out-patient diagnostic care		not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
e. surgical day care (out-patient)		814,595	879,826	896,833	943,045	983,916
f. alternative level of care		not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
g. newborns		140,746	137,114	134,505	134,136	130,062
h. other		not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
i. total separations		not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		6.5 [9]	6.4 [9]	6.5 [9]	6.6 [9]	7.0 [9]
b. chronic care		162.1 [9]	140.8 [9]	129.1 [9]	128.9 [9]	118.1 [9]
c. rehabilitative care		32.3	32.3	30.3	29.9	26.3
d. newborns		2.9	2.9	2.8	2.9	3.0
e. other		not available [10]	not available [10]	not available [10]	not available [10]	not available [10]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
b. chronic care		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
c. rehabilitative care		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
d. out-patient diagnostic care		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
e. surgical day care (out-patient)		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
f. other		not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
g. total payments to facilities providing insured hospital services		7.4 B [12]	6.7 B [12]	7.1 B [12]	7.5 B [12]	8.0 B [12]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		626.0	654.0	691.0	761.0	not available [13]
b. chronic care		253.0	266.0	274.0	287.0	not available [13]
c. rehabilitative care		363.0	369.0	385.0	436.0	not available [13]
d. other		not available [10]	not available [10]	not available [10]	not available [10]	not available [10]

[5] Total is not available since some of the items in the list are not available.

[8] Not available - the data is not collected by these classifications -e.g. alternative level of care is included with acute separations.

[9] Data has been revised - acute length of stay previously omitted acute mental health patients - chronic data was reviewed and revised to match internal reporting.

[10] Other types of care are not segregated.

[11] a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed.

b) Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.

[12] B = Billion.

[13] Data not available at time of report production.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. out-patient diagnostic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
e. surgical day care (out-patient)		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
f. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total insured hospital services provided at private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total payments to private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]

[14] Not available - the reliability of the data is questionable and the results of the calculations are questionable and are not supportable or reportable.

a) Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of activity.

b) Separating by facility type gives a small sample size and significantly understates the amount of activity related to chronic and rehabilitative outpatients.

c) Mergers and amalgamations during this period also contribute variability to the figures particularly when viewed by main activity.

[15] Not available - the data is not collected within a single system in the ministry.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	6,494	8,004	8,431	9,031	9,540
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	80,263	102,504	104,398	155,648	161,882
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	27.9 M	36.2 M	32.8 M	41.3 M	39.9 M
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	8.3 M	10.7 M	13.3 M	18.7 M	22.0 M
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	4,296.0	4,523.0	3,890.0	4,573.0	4,182.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	103.0	104.0	127.0	120.0	136.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	30,688	26,211	24,141	20,657	20,503
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	included in #20	included in #20	included in #20	included in #20	included in #20
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	31.6 M	25.0 M	21.4 M	17.0 M	18.8 M
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	included in #22	included in #22	included in #22	included in #22	included in #22
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	1,030.0	954.0	886.0	823.0	918.0
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	included in #24	included in #24	included in #24	included in #24	included in #24

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	367	366	350	350 [16]	357
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	67,156	69,163	70,658	69,400	71,660
28. Total payments to dentists for insured surgical-dental services.	**($)**	7.8 M	7.9 M	7.9 M	8.1 M	8.2 M
29. Average payment per service for insured surgical-dental services.	**($)**	116.2	114.2	111.8	116.7	115.2

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		10,475 [17]	10,319	10,221	10,227	10,281
b. specialists		9,825	9,944	9,994	10,284	10,392
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		20,300	20,263	20,215	20,511	20,673
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		33	29	26	25	25
b. specialists		221	209	196	188	177
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		254	238	222	213	202
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
b. specialists		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
c. other		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
d. total		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]

[16] Number of participating dentists was 350, but over 700 are registered on the Corporate Provider Database.

[17] a) Source for all insured physician services data: Ontario Statistical Reporting System (OSRS) April 1996-March 2000.
b) Numbers in the Annex are number of physicians who bill through the fee-for-service (FFS) system. The Annex numbers are derived from the Ontario Statistical Reporting System. Not all physicians who are registered bill under the FFS system. Number of physician services do not include laboratory services. Also, obstetrical care is included under medical services.
c) Physician services include assistant and anaesthetist time based units, and the diagnostic portion includes both the professional and technical components counted separately.
d) Numbers as of end of March of each fiscal year.

[18] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

[19] Ontario has no non-participating physicians, only opted-out physicians who are reported under item #31.

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		82.0 M	83.6 M	80.4 M	79.6 M	79.7 M
b. specialists		85.9 M	90.8 M	89.9 M	91.4 M	93.6 M
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		167.9 M	174.4 M	170.3 M	171.0 M	173.3 M
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		84.1 M	85.3 M	84.2 M	84.1 M	82.9 M
b. surgical		21.4 M	22.2 M	21.6 M	22.0 M	22.3 M
c. diagnostic		62.4 M	66.8 M	64.4 M	64.8 M	68.1 M
d. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. total		167.9 M	174.3 M	170.2 M	170.9 M	173.3 M
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		1,688.3 M	1,722.7 M	1,676.9 M	1,725.2 M	1,734.1 M
b. specialists		2,443.5 M	2,618.6 M	2,587.2 M	2,699.2 M	2,824.3 M
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. total		4131.8 M	4341.3 M	4264.1 M	4424.4 M	4,558.4 M
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		2,593.9 M	2,664.5 M	2,605.6 M	2,678.6 M	2,699.8 M
b. surgical		586.2 M	616.0 M	608.5 M	633.8 M	670.8 M
c. diagnostic		951.7 M	1,060.8 M	1,050.1 M	1,112.0 M	1,187.8 M
d. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. total		4,131.8 M	4,341.3 M	4,264.2 M	4,424.4 M	4,558.4 M
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		20.6	20.6	20.9	21.7	21.8
b. specialists		28.5	28.8	28.8	29.5	30.2
c. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
d. all physicians		24.6	24.9	25.1	25.9	26.3
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		30.8	31.2	30.9	31.8	32.6
b. surgical		27.5	27.7	28.2	28.8	30.1
c. diagnostic		15.2	15.9	16.3	17.2	17.5
d. other		not available [18]	not available [18]	not available [18]	not available [18]	not available [18]
e. all services		24.6	24.9	25.1	25.9	26.3

[18] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	399,005	428,329	433,396	455,136	433,463
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	12.9 M	12.8 M	13.3 M	14.0 M	14.3 M
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	32.0	30.0	31.0	31.0	33.0

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	266,856	228,379	207,736	184,107	179,679
43. Total payments for out-of-country insured physician services.	**($)**	8.1 M	7.5 M	7.0 M	11.6 M	15.5 M
44. Average payment per service for out-of-country insured physician services.	**($)**	30.0	33.0	34.0	63.0	86.0

Manitoba

Registered Persons [1]					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	1,144,643	1,146,331	1,142,465	1,144,424	1,149,904

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	95	95	95	95	95
b. chronic care	4 [2]	4 [2]	4 [2]	4 [2]	3 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities	99	99	99	99	98
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: [3] **(#)**					
a. acute care	4,628	4,559	4,436	4,394	4,406
b. chronic care	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: [3] **(#)**					
a. acute care	4,628	4,559	4,439	4,394	4,406
b. chronic care	559 [2]	392 [2]	402 [2]	402 [2]	385 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total approved bed complement	5,187	4,951	4,841	4,796	4,791

1 The population data is based on records of residents registered with Manitoba Health as at June 1.

2 Includes both chronic care and rehabilitative care.

3 The number of beds that are set up as of March 31 for patient accommodation by a hospital.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		139,463	136,931	136,499	132,650	127,903
b. chronic care		1,640	1,746	1,757	1,876	1,905
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		99,571	107,418	111,931	115,136	116,305
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		15,838	14,784	14,814	14,807	14,403
h. other		not available	not available	not available	not available	not available
i. total separations		256,512	260,879	265,001	264,469	260,516
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		9.3	9.3	9.5	9.7	9.9
b. chronic care		103.6 [2]	118.0 [2]	74.3 [2]	69.0 [2]	78.4 [2]
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		3.6	3.7	3.9	3.5	3.5
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		not available	not available	not available	not available	953,834,797
b. chronic care		not available	not available	not available	not available	65,153,895
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

