Health Canada Santé Canada








CANADA'S HEALTH CARE SYSTEM

Canada

Our mission is to help the people of Canada
maintain and improve their health.

Health Canada

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INTRODUCTION

Canada's publicly funded health care system is dynamic — reforms have been made over the past four decades and will continue in response to changes within medicine and throughout society. The basics, however, remain the same — universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay.

HOW HEALTH CARE SERVICES ARE DELIVERED

Canada's publicly funded health care system is best described as an interlocking set of ten provincial and three territorial health insurance plans. Known to Canadians as "medicare," the system provides access to universal, comprehensive coverage for medically necessary hospital and physician services. These services are administered and delivered by the provincial and territorial (i.e., state or regional) governments, and are provided free of charge. The provincial and territorial governments fund health care services with assistance from the federal (i.e., national) government.

In order to receive their full allocation of federal funding for health care, the provincial and territorial health insurance plans must meet five criteria — comprehensiveness, universality, portability, accessibility and public administration — that are provided in the federal government's *Canada Health Act*. In addition to setting and administering the *Canada Health Act* and providing funding, the federal government provides direct delivery of health care services to specific groups (e.g., First Nations people living on reserves; Inuit; serving members of the Canadian Forces and the Royal Canadian Mounted Police; eligible veterans). Many other organizations and groups, including health professional associations and accreditation, education, research and voluntary organizations, contribute to health care in Canada.

The responsibility for Aboriginal (First Nations people and Inuit) health services is shared by the federal, provincial and territorial governments, and Aboriginal organizations. The responsibility for public health is also shared. The federal Public Health Agency of Canada acts as a focal point for disease prevention and control, and for emergency response to infectious diseases; however public health services are generally delivered at the provincial/territorial and local levels.

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Ask a Canadian for a defining characteristic unique to Canada and invariably, even with [its] broad regional diversity, mention will be made of the country's publicly funded, universally accessible health care system. Medicare is often defined as a core value of our society.

Klatt, Understanding, 2000, p. 2

What Happens First (Primary Health Care Services)

When Canadians need health care, they generally contact a primary health care professional, who could be a family doctor, nurse, nurse practitioner, physiotherapist, pharmacist, etc., often working in a team of health care professionals. Services provided at the first point of contact with the health care system are known as primary health care services and they form the foundation of the health care system.

In general, primary health care serves a dual function. First, it provides direct provision of first-contact health care services. Second, it coordinates patients' health care services to ensure continuity of care and ease of movement across the health care system when more specialized services are needed (e.g., from specialists or in hospitals).

Primary health care services often include prevention and treatment of common diseases and injuries; basic emergency services; referrals to and coordination with other levels of care, such as hospital and specialist care; primary mental health care; palliative and end-of-life care; health promotion; healthy child development; primary maternity care; and rehabilitation services.

Doctors in private practice are generally paid through fee-for-service schedules negotiated between each provincial and territorial government and the medical associations in their respective jurisdictions. Those in other practice settings, such as clinics, community health centres and group practices, are more likely to be paid through an alternative payment scheme, such as salaries or a blended payment (e.g., fee-for-services plus incentives). Nurses and other health professionals are generally paid salaries that are negotiated between their unions and their employers.

When necessary, patients are referred to specialist services (medical specialist, allied health services, hospital admissions, diagnostic tests, prescription drug therapy, etc.).

Health Human Resources

Approximately 1.6 million people work in health care and social services in Canada, and include a mix of professionals in addition to nurses and physicians. The health industry is the 3rd largest employer after manufacturing and the retail trade.*

Health care providers may be regulated through their professional colleges or other bodies, or non-regulated; unionized or non-unionized; employed, self-employed or volunteer.

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* This industry-based statistic includes all employees of the health sector, including health support staff, such as clerical or cleaning staff, and not just health professionals. The data used come from Statistics Canada's *Survey of Employment, Payroll and Hours*, which excludes self-employed health industry workers (those who own and operate their own practice).

The health industry can be defined in several ways using the North American Industrial Classification System; however, no matter which definition is used, the health industry remains the third largest employer in Canada, behind manufacturing and retail trade. Data from Statistics Canada's *Labour Force Survey*, which does include self-employed people, supports this finding.