[2] Includes both chronic care and rehabilitative care.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	3,174	3,419	3,307	2,571	3,037
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	24,779	28,422	28,007	21,570	29,217
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	12,506,685	14,156,175	11,292,528	8,655,520	12,152,757
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	2,321,046	2,947,701	3,451,891	2,694,973	4,089,018
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	3,940.4	4,140.4	3,414.7	3,366.6	4,001.6
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	93.7	103.7	123.3	124.9	139.9

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	530	614	588	565	567
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	5,810	6,331	5,782	6,053	6,335
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	854,120	991,294	1,058,815	1,028,127	1,065,302
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	611,162	658,890	690,877	905,479	2,435,560
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	1,611.6	1,614.5	1,800.7	1,819.7	1,878.8
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	105.2	104.1	119.5	149.6	384.5

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	65	94	102	105	101
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	2,681	2,953	2,925	3,318	3,256
28. Total payments to dentists for insured surgical-dental services.	**($)**	496,505	539,940	589,378	590,125	660,870
29. Average payment per service for insured surgical-dental services.	**($)**	185.2	182.8	201.5	177.9	203.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		970	935	900	915	948
b. specialists		972	931	938	939	not available
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		1,882	1,866	1,838	1,854	not available
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		5,726,851	5,741,645	5,859,568	5,931,022	6,211,011
b. specialists		6,712,187	7,281,386	7,698,155	8,147,749	8,741,628
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		12,439,038	13,023,031	13,557,723	14,078,771	14,952,639
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
e. total		not available	not available	not available	not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		99,387,716	99,489,900	103,068,422	114,868,502	132,200,004
b. specialists		146,956,655	153,336,002	165,946,999	178,359,474	199,231,274
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		246,344,371	252,825,902	269,015,421	293,227,976	331,431,278
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
e. total		307,890,771	351,821,602	376,500,221	416,902,176	467,886,678
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		17.4	17.3	17.6	19.4	21.3
b. specialists		21.9	21.1	21.6	21.9	22.8
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians		19.8	19.4	19.8	20.8	22.2
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		not available	not available	not available	not available	not available
b. surgical		not available	not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
e. all services		not available	not available	not available	not available	not available

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	222,601	217,733	206,521	183,497	192,272
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	6,627,296	6,245,462	6,121,559	5,568,205	6,148,444
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	28.2	28.7	29.6	30.3	32.0

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	6,993	7,222	6,587	7,116	6,763
43. Total payments for out-of-country insured physician services.	**($)**	466,323	518,102	519,928	520,712	500,757
44. Average payment per service for out-of-country insured physician services.	**($)**	66.7	71.7	78.9	73.2	74.0

Saskatchewan

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	1,027,551	1,020,351	1,031,933	1,041,256	1,021,762

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	75	73	71	71	68
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	76	74	72	72	69
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	3,282 [1]	3,117	3,078	2,944	2,802
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not available	142	142	142	142
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other [2]	not available	722	735	718	670
f. total staffed beds	not available	3,981	3,955	3,804	3,614
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

1 Count of acute care staffed beds for 1996-1997 is an estimate.

2 "Other" staffed beds include long term care beds and beds in psychiatric units of hospitals.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		148,740	146,537	143,604	133,768	131,305 [3]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		1,401	1,338	1,058	927	977 [3]
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient) [4]		45,224	50,090	53,890	55,426	55,527 [3]
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		13,418	12,882	12,819	12,597	11,993 [3]
h. other [5]		4,106	3,988	3,309	4,065	4,393 [3]
i. total separations [6]		212,889	214,835	214,680	206,783	204,195 [3]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		5.7	5.7	5.8	5.6	5.7 [3]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		32.4	30.9	30.5	34.7	31.9 [3]
d. newborns		3.7	3.7	3.5	3.7	3.6 [3]
e. other [5]		16.3	16.5	15.4	15.8	15.9 [3]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		522,036,613	584,582,800	565,682,800	619,538,151	680,326,248
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		34,822,774	35,115,992	35,437,299	36,824,546	38,249,010
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		556,859,387	619,698,792	601,120,099	656,362,697	718,575,258
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

[3] Separations and average length of stay for 2000-2001 are based on preliminary data.

[4] Surgical day care (out-patient) cases shown are cases involving day procedures that appear on the Canadian Institute for Health Information's 1991 list of operative procedures.

[5] "Other" separations are separations from psychiatric units in acute care hospitals.

[6] Total separations exclude long term care separations.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Out-of-Province/Territory Hospital Services (In Canada)					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada). **(#)**	4,788	4,868	4,688	5,019	4,587
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada). **(#)**	35,493	38,279	41,375	44,327	45,195
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada). **($)**	21,051,931	23,988,792	18,973,762	19,911,192	20,203,300
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada). **($)**	3,836,058	4,161,896	3,472,464	3,504,388	6,046,600
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada). **($)**	4,396.8	4,927.9	4,047.3	3,967.2	4,404.5
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada). **($)**	108.1	108.7	83.9	79.1	133.8

Out-of-Country Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. **(#)**	337	317	273	382	286
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. **(#)**	1,574	1,695	1,252	1,201	1,355
22. Total payments for out-of-country, in-patient, insured hospital services. **($)**	288,000	710,626	1,193,449	2,484,961	1,022,000
23. Total payments for out-of-country, out-patient, insured hospital services. **($)**	132,500	228,968	151,558	348,379	377,600
24. Average payment for out-of-country, in-patient insured hospital services. **($)**	854.6	2,241.7	4,371.6	6,505.1	3,573.4
25. Average payment for out-of-country, out-patient insured hospital services. **($)**	84.2	135.1	121.1	290.1	278.7

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	126	119	113	97	92
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	18,600	18,700	18,500	18,100	19,900
28. Total payments to dentists for insured surgical-dental services.	**($)**	1,291,000	1,287,000	1,272,000	1,309,000	1,404,700
29. Average payment per service for insured surgical-dental services.	**($)**	69.4	68.8	68.8	72.3	70.6

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		860	865	907	940	1,016
b. specialists		583	592	595	610	593
c. other		0	0	0	0	0
d. total		1,443	1,457	1,502	1,550	1,609
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		6,868,246	6,595,192	6,742,712	6,785,673	6,873,539
b. specialists		3,121,981	3,068,576	3,127,345	3,163,046	3,250,953
c. other		0	0	0	0	0
d. total		9,990,227	9,663,768	9,870,057	9,948,719	10,124,492
34. Number of insured physician services provided, by category of service: [7]	**(#)**					
a. medical		6,229,799 [8]	5,989,580 [8]	6,048,849 [8]	6,028,070 [8]	6,071,567 [8]
b. surgical		739,787 [9]	728,803 [9]	735,770 [9]	723,626 [9]	787,655 [9]
c. diagnostic		2,404,982 [10]	2,323,818 [10]	2,345,180 [10]	2,312,606 [10]	2,288,038 [10]
d. other		615,659 [11]	621,567 [11]	740,258 [11]	884,417 [11]	977,232 [11]
e. total		9,990,227	9,663,768	9,870,057	9,948,719	10,124,492
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		122,511,451	119,002,444	128,784,792	133,042,948	134,989,267
b. specialists		118,134,845	117,666,741	122,465,930	125,735,201	129,470,569
c. other		0	0	0	0	0
d. total		240,646,296	236,669,185	251,250,722	258,778,149	264,459,836
36. Total payments to physicians for insured physician services, by category of service: [7]	**($)**					
a. medical		140,292,403 [8]	137,691,861 [8]	143,548,623 [8]	148,848,496 [8]	151,152,270 [8]
b. surgical		52,990,753 [9]	51,536,110 [9]	51,255,592 [9]	50,843,890 [9]	51,681,286 [9]
c. diagnostic		38,430,693 [10]	37,944,132 [10]	40,473,208 [10]	41,503,336 [10]	43,216,810 [10]
d. other		8,932,447 [11]	9,497,081 [11]	15,973,299 [11]	17,582,427 [11]	18,409,471 [11]
e. total		240,646,296	236,669,184	251,250,722	258,778,149	264,459,837
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		17.8	18.0	19.1	19.6	19.6
b. specialists		37.8	38.3	39.2	39.8	39.8
c. other		0.0	0.0	0.0	0.0	0.0
d. all physicians		24.1	24.5	25.5	26.0	26.1
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		22.5 [8]	23.0 [8]	23.7 [8]	24.7 [8]	24.9 [8]
b. surgical		71.6 [9]	70.7 [9]	69.7 [9]	70.3 [9]	65.6 [9]
c. diagnostic		16.0 [10]	16.3 [10]	17.3 [10]	17.9 [10]	18.9 [10]
d. other		14.5 [11]	15.3 [11]	21.6 [11]	19.9 [11]	18.8 [11]
e. all services		24.1	24.5	25.5	26.0	26.1

[7] Fee-for-service.

[8] Includes visits, hospital care, psychotherapy.

[9] Includes surgeries, surgical assistance, obstetrics, anaesthesia.

[10] Includes x-rays, laboratory, diagnostics.

[11] Includes surcharges, premiums, on-call.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	318,200	361,000	374,900	392,400	425,800
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	9,286,800	10,501,400	10,897,500	12,237,200	13,767,600
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	29.2	29.1	29.1	31.2	32.3

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	**($)**	519,400	644,300	658,400	1,186,900	722,400
44. Average payment per service for out-of-country insured physician services.	**($)**	not available	not available	not available	not available	not available

Alberta

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
1. Total number of persons registered under the health care insurance plan as of March 31st.	**(#)**	2,786,526	2,847,538	2,912,925	2,957,045	3,007,582

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	**(#)**					
a. acute care		102 [2]	102 [2]	102 [2]	102 [2]	102 [2]
b. chronic care		104	104	104	104	105
c. rehabilitative care		1	1	1	1	1
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		0	0	0	3	3
g. total facilities		207	207	207	210	211
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		6,176	6,305	6,404	6,275	6,284
b. chronic care		6,179	6,179	6,179	6,179	6,358
c. rehabilitative care		240	240	240	240	240
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		12,595	12,724	12,823	12,694	12,882
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		9,788	9,788	9,788	9,788	9,788
b. chronic care		6,114	6,114	6,114	6,114	6,164
c. rehabilitative care		240	240	240	240	240
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		16,142	16,142	16,142	16,142	16,192

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001*.

[2] Section 2 - acute care facilities was revised for the years 1996/1997 to 1999/2000 to include one extra facility.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. alternative level of care		not available	not available	not available	not available	not available
g. newborns		not available	not available	not available	not available	not available
h. other		not available	not available	not available	not available	not available
i. total separations		332,665	334,869	346,092	346,316	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. newborns		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services		not applicable	not applicable	not applicable	not applicable	not applicable
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total private for-profit health care facilities		not available	not available	not available	not available	not available
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	4,565	4,656	4,714	4,820	4,535
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	55,477	56,408	57,574	59,443	59,815
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	16,065,099	14,699,049	13,269,781	13,632,730	12,647,870
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	5,170,997	5,287,271	6,706,065	6,920,702	6,955,005
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	3,519.2	3,157.0	2,815.0	2,828.4	2,788.9
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	93.2	93.7	116.5	116.4	116.3

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. [3]	**(#)**	4,686 [4]	3,843 [4]	4,005 [4]	5,215 [4]	4,151
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. [3]	**(#)**	4,696 [4]	4,668 [4]	3,777 [4]	5,097 [4]	3,945
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	437,393 [4]	363,087 [4]	356,747 [4]	483,648 [4]	374,005
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	351,698 [4]	349,217 [4]	275,687 [4]	364,087 [4]	298,725
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	93.3 [4]	94.5 [4]	89.1 [4]	92.7 [4]	90.1
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	74.9 [4]	74.8 [4]	73.0 [4]	71.4 [4]	75.7

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

[3] Data are the total number of service units paid for out-of-country, insured hospital services.

[4] Sections 20 to 25 were revised from previous editions of the *Canada Health Act Annual Report* due to an error in designating services and payments between in-patients and out-patients for fiscal years 1996-1997 to 1999-2000.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
26. Number of dentists participating in the health insurance plan.	**(#)**	241	230	232	250	232
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	9,063	10,648	11,920	14,292	14,708
28. Total payments to dentists for insured surgical-dental services.	**($)**	1,571,065	1,691,797	1,853,322	2,092,003	2,116,386
29. Average payment per service for insured surgical-dental services.	**($)**	173.3	158.9	155.5	146.4	143.9

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		2,395	2,365	2,464	2,545	2,659
b. specialists		1,833	1,903	1,978	2,096	2,197
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		4,228	4,268	4,442	4,641	4,856
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	1
c. other		0	0	0	0	0
d. total		0	0	0	0	1

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
33. Number of insured physician services provided, by type of physician (fee-for-service):	**(#)**					
a. general practitioners		13,947,484	14,377,354	14,974,783	15,543,092	15,914,666
b. specialists		9,291,690	9,844,887	10,392,632	10,798,883	11,319,078
c. other		0	0	0	0	0
d. total		23,239,174	24,222,241	25,367,415	26,341,975	27,233,744
34. Number of insured physician services provided, by category of service:	**(#)**					
a. medical		17,875,863 [5]	18,411,601 [5]	19,119,550 [5]	19,829,029 [5]	20,328,498 [5]
b. surgical		1,117,537 [5]	1,155,663 [5]	1,211,712 [5]	1,238,043 [5]	1,316,312 [5]
c. diagnostic		4,245,774 [5]	4,654,977 [5]	5,036,153 [5]	5,274,903 [5]	5,588,934 [5]
d. other		0	0	0	0	0
e. total		23,239,174 [5]	24,222,241 [5]	25,367,415 [5]	26,341,975 [5]	27,233,744 [5]
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	**($)**					
a. general practitioners		346,643,288	357,611,870	383,842,634	410,502,506	430,681,658
b. specialists		399,772,398	427,232,284	464,270,463	493,040,446	528,392,197
c. other		0	0	0	0	0
d. total		746,415,686	784,844,154	848,113,097	903,542,952	959,073,855
36. Total payments to physicians for insured physician services, by category of service:	**($)**					
a. medical		498,946,649 [5]	514,667,078 [5]	549,507,274 [5]	586,587,852 [5]	618,596,110 [5]
b. surgical		120,802,134 [5]	125,595,149 [5]	133,916,239 [5]	140,067,988 [5]	150,223,933 [5]
c. diagnostic		126,666,903 [5]	144,581,927 [5]	164,689,584 [5]	176,887,112 [5]	190,253,812 [5]
d. other		0	0	0	0	0
e. total		746,415,686 [5]	784,844,154 [5]	848,113,097 [5]	903,542,952 [5]	959,073,855 [5]
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	**($)**					
a. general practitioners		24.9	24.9	25.6	26.4	27.1
b. specialists		43.0	43.4	44.7	45.7	46.7
c. other		0.0	0.0	0.0	0.0	0.0
d. all physicians		32.1	32.4	33.4	34.3	35.2
38. Average payment per service for insured physician services, by category of service:	**($)**					
a. medical		27.9 [5]	28.0 [5]	28.7 [5]	29.6 [5]	30.4 [5]
b. surgical		108.1 [5]	108.7 [5]	110.5 [5]	113.1 [5]	114.1 [5]
c. diagnostic		29.8 [5]	31.1 [5]	32.7 [5]	33.5 [5]	34.0 [5]
d. other		0.0	0.0	0.0	0.0	0.0
e. all services		32.1 [5]	32.4 [5]	33.4 [5]	34.3 [5]	35.2 [5]

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

[5] Sections 34, 36 and 38 were revised to reflect services and payments based on type of service rather than specialty of the physician. This data was revised for the years ended March 31, 1996/1997 to 1999/2000.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	355,985	348,480	359,653	380,635	418,587
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	10,412,565	10,092,203	9,983,110	11,397,620	12,436,188
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	29.3	29.0	27.8	29.9	29.7

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001** [1]
42. Number of services paid for out-of-country, insured physician services.	**(#)**	34,221	30,649	25,192	21,989	20,891
43. Total payments for out-of-country insured physician services.	**($)**	1,128,302	972,645	862,852	871,292	907,010
44. Average payment per service for out-of-country insured physician services.	**($)**	33.0	31.7	34.3	39.6	43.4

[1] These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' *Alberta Health Care Insurance Plan Statistical Supplement, 2000-2001* .

British Columbia

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**	3,920,273	3,951,853	3,924,490	3,943,991	4,022,789

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care	93	93	94	94	94
b. chronic care	17	17	17	17	18
c. rehabilitative care	2	3	3	3	3
d. out-patient diagnostic care	25	25	25	25	25
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	1	1	0	0	0
g. total facilities	138	139	139	139	140
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care	8,871	8,822	8,834	8,533	8,994
b. chronic care	8,641	8,628	8,018	8,733	9,102
c. rehabilitative care	193	242	242	468	474
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	17,705	17,692	17,094	17,734	18,570

Estimates and projections have been made where there is incomplete data.