What Happens Next (Secondary Services)

A patient may be referred for specialized care at a hospital, at a long-term care facility or in the community. The majority of Canadian hospitals are operated by community boards of trustees, voluntary organizations or municipalities. Hospitals are paid through annual, global budgets negotiated with the provincial and territorial ministries of health, or with a regional health authority or board.

Alternatively, health care services may be provided in the home or community (generally short-term care) and in institutions (mostly long-term and chronic care). For the most part, these services are not covered by the *Canada Health Act*; however, all the provinces and territories provide and pay for certain home care services. Regulation of these programs varies, as does the range of services. Referrals can be made by doctors, hospitals, community agencies, families and potential residents. Needs are assessed and services are coordinated to provide continuity of care and comprehensive care. Care is provided by a range of formal, informal (often family) and volunteer caregivers.

Short-term care, usually specialized nursing care, homemaker services and adult day care, is provided to people who are partially or totally incapacitated. For the most part, health care services provided in long-term institutions are paid for by the provincial and territorial governments, while room and board are paid for by the individual; in some cases these payments are subsidized by the provincial and territorial governments. The federal department of Veterans Affairs Canada provides home care services to certain veterans when such services are not available through their province or territory. As well, the federal government provides home care services to First Nations people living on reserves and to Inuit in certain communities.

Palliative care is delivered in a variety of settings, such as hospitals or long-term care facilities, hospices, in the community and at home. Palliative care for those nearing death includes medical and emotional support, pain and symptom management, help with community services and programs, and bereavement counselling.

Most doctors work in independent or group practices, and are not employed by the government. Some work in community health centres, hospital-based group practices, primary health care teams or are affiliated with hospital out-patient departments.

Nurses are primarily employed in acute care institutions (hospitals); however, they also provide community health care, including home care and public health services.

Most dentists work in independent practices; in general, their services are not covered under the publicly funded health care system, except where in-hospital dental surgery is required.

Other health professionals include: optometrists; laboratory and medical technicians; therapists; speech language pathologists and audiologists; psychologists; pharmacists; public health inspectors, etc.

Additional (Supplementary) Services

The provinces and territories provide coverage to certain people (e.g., seniors, children and social assistance recipients) for health services that are not generally covered under the publicly funded health care system. These supplementary health benefits often include prescription drugs, dental care, vision care, medical equipment and appliances (prostheses, wheelchairs, etc.), independent living and the services of other health professionals, such as podiatrists and chiropractors. The level of coverage varies across the country.

Those who do not qualify for supplementary benefits under government plans pay for these services with individual, out-of-pocket payments or through private health insurance plans. Many Canadians, either through their employers or on their own, are covered by private health insurance and the level of service provided varies according to the plan purchased.

Trends/Changes in Health Care

The Canadian health care system has come under stress in recent years, due to a number of factors, including changes in the way services are delivered, fiscal constraints, the aging of the baby boom generation and the high cost of new technology. These factors are expected to continue in the future.

Since publicly funded health care began in Canada, health care services and the way they are delivered have changed from a reliance on hospitals and doctors to alternative care in clinics, primary health care centres, community health centres and home care; treatment using medical equipment and drugs; and public health interventions.

The number of acute-care hospitals and acute-care hospital beds decreased from 1995 to 2000. Medical advances have led to more procedures being done on an out-patient basis, and to a rise in the number of day surgeries. During this time, the number of nights Canadians spent in acute-care hospitals fell by 10%. Post-acute or hospital alternative services provided in the home and community have grown, with reforms such as hospital consolidation, less time spent in hospitals, growth in day surgery, etc.

Other reforms have focused on primary health care delivery, including setting up more community primary health care centres that provide services around-the-clock; creating primary health care teams; placing greater emphasis on promoting health, preventing illness and injury, and managing chronic diseases; increasing coordination and integration of comprehensive health services; and improving the work environments of primary health care providers.

> When we first started debating Medicare 40 years ago, "medically necessary" health care could be summed up in two words: hospitals and doctors. Today, hospital and physician services account for less than half of the total cost of the system. ... In short, the practice of health care has evolved.
>
> Canada. Commission, Shape the Future, 2002, p. 2

Coordinated primary health care teams include family doctors, nurses, nurse practitioners and other health professionals, and provide a broad range of primary health care services. These team members can vary according to the needs of the community they serve, and provincial and territorial priorities. This team approach, along with the introduction of medical telephone call centres (telehealth), reduces the use of emergency units by providing advice and after-hours access to primary health care services.

Most provinces and territories have tried to control costs and improve delivery by decentralizing decision making on health care delivery to the regional or local board level. Such regional authorities are managed by elected and/or appointed members who oversee hospitals, nursing homes, home care and public health services in their area.

THE ROLE OF GOVERNMENT

The organization of Canada's health care system is largely determined by the Canadian Constitution, in which roles and responsibilities are divided between the federal, and provincial and territorial governments. The provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is also responsible for some direct delivery of services for certain groups of people.

Publicly funded health care is financed with general revenue raised through federal, provincial and territorial taxation, such as personal and corporate taxes, sales taxes, payroll levies and other revenue. Three provinces, British Columbia, Alberta and Ontario, charge health care premiums, but non-payment of a premium does not limit access to medically necessary services.

The competitive advantage that publicly financed health care provides to Canadian business is significant. Public financing spreads the cost of providing health services equitably across the country. In addition, financing health insurance through the taxation system is cost-efficient because it does not require a separate collection process.

There is more to health than the health care system. The responsibility for public health, which includes sanitation, infectious diseases and related education, is shared between the three levels of government: federal, provincial/territorial and local or municipal; however, as noted above, these services are generally delivered at the provincial/territorial and local levels.

> Undoubtedly, the most important conclusion of the [1965 Royal] Commission was that the objectives of the Canadian people could best be achieved through a universal program administered by public authority with twelve provincial or territorial health insurance funds subsidized from federal general revenues rather than by means-testing and subsidizing several millions of individual Canadians and family heads to enable them to pay voluntary plan or commercial insurance premiums.
>
> Canada. Health, Canada's National-Provincial, 1980, p. 5

The Federal Government

The federal government's role in health includes setting and administering national principles for the system under the *Canada Health Act*; financial support to the provinces and territories; and several other functions, including the direct delivery of primary and supplementary services to certain groups of people; public health programs to prevent disease, and to promote health and educate the public on health implications of the choices they make; health protection (food safety and nutrition, and regulation of pharmaceuticals, medical devices, consumer products and pest management products); and funding for health research and health information activities.

The *Canada Health Act* establishes the principles and criteria for health insurance plans that the provinces and territories must meet in order to receive full federal cash transfers in support of health. The *Canada Health Act* lists five basic principles, which state that health care plans must be: available to all eligible residents of Canada; comprehensive in coverage; accessible without financial and other barriers; portable within the country and during travel abroad; and publicly administered.

The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer. To support the costs of publicly funded services, including health care, the federal government also provides equalization payments to less prosperous provinces and territorial financing to the territories.

Approximately 1 million people in certain groups receive primary and supplementary health care services directly from the federal government. These groups include: First Nations people living on reserves; Inuit; serving members of the Canadian Forces and the Royal Canadian Mounted Police; eligible veterans; inmates in federal penitentiaries; and refugee protection claimants.

Direct delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services are readily available; community-based health programs both on reserves and in Inuit communities; and a non-insured health

The five *Canada Health Act* principles provide for:

Public Administration:
The provincial and territorial plans must be administered and operated on a non profit basis by a public authority accountable to the provincial or territorial government.

Comprehensiveness:
The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners and dentists working within a hospital setting.

Universality:
The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.

Accessibility:
The provincial and territorial plans must provide all insured persons reasonable access to medically necessary hospital and physician services without financial or other barriers.

Portability:
The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada, and may require prior approval for non-emergency services delivered outside their jurisdiction.

benefits program (drug, dental and ancillary health services) for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided by community health nurses, and at nursing stations; health centres; in-patient treatment centres; hospitals; and on-reserve head-start projects for Aboriginal children. Increasingly, both levels of government are working together to integrate the delivery of these services with the provincial and territorial systems.

The federal government is also responsible for health protection and regulation (e.g., regulation of pharmaceuticals, food and medical devices), consumer safety, and disease surveillance and prevention, and provides support for health promotion and health research. There are also federal health-related tax measures, including tax credits for medical expenses, disability, caregivers and infirm dependents; tax rebates to public institutions for health services; and deductions for private health insurance premiums for the self-employed.