There is some instability in reporting due to regionalization and changes in reporting for health authorities.

Figures shown may differ from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database due to varying definitions.

Some health authorities use a non specific category (i.e. other) for statistics. Most often this is included in the acute care category.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		345,523	367,465	376,369	374,246	378,427
b. chronic care		7,805	9,072	9,016	7,132	7,502
c. rehabilitative care		2,612	2,445	2,497	2,466	2,753
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		295,117	289,951	274,295	293,530	288,705
f. alternative level of care		5,365	3,591	3,060	3,798	3,882
g. newborns		36,462	40,968	41,085	40,566	39,947
h. other		not applicable	not applicable	not applicable	not applicable	not applicable
i. total separations		692,884	713,492	706,322	721,738	721,216
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		5.6	5.9	5.8	6.0	6.0
b. chronic care		351.0	325.7	211.5	340.6	379.0
c. rehabilitative care		33.5	32.2	28.9	28.5	26.9
d. newborns		2.9	6.7	2.2	2.4	2.6
e. other		30.8	33.7	29.0	29.3	28.5
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available

Estimates and projections have been made where there is incomplete data.

There is some instability in reporting due to regionalization and changes in reporting for health authorities.

Figures shown may differ from the Canadian Institute for Health Information's (CIHI) Discharge Abstract Database due to varying definitions.

Some health authorities use a non specific category (i.e. other) for statistics. Most often this is included in the acute care category.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	1	1
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total private for-profit health care facilities		not available	not available	not available	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**	7,225	7,383	7,994	7,231	8,113
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**	62,604	68,146	73,807	70,070	83,765
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**	37,483,341	35,898,630	35,830,522	34,477,406	35,882,521
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**	6,145,727	7,441,321	9,075,191	9,585,916	9,149,496
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**	5,188.0	4,862.0	4,482.0	4,768.0	4,422.8
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**	98.0	109.0	123.0	137.0	109.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**	2,946	2,888	2,793	2,494	2,097
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**	340	431	435	324	720
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**	2,251,755	3,073,456	3,492,437	5,375,289	6,463,676
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**	77,502	109,347	100,863	65,137	134,789
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**	764.0	1,064.0	1,250.0	2,155.0	3,082.3
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**	228.0	254.0	232.0	201.0	187.2

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	284	289	280	265	283
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	53,130	53,163	51,096	54,507	55,820
28. Total payments to dentists for insured surgical-dental services.	**($)**	5,663,597	5,818,127	5,474,563	5,854,368	5,718,859
29. Average payment per service for insured surgical-dental services.	**($)**	106.6	109.4	107.1	107.4	102.0

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		4,154	4,248	4,269	4,276	4,360
b. specialists		3,116	3,181	3,232	3,269	3,298
c. other		0	0	0	0	0
d. total		7,270	7,429	7,501	7,545	7,658
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		5	3	4	4	3
b. specialists		13	11	13	10	5
c. other		0	0	0	0	0
d. total		18	14	17	14	8
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		1	1	1	1	1
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		1	1	1	1	1

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): **(#)**					
a. general practitioners	22,197,196	22,378,959	21,903,525	22,875,620	23,051,810
b. specialists	28,828,096	29,424,394	29,860,276	32,697,836	34,551,897
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	51,025,292	51,803,353	51,763,801	55,573,456	57,603,707
34. Number of insured physician services provided, by category of service: **(#)**					
a. medical	23,535,944 [1]	24,309,601 [1]	24,012,366 [1]	25,065,926 [1]	25,201,483 [1]
b. surgical	5,601,151 [2]	4,209,195 [2]	4,163,434 [2]	4,426,656 [2]	4,417,069 [2]
c. diagnostic	21,888,197 [3]	23,294,557 [3]	23,588,001 [3]	26,080,874 [3]	27,985,155 [3]
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	51,025,292	51,813,353	51,763,801	55,573,456	57,603,707
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: [4] **($)**					
a. general practitioners	613,317,385	614,713,789	626,992,277	654,305,224	663,325,757
b. specialists	817,739,525	831,174,498	845,235,143	928,642,083	965,611,051
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,431,056,910	1,445,888,287	1,472,227,420	1,582,947,307	1,628,936,808
36. Total payments to physicians for insured physician services, by category of service: [5] **($)**					
a. medical	834,731,808	850,453,217	874,004,742	920,552,743	936,095,517
b. surgical	230,651,787	231,507,497	229,196,329	250,267,000	252,827,989
c. diagnostic	365,673,314	363,927,573	369,026,348	412,127,564	440,013,302
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,431,056,909	1,445,888,287	1,472,227,419	1,582,947,307	1,628,936,808
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: **($)**					
a. general practitioners	27.6	27.4	28.6	28.6	27.8
b. specialists	28.3	28.2	28.3	28.4	28.0
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	28.0	27.9	28.4	28.5	28.3
38. Average payment per service for insured physician services, by category of service: **($)**					
a. medical	35.5	35.0	36.4	36.7	37.1
b. surgical	41.2	55.0	55.0	56.5	57.2
c. diagnostic	16.7	15.6	15.6	15.8	15.7
d. other	0.0	0.0	0.0	0.0	0.0
e. all services	28.0	27.9	28.4	28.5	28.3

1 Medical services consist of the following services: regional examinations, consultations, complete examinations, counselling, home visits, emergency visits, institutional visits, dialysis/transfusions, general services and therapeutic radiation (service codes 1 through 8, 22 through 28, 30, and 46 through 48).

2 Surgical services consist of the following services: anaesthesia, cardiovascular, obstetrics minor and non-minor surgeries (service codes 40 through 45).

3 Diagnostic services consist of the following services: diagnostic ophthamology, diagnostic radiology, diagnostic ultrasound, nuclear medicine, pathology, pulmonary function, electro-diagnosis, and procedural cardiology (service codes 89 through 98).

4 Expenditure includes paid amount, Northern and Isolation Allowance, premiums, and exclude tray fees.

5 Paid services consist of MSP fee-for-services provided between April 1, 2000 and March 31, 2001, paid to September 30, 2001.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	477,236	461,571	438,186	446,232	not available
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	13,844,944	13,849,906	13,495,893	14,134,689	not available
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	29.0	30.0	30.8	31.7	not available

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	not available	not available	73,297	66,361	68,707
43. Total payments for out-of-country insured physician services.	**($)**	not available	not available	3,504,870	3,336,415	3,947,293
44. Average payment per service for out-of-country insured physician services.	**($)**	not available	not available	47.8	50.3	57.5

Yukon

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st.	**(#)**	33,984	33,557	31,925	31,255	31,133

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	**(#)**					
a. acute care		2	2	2	2	2
b. chronic care		0	0	0	0	0
c. rehabilitative care		0	0	0	0	0
d. out-patient diagnostic care		0	0	0	0	0
e. surgical day care (out-patient)		0	0	0	0	0
f. other		13 [1]	13 [1]	13 [1]	13 [1]	13 [1]
g. total facilities		15	15	15	15	15
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		70	59	59	61	61
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total staffed beds		79	68	68	70	70
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care		70	59	59	61	61
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total approved bed complement		79	68	68	70	70

[1] Includes health centres and one health station.

[2] Day surgery beds.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care		3,481	3,283	3,117	2,967	3,021
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		1,646	1,524	1,606	1,624	1,619
f. alternative level of care		0	0	0	0	0
g. newborns		452	437	392	374	363
h. other		0 [1]	0 [1]	0 [1]	0 [1]	0 [1]
i. total separations		5,579	5,244	5,115	4,965	5,003
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care		4.5	4.0	4.5	4.7	4.7
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. newborns		3.0	3.0	2.9	3.0	3.1
e. other		not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care		18,567,847	18,836,846	19,023,617	19,587,158	20,350,026
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		0	0	0	0	0
f. other		4,692,893 [1]	4,722,168 [1]	4,796,107 [1]	5,502,144 [1]	5,483,948 [1]
g. total payments to facilities providing insured hospital services		23,260,740	23,559,014	23,819,724	25,089,302	25,833,974
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care		505.0	505.0	694.5	694.5	694.5
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not available	not available	not available	not available	not available

[1] Includes health centres and one health station.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care		89.0	89.0	110.0	110.0	110.0
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		292.0	292.0	400.0	400.0	400.0
f. other		not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care		311.1	362.7	349.7	337.2	335.5
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

[1] Includes health centres and one health station.