The Provincial and Territorial Governments

The provinces and territories administer and deliver most of Canada's health care services, with all provincial and territorial health insurance plans expected to meet national principles set out under the *Canada Health Act*. Each provincial and territorial health insurance plan covers medically necessary hospital and doctors' services that are provided free of charge, without deductible amounts, co-payments or dollar limits. The provincial and territorial governments fund these services with assistance from federal cash and tax transfers.

The role of the provincial and territorial governments in health care includes administering their health insurance plans; planning, paying for and evaluating hospital care, physician care, allied health care, prescription drug care in hospitals and public health; and negotiating fee schedules for health professionals. Most provincial and territorial governments offer and fund supplementary benefits for certain groups (e.g., low-income residents and seniors) such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision and dental care, that are not covered under the *Canada Health Act*.

Although the provinces and territories provide these additional benefits for certain groups of people, supplementary health services are largely privately financed. Individuals and families who do not qualify for this publicly funded coverage may pay these costs directly (out-of-pocket), be covered under an employment-based group insurance plan or buy private insurance. Under most provincial and territorial laws, private insurers are restricted from offering coverage that duplicates that of the publicly funded plans, but they can compete in the supplementary coverage market.

As well, each province and territory has an arm's-length workers' compensation agency, funded by employers, which provides services to workers who are injured on the job.

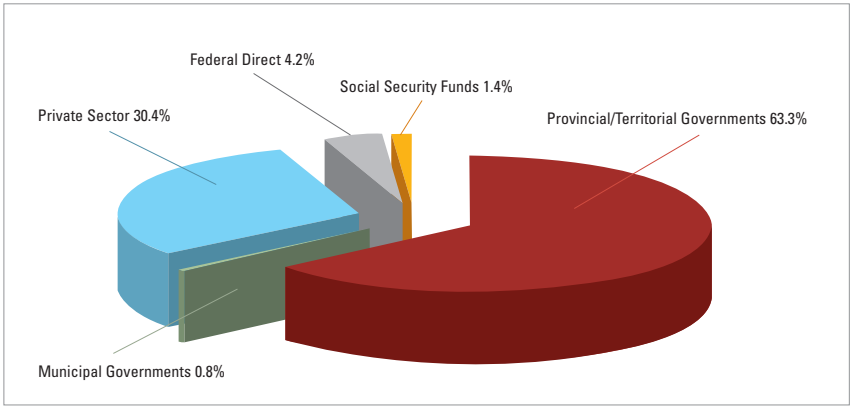
HEALTH EXPENDITURES

Within the publicly funded health care system, health expenditures vary across the provinces and territories. This is, in part, due to differences in the services that each province and territory specifies to be medically necessary and on demographic factors, such as a population's age. Other factors, such as areas where there are small and/or scattered populations, may also have an impact on health care costs.

In 1975, total Canadian health care costs consumed 7% of the Gross Domestic Product (GDP). Canada's total health care expenditures as a percentage of GDP grew to an estimated 10.4% in 2005 (or $4411 CDN per person)[1]. According to the Canadian Institute for Health Information, in 2005, on average, public health expenditures accounted for seven out of every 10 dollars spent on health care. The remaining three out of every 10 dollars came from private sources and covered the costs of supplementary services such as drugs, dental care and vision care.[2]