Out-of-Province/Territory Hospital Services (In Canada) [3]					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada). **(#)**	712	732	769	735	698
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada). **(#)**	5,621	6,109	6,637	7,025	6,690
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada). **($)**	4,751,127	4,434,174	4,196,661	4,683,562	4,220,525
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada). **($)**	584,070	645,165	826,425	920,769	857,580
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada). **($)**	6,673.0	6,058.0	5,457.0	6,372.0	6,047.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada). **($)**	104.0	106.0	125.0	131.0	128.0

Out-of-Country Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. **(#)**	11	14	13	11	8
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. **(#)**	67	42	53	67	54
22. Total payments for out-of-country, in-patient, insured hospital services. **($)**	62,847	34,445	45,440	22,125	20,597
23. Total payments for out-of-country, out-patient, insured hospital services. **($)**	32,462	5,502	7,354	7,080	8,368
24. Average payment for out-of-country, in-patient insured hospital services. **($)**	5,713.0	2,460.0	3,495.0	2,011.0	2,575.0
25. Average payment for out-of-country, out-patient insured hospital services. **($)**	485.0	131.0	139.0	102.0	156.0

[3] Claims for out of Province/Territory in Canada are still being received. Provinces have 12 months to submit their claims.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**	12	10	12	9	11
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**	309	203	297	214	222
28. Total payments to dentists for insured surgical-dental services.	**($)**	75,331	50,840	64,397	59,458	50,876
29. Average payment per service for insured surgical-dental services.	**($)**	243.8	250.4	217.2	277.8	229.2

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		48	52	40	41	43
b. specialists		4	4	4	5	6
c. other		0	0	0	0	0
d. total		52	56	44	46	49
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): **(#)**					
a. general practitioners	161,680	164,544	151,743	153,542	164,497
b. specialists	12,522	10,885	14,170	11,704	14,789
c. other	0	0	0	0	0
d. total	174,202	175,429	165,913	165,246	179,286
34. Number of insured physician services provided, by category of service: **(#)**					
a. medical	125,230	127,479	120,830	123,333	131,685
b. surgical	26,775	25,425	23,110	22,092	25,670
c. diagnostic	22,197	22,525	21,972	19,822	18,978
d. other	0	0	0	0	0
e. total	174,202	175,429	165,912	165,247	176,333
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: **($)**					
a. general practitioners	5,198,864	5,335,775	5,058,606	5,248,704	5,803,619
b. specialists	1,076,028	1,184,312	1,321,577	1,189,271	1,263,380
c. other	0	0	0	0	0
d. total	6,274,892	6,520,087	6,380,183	6,437,975	7,066,999
36. Total payments to physicians for insured physician services, by category of service: **($)**					
a. medical	5,040,362	5,182,278	5,026,530	5,144,453	5,729,729
b. surgical	918,797	995,148	1,005,170	978,628	1,028,529
c. diagnostic	315,733	342,661	348,483	314,893	308,741
d. other	0	0	0	0	0
e. total	6,274,892	6,520,087	6,380,183	6,437,974	7,066,999
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: **($)**					
a. general practitioners	32.2	32.4	33.3	34.2	35.3
b. specialists	85.9	108.8	93.3	101.6	85.4
c. other	0.0	0.0	0.0	0.0	0.0
d. all physicians	36.0	37.2	38.5	39.0	39.4
38. Average payment per service for insured physician services, by category of service: **($)**					
a. medical	40.2	40.7	41.6	41.7	43.5
b. surgical	34.3	39.1	43.5	44.3	40.1
c. diagnostic	14.2	15.2	15.9	15.9	16.3
d. other	0.0	0.0	0.0	0.0	0.0
e. all services	36.0	37.2	38.5	39.0	40.1

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**	33,313	28,656	29,834	31,020	36,828
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**	1,180,306	1,183,519	1,207,371	1,404,195	1,642,495
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**	35.4	41.3	40.5	45.3	44.6

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	**($)**	not available	not available	not available	not available	not available
44. Average payment per service for out-of-country insured physician services.	**($)**	not available	not available	not available	not available	not available

In-Province/Territory Physician Services [4]					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
45. Number of physicians participating in the health insurance plan, by type of physician: **(#)**					
a. general practitioners	not available	not available	not available	not available	not available
b. specialists	not available	not available	not available	not available	not available
c. all physicians	not available	not available	not available	not available	not available
46. Number of insured services provided, by category of physicians (fee-for-service): **(#)**					
a. general practitioners	23,759	27,583	30,391	27,757	21,028
b. specialists	11,411	11,848	10,443	11,332	5,254
c. all physicians	35,170	39,431	40,834	39,089	26,282
47. Number of insured services provided, by category services **(#)**					
a. medical services	29,629	33,975	33,007	31,609	19,865
b. surgical services	2,134	1,842	4,483	5,141	4,208
c. diagnostic services	3,407	3,614	3,344	2,339	2,209
d. all insured physician services	35,170	39,431	40,834	39,089	26,282
48. Total payment of (fee-for-service) physicians for insured services by category of physicians: **(#)**					
a. general practitioners	815,233	983,271	994,636	907,848	756,866
b. specialists	924,791	756,719	681,869	727,972	695,927
c. all physicians	1,740,024	1,739,990	1,676,505	1,635,820	1,452,793
49. Total payment to physicians for insured services, by category of **(#)**					
a. medical services	1,415,810	1,542,518	1,477,892	1,436,115	1,159,117
b. surgical services	232,831	112,736	121,755	132,349	208,679
c. diagnostic services	91,383	84,736	76,857	67,356	84,997
d. all insured physician services	1,740,024	1,739,990	1,676,504	1,635,820	1,452,793
50. Average payment for insured (fee-for-service) physicians services by category of physicians: **($)**					
a. general practitioners	34.3	35.7	32.7	32.7	36.0
b. specialists	81.0	63.9	65.3	64.2	132.5
c. all physicians	49.5	44.1	41.1	41.9	55.3
51. Average payment for insured physician services by category of **($)**					
a. medical services	47.8	45.4	44.8	45.4	58.4
b. surgical services	109.1	61.2	27.2	25.7	49.6
c. diagnostic services	26.8	23.5	23.0	28.8	38.5
d. all insured physician services	49.5	44.1	41.1	41.9	55.3

[4] Visiting Specialists, Locum Doctors and Member Reimbursements.

Northwest Territories

Registered Persons					
Population	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st. **(#)**				41,000	41,673

In-Province/Territory Hospital Services					
Insured Hospital Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: **(#)**					
a. acute care				4 hospitals	4 hospitals
b. chronic care				not available [1]	not available [1]
c. rehabilitative care				not available [1]	not available [1]
d. out-patient diagnostic care				not available [1]	not available [1]
e. surgical day care (out-patient)				not available [1]	not available [1]
f. other				28	28
g. total facilities				32	32
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total staffed beds				212	220
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: **(#)**					
a. acute care				not available	not available
b. chronic care				not available	not available
c. rehabilitative care				not available	not available
d. out-patient diagnostic care				not available	not available
e. other				not available	not available
f. total approved bed complement				212	220

[1] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					7,907	7,185
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					2,748	2,438
f. alternative level of care					not available	not available
g. newborns					472	717
h. other					59,253	64,995
i. total separations					70,380	75,335
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					15.2	10.6
d. newborns					2.9	3.0
e. other					4.8	4.3
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					1,205,469	1,129,741
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					1,099,200	975,200
f. other					34,548,885	33,823,823
g. total payments to facilities providing insured hospital services					36,853,554	35,928,763
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					1,479.6	1,625.7
d. other					1,354.7	1,357.7

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In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					110.0	109.8
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					400.0	400.0
f. other					109.1	108.6
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					152.5	157.2
d. other					570.6	510.6
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total private for-profit health care facilities					0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total insured hospital services provided at private for-profit health care facilities					0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total payments to private for-profit health care facilities					0	0

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**				1,063	930
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**				7,798	7,999
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**				7,092,119	5,254,269
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**				1,150,303	1,361,059
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**				6,671.8	5,649.8
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**				147.5	170.2

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**				6	5
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**				12	15
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**				10,190	2,908
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**				2,270	1,459
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**				1,698.4	581.5
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**				189.2	97.3

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**				not available	not available
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**				not available	not available
28. Total payments to dentists for insured surgical-dental services.	**($)**				not available	not available
29. Average payment per service for insured surgical-dental services.	**($)**				not available	not available

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					35 [2]	29 [2]
b. specialists					18 [2]	18 [2]
c. other					106 [3]	151 [3]
d. total					159 [4]	198 [4]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					0	0
b. specialists					0	0
c. other					0	0
d. total					0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					0	0
b. specialists					0	0
c. other					0	0
d. total					0	0

[2] Southam Medical Database, Canadian Institute for Health Information.

[3] This is an estimate of the number of locum physicians.

[4] Total is based on number of names.

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): **(#)**					
a. general practitioners				134,396	81,777
b. specialists				9,432	5,355
c. other				7,203	0
d. total				151,031	87,132
34. Number of insured physician services provided, by category of service: **(#)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				212,997	199,277
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: **($)**					
a. general practitioners				5,225,870	3,380,039
b. specialists				645,959	584,280
c. other				347,425	0
d. total				6,219,254	3,964,319
36. Total payments to physicians for insured physician services, by category of service: **($)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				9,315,675	8,468,518
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: **($)**					
a. general practitioners				38.9	41.3
b. specialists				68.5	109.1
c. other				48.2	not available
d. all physicians				41.2	45.5
38. Average payment per service for insured physician services, by category of service: **($)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. all services				43.7	42.5

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**				36,002	35,301
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**				1,931,528	1,908,213
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**				53.7	54.1

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**				212	176
43. Total payments for out-of-country insured physician services.	**($)**				18,197	13,296
44. Average payment per service for out-of-country insured physician services.	**($)**				85.8	75.5

Statistics for 1996-1997 to 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Nunavut

Registered Persons						
Population		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
1. Total number of persons registered under the health care insurance plan as of March 31st.	**(#)**				not available	26,829

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	**(#)**				1 Hospital 25 Health Centres	1 Hospital 25 Health Centres
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. other					not available	not available
g. total facilities					not available	not available
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. other					not available	not available
f. total staffed beds					not available	not available
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed:	**(#)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. other					not available	not available
f. total approved bed complement					not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
5. Number of separations from all facilities providing insured hospital services, by type of care:	**(#)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. alternative level of care					not available	not available
g. newborns					not available	not available
h. other					not available	not available
i. total separations					not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care:	**(# of days)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. newborns					not available	not available
e. other					not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. other					not available	not available
g. total payments to facilities providing insured hospital services					not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. other					not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. out-patient diagnostic care					not available	not available
e. surgical day care (out-patient)					not available	not available
f. other					not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	**($)**					
a. acute care					not available	not available
b. chronic care					not available	not available
c. rehabilitative care					not available	not available
d. other					not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	**(#)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total private for-profit health care facilities					0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	**(#)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total insured hospital services provided at private for-profit health care facilities					0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	**($)**					
a. private surgical facilities					0	0
b. private diagnostic imaging facilities					0	0
c. Total payments to private for-profit health care facilities					0	0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Out-of-Province/Territory Hospital Services (In Canada)						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	**(#)**				1,842	1,549
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	**(#)**				9,656	8,682
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	**($)**				8,546,013	7,612,791
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	**($)**				1,470,018	1,352,594
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	**($)**				4,639.0	4,915.0
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	**($)**				152.0	156.0

Out-of-Country Hospital Services						
Insured Hospital Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	**(#)**				14	0
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	**(#)**				5	1
22. Total payments for out-of-country, in-patient, insured hospital services.	**($)**				12,010	0
23. Total payments for out-of-country, out-patient, insured hospital services.	**($)**				1,130	110
24. Average payment for out-of-country, in-patient insured hospital services.	**($)**				857.0	0.0
25. Average payment for out-of-country, out-patient insured hospital services.	**($)**				226.0	110.0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Surgical-Dental Services						
Insured Dental Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
26. Number of dentists participating in the health insurance plan.	**(#)**				27	21
27. Number of insured surgical-dental services provided by participating dentists.	**(#)**				0	not available
28. Total payments to dentists for insured surgical-dental services.	**($)**				0	not available
29. Average payment per service for insured surgical-dental services.	**($)**				0.0	not available

In-Province/Territory Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
30. Number of physicians participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					85	59
b. specialists					79	55
c. other					0	0
d. total					164	114
31. Number of physicians opted-out of the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					not available	0
b. specialists					not available	0
c. other					not available	0
d. total					not available	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	**(#)**					
a. general practitioners					not available	0
b. specialists					not available	0
c. other					not available	0
d. total					not available	0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

In-Province/Territory Physician Services					
Insured Physician Services	**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
33. Number of insured physician services provided, by type of physician (fee-for-service): **(#)**					
a. general practitioners				not available	61,074
b. specialists				not available	29,485
c. other				not available	0
d. total				not available	0
34. Number of insured physician services provided, by category of service: **(#)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: **($)**					
a. general practitioners				2,323,234	2,494,221
b. specialists				1,146,522	1,229,811
c. other				not available	0
d. total				3,469,756	3,724,032
36. Total payments to physicians for insured physician services, by category of service: **($)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. total				not available	not available
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: **($)**					
a. general practitioners				not available	40.8
b. specialists				not available	41.0
c. other				not available	0.0
d. all physicians				not available	40.9
38. Average payment per service for insured physician services, by category of service: **($)**					
a. medical				not available	not available
b. surgical				not available	not available
c. diagnostic				not available	not available
d. other				not available	not available
e. all services				not available	not available

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Out-of-Province/Territory Physician Services (In Canada)						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	**(#)**				not available	55,389
40. Total payments for out-of-province/territory insured physician services (in Canada).	**($)**				not available	3,232,940
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	**($)**				not available	58.0

Out-of-Country Physician Services						
Insured Physician Services		**1996-1997**	**1997-1998**	**1998-1999**	**1999-2000**	**2000-2001**
42. Number of services paid for out-of-country, insured physician services.	**(#)**				0	0
43. Total payments for out-of-country insured physician services.	**($)**				0	0
44. Average payment per service for out-of-country insured physician services.	**($)**				0.0	0.0

Statistics for 1996-1997 to 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Annex B – 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

Extra-billing and User Charges Information Regulations

SOR/86-259

June, 2001

CODIFICATION ADMINISTRATIVE

Loi canadienne sur la santé

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

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

DORS/86-259

Juin 2001

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.

CANADA

OFFICE CONSOLIDATION **CODIFICATION ADMINISTRATIVE**

Canada Health Act

Loi canadienne sur la santé

R.S., 1985, c. C-6 **L.R. (1985), ch. C-6**

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AVERTISSEMENT

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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 services

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;

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 thereof that provides hospital care, including

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.

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;

"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,

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

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

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

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

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

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

«ministre» Le ministre de la Santé. «ministre» *"Minister"*

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

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

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

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

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

(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.

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.

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.

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.

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.

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.

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.

Universalité

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

1984, ch. 6, art. 10.

Portability

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

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

(b) must provide for and be administered and operated so as to provide for the payment of

Transférabilité

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

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

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

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.

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) offre les services de santé assurés selon des modalités uniformes et ne fasse pas

(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.

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.

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.

Rémunération raisonnable

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

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

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

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

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

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

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister

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

may reasonably require for the purposes of this Act; and

(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.

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.

DEFAULTS

MANQUEMENTS

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.

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.

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.

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.

Where no consultation can be achieved

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

1984, c. 6, s. 14.

Impossibilité de consultation

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

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of

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

a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

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

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

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

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

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

Amending orders

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

Modification des décrets

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

Notice of order

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

Avis

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

Commencement of order

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

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).

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

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

Reimposition of reductions or withholdings

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

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.

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

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

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

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.

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 AND USER CHARGES

SURFACTURATION ET FRAIS MODÉRATEURS

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.

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.

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.

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.

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.

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.

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.

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.

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.

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 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.

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.

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.

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.

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.

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

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.

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.

Application aux exercices ultérieurs

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

1984, ch. 6, art. 21.

REGULATIONS

RÈGLEMENTS

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)*.

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 13*a)* 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 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.

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.

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 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.

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.

REPORT TO PARLIAMENT

RAPPORT AU PARLEMENT

Annual report by Minister

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

1984, c. 6, s. 23.