69.6% OF TOTAL HEALTH CARE EXPENDITURES ARE PAID FOR PUBLICLY

HEALTH EXPENDITURES BY SECTOR FUNDING, 2005 FORECAST

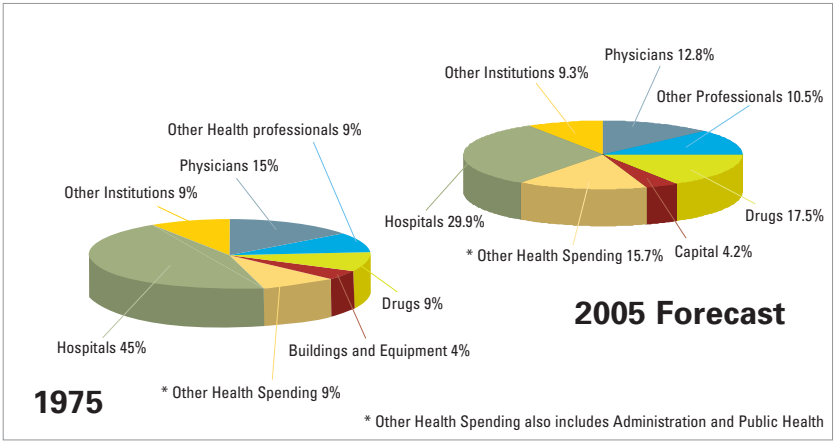


Source: Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2005*

How health care dollars are spent has changed significantly over the last three decades. On average, the share of total health expenditures paid to hospitals and physicians declined, while spending on prescription drugs has greatly increased. Still, expenditures for hospitals and physicians take 43% of the amount that is directed to health care.[3]

In 1975, a much larger share went to hospitals (45%) than in 2005 (30%). Payments to physicians in 1975 (15%) accounted for the second largest share of expenditures; this declined to the third largest area of spending (13%) by 2005.[4] In contrast, drug therapies, particularly those prescribed by physicians, accounted for 9% of total health expenditure in 1975. This had nearly doubled by 2005, and at almost 18% had become the second largest share of total health expenditure.[5]

DIVIDING THE HEALTH CARE DOLLAR



Source: Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2005*

THE HEALTH STATUS OF CANADIANS

Many factors affect a person's health. Throughout the world, economic status has a strong impact on illness, disability and mortality. Where a person lives, either in urban or rural areas, affects service delivery and costs. Age is also a factor—young people and the elderly have distinct health concerns. Gender must also be considered because women tend to live longer than men but suffer more from chronic poor health. Jobs and the workplace play their part through exposure to hazards that can affect health such as chemicals, noise, radiation, infectious agents and psychosocial stress.

Canadians have a very favourable health status. Canada's high ranking on the United Nations Human Development Index is due, in large measure, to Canada's health care system.[6] The length of time a person could be expected to live (life expectancy) is widely used to show health status. As of 2002, the average life expectancy at birth for Canadians was 82.1 years for women and 77.2 years for men, which is among the highest in the industrialized countries.[7] The number of deaths of children under one year (infant mortality) is another widely used measure to demonstrate health status. Canada's infant mortality rate for 2002 of 5.4 deaths per 1,000 live births is one of the lowest in the world.[8]

The good health status of Canadians is based on more than health care services. Health is now considered to be a state of complete physical, mental and social well-being, and not just the absence of disease or illness. This approach includes social, economic and physical environmental factors that contribute to health. Focusing on health promotion, public health, population health and prevention aims to improve the health of an entire population and to reduce health inequities among population groups.

> The principle which has dominated our thinking is that money spent on essential health care is money well spent, an investment in human resources that will pay handsome dividends not only in terms of economics but in human well-being.
>
> Canada. Royal, Royal Commission …: [Report], Vol. II, 1965, p. 18

BACKGROUND

Modifications and major reforms have been made to Canada's health care system since its inception. As has been recognized in every major review of the system, the basic values of fairness and equity that are demonstrated by the willingness of Canadians to share resources and responsibility remain constant. However, coverage has been and continues to be modified as the country's population and circumstances change, and as the nature of health care itself evolves.

The Political, Economic and Social Framework

Canada's health care system is based on political, social and economic unions. In general, Canada's Constitution sets out the powers of the federal and the provincial and territorial governments. The provinces and territories form a political and economic union within this constitutional federation. Collective action by both levels of government on social policy and program development is provided for in the Social Union Framework Agreement.

Evolution of Our Health Care System

Under the *Constitution Act*, 1867, the provinces were responsible for establishing, maintaining and managing hospitals, asylums, charities and charitable institutions, and the federal government was given jurisdiction over marine hospitals and quarantine. The federal government was also given powers to tax and borrow, and to spend such money as long as this did not infringe on provincial powers.

The federal department of Agriculture covered federal health responsibilities from 1867 until 1919, when the department of Health was created. Over the years, as noted above, the responsibilities of both levels of government have changed.

Before "medicare," health care in Canada was for the most part privately delivered and funded. In 1947, the government of Saskatchewan introduced a province-wide, universal hospital care plan. By 1949, both British Columbia and Alberta had similar plans. The federal government passed the *Hospital Insurance and Diagnostic Services Act* in 1957, which offered to reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services. The act provided for publicly administered universal coverage for a specific set of services under uniform terms and conditions. Four years later, all the provinces and territories had agreed to provide publicly funded inpatient hospital and diagnostic services.

Saskatchewan introduced a universal, provincial medical insurance plan to provide doctors' services to all its residents in 1962. The federal government passed the *Medical Care Act* in 1966, which offered to reimburse, or cost share, one-

> The number of Canadians who knew life before medicare will very soon be, if it is not already, a minority. Of course, how life was before was the essential reason medicare developed ... .
>
> Tom Kent, in Canada. Parliament, The Health ... : Interim Report, Vol. 1, 2001, p. 7

half of provincial and territorial costs for medical services provided by a doctor outside hospitals. The act set out four points or criteria, universality, comprehensiveness, public administration and portability, which were governed by five essential elements that included these four points plus accessibility. Within six years, all the provinces and territories had universal physician services insurance plans.

For the first 20 years, the federal government's financial contribution in support of health care was determined as a percentage (one-half) of provincial and territorial expenditure on specific insured hospital and physician services. In 1977, *under the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977* (EPF), cost sharing was replaced with a block fund, in this case, a combination of cash payments and tax points. In general, a block fund is provided from one level of government to another for a specific purpose. This new funding arrangement meant that the provincial and territorial governments had the flexibility to invest health care funding according to their needs and priorities. Federal transfers for post-secondary education were included in the EPF transfer, in addition to funding for medical and hospital services.

In 1984, federal legislation, the *Canada Health Act*, was passed. This new legislation included the principles provided in the federal hospital and medical insurance acts, and added provisions that prohibited extra-billing and user fees for insured services. Federal legislation passed in 1995 consolidated federal cash and tax transfers in support of health care and post-secondary education with federal transfers in support of social services and social assistance into a single block funding mechanism, the Canada Health and Social Transfer (CHST), beginning in fiscal year 1996-1997.

An agreement on health reached in 2000 by the federal, provincial and territorial government leaders (or first ministers) set out key reforms in primary health care, pharmaceuticals management, health information and communications technology, and health equipment and infrastructure. At the same time, the federal government increased cash transfers in support of health.

In 2003, the first ministers agreed on the *Accord on Health Care Renewal*, which provided for structural change to the health care system to support access, quality and long-term sustainability. Targeted reforms included accelerated primary health care renewal; coverage for short-term acute home care and for the cost of prescribed drugs that reach high or catastrophic levels; enhanced access to diagnostic and medical equipment; and better accountability from governments.

Under the Accord, federal government cash transfers in support of health care were increased, and the CHST cash and tax transfers were split into the Canada Health Transfer for health, and the Canada Social Transfer for post-secondary education, social services and social assistance, effective April 2004.

Further reforms were announced by the first ministers in *A 10-Year Plan to Strengthen Health Care* in 2004. The Plan is focused on improving access to quality care and reducing wait times. Other key reforms address: health human resources; Aboriginal health; home care; primary health care; prescription drug coverage and other elements of a national pharmaceutical strategy; health care services in the North; medical equipment; prevention, promotion and public health;

and enhanced reporting on progress made on these reforms. To support the Plan, the federal government increased health care cash transfers and applied an escalator as of 2006-2007 to provide predictable growth in federal funding.

For more detail on the history of our health care system, start with the resources at the end of this brochure: the Timeline, Bibliography and On-Line Resources.

WHAT HAS BEEN SAID ABOUT OUR SYSTEM

First and foremost, Canadians support their health care system. As The Conference Board of Canada has noted: "Of all of Canada's social policies, [the health care system] is the most prized, and it is central to Canadians' views of what is necessary for a high quality of life." [9]

Studies show that a publicly funded health care system provides many economic benefits. Public funding spreads the cost of health care services across the entire population. The European Observatory on Health Care Systems has pointed to the advantages of public funding of health care systems, which are: free access at point of use; pooling of risks across a larger population; universal coverage; and better cost control.[10]

Canada's labour costs are lower because employers do not have to fully fund employee health benefits; this gives businesses in Canada a competitive edge. The annual KPMG competitiveness report, which compares business costs in several industrialized countries, continues to find that Canada has lower business costs than the US, and the lowest total labour costs of the countries compared.[11] As well, the excellent health status of Canadians contributes to a productive workforce.