Rapport annuel du ministre

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

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

CODIFICATION ADMINISTRATIVE

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

WARNING NOTE

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

AVERTISSEMENT

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

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

SHORT TITLE

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

INTERPRETATION

2. In these Regulations,

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

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

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

TYPES OF INFORMATION

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

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

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

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

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

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

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13*a)* 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 13*a)* 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 13*a)* 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 3*a)* et 4*a)*, 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 C – Policy Statements: The Epp Letter and the Federal Policy on Private Clinics

Annex C contains the texts for both the Epp Letter and the Marleau Letter (Federal Policy on Private Clinics). While the *Canada Health Act* sets out the criteria, conditions and provisions that provinces and territories must meet in order to qualify for full cash contributions under the Canada Health and Social Transfer, these two documents are acknowledged as providing the federal position related to the interpretation of those criteria, conditions and provisions.

Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp Letter remains an important reference for interpretation of the Act.

On January 6, 1995, federal Minister of Health Marleau wrote to all provinces and territories, 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. The charging of user fees is a violation of the *Canada Health Act* and cause for deductions to be made from the annual federal cash contribution payable to each province or territory.

[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

Sent to all Ministers of Health (except the Minister for Quebec, who received an equivalent letter in French on July 15, 1985)

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 priori-ties 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 reply 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 partner-ship 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 on page 6.

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 D – Deductions and Refunds Under the Canada Health Act

Annex D details the deductions and refunds made to provincial and territorial transfer payments since the passage of the *Canada Health Act* in 1984.

Table 1 presents annual deductions from transfer payments by province and territory, while Table 2 summarizes all deductions and refunds since the Act came into force. In 2000-2001 deductions of $58,000 were made to transfer payments under the Canada Health and Social Transfer for the Province of Nova Scotia with respect to user fees.

Refunds of deductions were permitted during the first three years of the Act under Section 20(5), where provinces were deemed to have eliminated extra-billing and user charges.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/ Territory	1984-85[1]		1985-86[1]		1986-87[1]		1987-1992		1992-93		1993-94		1994-95	
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges
Newfoundland and Labrador							There were no deductions during this period.							
Prince Edward Island														
Nova Scotia														
New Brunswick	63	3,015	84	3,222	206	296								
Quebec		7,893		6,139										
Ontario	39,996		55,328		13,332									
Manitoba	810		460											
Saskatchewan	1,451		656											
Alberta	8,109	1,827	9,216	2,640	5,878	1,362								
British Columbia		22,797		30,620		31,332			83		1,223		676	
Yukon														
Northwest Territories														
Nunavut														
Provincial/Territorial Total	50,429	35,532	65,744	42,621	19,416	32,990			83		1,223		676	

[1] These monies were subsequently reimbursed pursuant to Section 20.(5) of the *Canada Health Act*, for extra-billing and user charges deductions made during the period 1984-85 to 1986-87.

Table 1 – Annual Deductions by Province and Territory Since Passage of the Canada Health Act (continued)

(in thousands of dollars)

Province/ Territory	1995-96		1996-97		1997-98		1998-99		1999-2000		2000-2001		Total Gross Deductions 1984-85 to 2000-2001		
	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Extra-Billing	User Charges	Total
Newfoundland and Labrador		46		96		128		53						323	323
Prince Edward Island															
Nova Scotia		32		72		57		39		61[2]		58		319	319
New Brunswick													353	6,533	6,886
Quebec														14,032	14,032
Ontario													108,656		108,656
Manitoba		269		588		587		612					1,270	2,056	3,326
Saskatchewan													2,107		2,107
Alberta		2,319		1,266									23,203	9,414	32,617
British Columbia	43												2,025	84,749	86,774
Yukon															
Northwest Territories															
Nunavut															
Provincial/Territorial Total	43	2,666		2,022		772		704		61		58	137,614	117,426	255,040

[2] This is a revision from the number published in the CHA Annual Report for 1999-2000.

Table 2 – Summary of Deductions and Refunds by Province and Territory Since Passage of the Canada Health Act

(in thousands of dollars)

Province/ Territory	Total Gross Deductions 1984-85 to 2000-2001			Refunds 1984-85 to 1986-87			Total Net Deductions 1984-85 to 2000-2001		
	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total	Extra-Billing	User Charges	Total
Newfoundland and Labrador		323	323					323	323
Prince Edward Island									
Nova Scotia		319	319					319	319
New Brunswick	353	6,533	6,886	(353)	(6,533)	(6,886)			
Quebec		14,032	14,032		(14,032)	(14,032)			
Ontario	108,656		108,656	(108,656)		(108,656)			
Manitoba	1,270	2,056	3,326	(1,270)		(1,270)		2,056	2,056
Saskatchewan	2,107		2,107	(2,107)		(2,107)			
Alberta	23,203	9,414	32,617	(23,203)	(5,829)	(29,032)		3,585	3,585
British Columbia	2,025	84,749	86,774		(84,479)	(84,749)	2,025		2,025
Yukon									
Northwest Territories									
Nunavut									
Provincial / Territorial Total	137,614	117,426	255,040	(135,589)	(111,143)	(246,732)	2,025	6,283	8,308

Annex E – Evolution of Federal Transfers and the Canada Health and Social Transfer

Since the federal government began contributing to provincial and territorial health insurance programs in 1958, the arrangements for these contributions have evolved. Prior to 1977, the federal government cost shared hospital and physician services with the provinces and territories. In 1977, cost sharing was replaced by block funding (Established Programs Financing - EPF). Then, on April 1, 1996, the Canada Health and Social Transfer (CHST) replaced the EPF and the Canada Assistance Plan (CAP) and continues to provide support through both cash and tax transfers for health and other social programs delivered by the provinces and territories. These arrangements are described in the following section. Further information of federal fiscal programs and arrangements are available from the Department of Finance.

Cost Sharing

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* (passed in 1966, came into effect in 1968), the federal contribution in support of medical care was 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.

Established Programs Financing (EPF)

In 1977, cost-sharing arrangements were replaced by Established Programs Financing. Unlike the previous cost-sharing arrangements, EPF was a block-funding system, no longer open-ended, although funding was from the start and for most of EPF history, tied to economic growth under various formulae.

Under EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. Except for the first few years, the EPF (cash plus tax transfers) was distributed among provinces and territories on an equal per capita basis.

Tax transfers were calculated based on the value of income tax points transferred by the federal government to the provinces and territories in 1977 (13.5 personal income tax points and one corporate income tax point).

EPF cash funds were transferred monthly to each province and territory, provided the provincial/territorial plan satisfied the criteria and conditions set out in the *Canada Health Act*.

In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion total EPF entitlements (cash and tax), 71.2 percent of which was intended for health care and the rest for post-secondary education.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced the Canada Health and Social Transfer, which replaced the EPF and the Canada Assistance Plan (CAP), the federal provincial cost-sharing plan for social services. When the CHST came into effect in 1996, provinces and territories received the same share of the CHST that they had received under the Canada Assistance Plan (CAP), and health and post-secondary education funding made under Established Programs Financing. The provincial and territorial distribution that existed under the previous programs was carried over into the CHST, but has been gradually adjusted to more closely reflect each province and territory's share of the Canadian population.

The CHST is a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments in support of health, post-secondary education, and social services/ assistance programs.

For fiscal year 2000-2001, CHST payments amounted to $32 billion in the form of tax point transfers and cash contributions (Source: Finance Canada, October 2001).

Making CHST Payments

The Department of Finance has been responsible for making CHST payments to the provinces and territories since April 1, 1996. However, the Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act,* including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance in advance of the payment dates. The Department of Finance then makes the actual deductions from the twice-monthly CHST payments to the provinces and territories.

Annex F – Glossary of Terms Used in the Annual Report

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

Term	Explanation
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health 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 to physicians and dentists for all the insured health care services they provide; and • payment to hospitals to cover the cost of insured health care services.
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 Bed	An acute care bed is a bed in a health care facility that has been designated for the treatment or care of an in-patient with an acute disease or health condition.
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.
Approved Bed Complement	Number of beds that a health care facility has been approved to operate in order to meet health service delivery expectations. Approval is by the province, territory or the federal government in the case of a federal hospital.
Average In-Patient Per Diem Cost	This is the estimated average amount that a province or territory establishes as the average daily cost of an in-patient treatment or a stay in a health care facility.
Block Fee	This is a fee charged by a physician for services that are uninsured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.

Term	Explanation
Canada Health Act	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.
Canada Health and Social Transfer	The Canada Health and Social Transfer (CHST) is the largest federal transfer to provinces and territories, providing them with cash payments and tax transfers in support of health care, post-secondary education, social assistance and social services. The tax transfer component of the CHST occurred in 1977 when the federal government agreed with provincial and territorial governments to reduce its personal and corporate income tax rates, thus allowing them to raise their tax rates by the same amount. As a result, revenue that would have flowed to the federal government began to flow directly to provincial and territorial governments. The CHST gives provinces and territories the flexibility to allocate payments among social programs according to their priorities, while upholding the principles of the *Canada Health Act* and the condition that there be no period of minimum residency with respect to social assistance. The CHST came into effect on April 1, 1996, replacing the Canada Assistance Plan (CAP), which cost-shared provincial and territorial social assistance and social service programs, and Established Programs Financing (EPF), which provided funding to support health care and post-secondary education.
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 Bed	A chronic care bed is a bed designated for ongoing in-patient, long-term medical services.
Chronic Care Facility	A chronic care facility is a facility providing 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 has been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group or political opinion. In Canada, the Immigration and Refugee Board, Convention Refugee Determination Division, decides who is a Convention Refugee.

Term	Explanation
Coordinating Committee on Reciprocal Billing	The Coordinating Committee on Reciprocal Billing (CCRB), comprised of federal, provincial and territorial government health officials, was formed in 1991 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.
Day Surgery Bed	A day surgery bed is a bed in a health care facility designated for short-term (less than 24 hours) surgical services.
Diagnostic Physician Service	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 be made when a breach 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.
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.
Epp Letter	Confirmation of the federal position related to interpreting and implementing the *Canada Health Act* was communicated to provinces and territories in June 1985 by then-federal Health Minister Jake Epp. The Epp Letter (see Annex C) remains an important reference for interpretation of the Act.
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 was a block-funding system that was tied to economic and population growth. Under the EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. In 1996, the EPF was replaced 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.

Term	Explanation
Extra-billing	This is defined as 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	Under the Extra-billing and User Charges Information Regulations of the *Canada Health Act* (see Annex B), provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Marleau wrote to all provinces and territories, 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. The charging of user fees is a violation of the CHA and cause for deductions to be made from the annual federal cash contribution payable to each province or territory. The Marleau Letter is included in Annex C of this annual 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.
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) to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	Health care insurance plan means, in relation to a province or territory, a plan or plans established by the law of the province to provide insured health services.
Health Insurance Supplementary Fund	This is a fund, administered by the Canada Health Act Division, to assist 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*.
Hospital	A hospital is a health care facility located in Canada that provides medical or surgical treatment for the sick or injured, including acute, rehabilitative or chronic care, but does not include an institution primarily for the mentally disordered, nor does it include a facility or portion thereof that provides nursing home care, adult residential care, or comparable services for children.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between provinces or territories that allows for the reciprocal processing of out-of-province or territory claims for hospital in- and out-patient services. 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 the Coordinating Committee on Reciprocal Billing (CCRB).

Term	Explanation
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 Service	The *Canada Health Act* defines insured health services as 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' Compensation.
Insured Hospital Services	Insured hospital services are interpreted from the *Canada Health Act* as any of the following services provided to in- or out-patients at a hospital or health care facility, if the services are medically necessary, for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability. These are: • 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 from the hospital or health care facility.
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 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.
Insured Physician Service	This is a medically required service covered by a provincial or territorial health insurance plan and administered by a medical practitioner.
Insured Surgical-Dental Service	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 procedure.
Length of Stay	This is the number of days a patient is admitted to a health care services facility.

Term	Explanation
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 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 Practitioner	Medical practitioner means 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 provinces and territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licensed physician. Where an 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 Physicians	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at the provincial or territorial rate. The provincial or territorial plans reimburse these patients for charges up to, but not more than the amount paid by the plan for that service under fee schedule agreements.
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 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	For purposes of the *Canada Health Act*, physician services means 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.

Term	Explanation
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that pays out dividends and/or profits to its owners, shareholders, operators or members.
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.
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	This criterion of the *Canada Health Act* (section 8) requires that provincial and territorial health care insurance plans be administered and operated on a non-profit basis, by public authorities responsible to the provincial or territorial governments, and be subject to audits of their accounts and financial transactions.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides publicly insured health care services on an in- or out-patient basis.
Recognition Condition	The *Canada Health Act* (section 13(b)) requires that provinces and territories give recognition to the Canada Health and Social Transfer in any public documents, advertisements or promotional material relating to insured health care services and extended health services in that province or territory.
Refugee Claimant	A refugee claimant is a person who has arrived in Canada and who requests refugee status. If a refugee claimant receives a final determination that he or she has been determined to be a Convention Refugee, he or she may then apply for permanent residence.
Rehabilitative Bed	This is a bed designated for in-patient, rehabilitative treatment services in a hospital setting (e.g., rehabilitative treatment for spinal or head injuries).
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 for a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Resident	This is 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.
Separations	This is the total number of in- and out-patients released from a health facility following discharge, transfer, day surgery or death.

Term	Explanation
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, but are not limited to, anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, opthalmology, paediatrics, plastic surgery, radiology and urology.
Staffed Beds	This is the number of beds for which a health care facility has staff to provide health services.
Surgical Day Care	Surgical day care includes health care services involving medical operative procedures delivered in a health care facility that do not require an overnight stay for post-operative recovery or observation.
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	This is where a person is absent from the province or territory of origin for business, education, vacation or other reasons, without assuming permanent residence.
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 for items such as alcohol swabs, instruments and sutures that are associated with the provision of an insured physician service.
Universality	This criterion of the *Canada Health Act* (section 10) requires that provincial and territorial health care insurance plans entitle all insured persons in the province or territory to insured services on uniform terms and conditions.
User Charge	This is 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 insurance plan, but does not include any charge imposed by extra-billing.

How to Contact Provincial and Territorial Departments of Health

Newfoundland and Labrador
Newfoundland Medical Care Plan
P.O. Box 200, Elizabeth Towers
100 Elizabeth Avenue
St. John's, Newfoundland A1C 5J3
(709) 292-4000
www.gov.nf.ca/mcp/

Prince Edward Island
Director, Acute and Continuing Care
16 Garfield Street
P.O. Box 2000
Charlottetown, PEI C1A 7N8
(902) 368-6184
www.gov.pe.ca/hss/aacc-info/

Nova Scotia
Director, Inter-Agency Initiatives
Office of the Deputy Minister
Nova Scotia Department of Health
P.O. Box 488
Halifax, NS B3J 2R8
(902) 424-5868
www.gov.ns.ca/health/

New Brunswick
Department of Health and Wellness
P.O. Box 5100
Fredericton, New Brunswick E3B 5G8
(506) 453-2536
www.gnb.ca/HW-SM/hw/

Quebec
Ministère de la Santé et des Services Sociaux
1075, chemin Sainte-Foy, r.-c.
Québec (Québec) G1S 2M1
1-800-707-3380
www.msss.gouv.qc.ca/
www.ramq.gouv.qc.ca/eng/cit/

Ontario
Ministry of Health and Long-Term Care
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4
1-800-268-1153
www.gov.on.ca/health/

Manitoba
Client Service Centre
Manitoba Health
300 Carlton Street
Winnipeg, Manitoba R3B 3M9
1-800-392-1207
www.gov.mb.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, Saskatchewan S4S 6X6
1-800-667-7766
www.health.gov.sk.ca/ps_benefits.html

Alberta
Alberta Health Care Insurance Plan
P.O. Box 1360
Edmonton, AB T5J 2N3
(780) 427-1432 (Edmonton)
www.health.gov.ab.ca/ahcip/

British Columbia
Ministry of Health Services
PO Box 9050 Stn Prov Govt
Victoria, British Columbia V8W 9E2
1-800-661-4337
www.healthservices.gov.bc.ca
health@moh.hnet.bc.ca

Yukon
Yukon Health Care Insurance
P.O. Box 2703
Whitehorse, Yukon Y1A 2C6
www.hss.gov.yk.ca/hsframe.html

Northwest Territories
Health Services Administration
Department of Health and Social Services
Government of N.W.T.
Bag Service # 9 Inuvik, NT X0E 0T0
1-800-661-0830 or 1-867-777-7400
www.hlthss.gov.nt.ca/programs/benefits.htm

Nunavut
Government of Nunavut
Department of Health and Social Services
P.O. Box 1000 Station 1000
Iqaluit, NU X0A 0H0
1-867-975-5700
www.gov.nu.ca/hss.htm