In their discussions with me, Canadians have been clear that they still strongly support the core values on which our health care system is premised—equity, fairness and solidarity. These values are tied to their understanding of citizenship.

Canada. Commission, Building on Values, 2002, p. xvi

ENDNOTES

[1] Canadian Institute for Health Information. *National Health Expenditure Trends, 1975 – 2005*. Ottawa: the Institute, 2005, pp. 4-5, 99.

[2] CIHI, *National*, pp. iii, 7.

[3] CIHI, *National*, p. 108.

[4] CIHI, *National*, p. 108.

[5] CIHI, *National*, p. 109.

[6] The UN Human Development Index measures human development of 175 countries in three areas: life expectancy at birth; educational attainment; and standard of living.
For further information see www.undp.org.

[7] Organisation for Economic Co-operation and Development. *Health Data*. Paris: OECD, 2004.

[8] OECD, *Health …*, 2004.

[9] The Conference Board of Canada. *Performance and Potential 2002-03: Canada 2010: Challenges and Choices at Home and Abroad*. Ottawa: The Board, 2003, p. 78.

[10] European Observatory on Health Care Systems. *Funding Health Care: Options for Europe*. Policy Brief No. 4. Copenhagen: The Observatory, 2002, p.14.

[11] KPMG. *Competitive Alternatives: the CEO's Guide to International Business Costs*. G7 - 2004 ed. Canada: KPMG LLP, 2004, p. 52.

TIMELINE
BIBLIOGRAPHY
ON-LINE RESOURCES

Timeline

1867
British North American Act passed: federal government responsible for marine hospitals and quarantine; provincial/territorial governments responsible for hospitals, asylums, charities and charitable institutions.

1897 to 1919
Federal Department of Agriculture handles federal health responsibilities until Sept. 1, 1919, when first federal Department of Health created.

1920s
Municipal hospital plans established in Manitoba, Saskatchewan and Alberta.

1921
Royal Commission on Health Insurance, British Columbia.

1947
Saskatchewan initiates provincial universal public hospital insurance plan, January 1.

1948
National Health Grants Program, federal; provides grants to provinces and territories to support health-related initiatives, including hospital construction, public health, professional training, provincial surveys and public health research.

1949
British Columbia creates limited provincial hospital insurance plan.

Newfoundland joins Canada, has a cottage hospital insurance plan.

1950
Alberta creates limited provincial hospital insurance plan, July 1.

1960
Northwest Territories creates hospital insurance plan with federal cost sharing, April 1.

Yukon creates hospital insurance plan with federal cost sharing, July 1.

1961
Québec creates hospital insurance plan with federal cost sharing, January 1.

Federal government creates Royal Commission on Health Services to study need for health insurance and health services; appoint Emmet M. Hall as Chair.

1962
Saskatchewan creates medical insurance plan for physicians' services, July 1; doctors in province strike for 23 days.

1964
Royal Commission on Health Services, federal, reports; recommends national health care program.

1936
British Columbia and Alberta pass health insurance legislation, but without an operating program.

1940
Federal Dominion Council of Health created.

1942
Federal Interdepartmental Advisory Committee on Health Insurance created.

1957
Hospital Insurance and Diagnostic Services Act, federal, proclaimed (Royal Assent) May 1; provides 50/50 cost sharing for provincial and territorial hospital insurance plans, in force July 1, 1958.

1958
Manitoba, Newfoundland, Alberta and British Columbia create hospital insurance plans with federal cost sharing, July 1.

Saskatchewan hospital insurance plan brought in under federal cost sharing, July 1.

1959
Ontario, New Brunswick and Nova Scotia create hospital insurance plans with federal cost sharing, January 1.

Prince Edward Island creates hospital insurance plan with federal cost sharing, October 1.

1965
British Columbia creates provincial medical plan.

1966
Canada Assistance Plan (CAP), federal, introduced; provides cost-sharing for social services, including health care not covered under hospital plans, for those in need, Royal Assent July, effective April 1.

Medical Care Act, federal, proclaimed (Royal Assent), December 19; provides 50/50 cost sharing for provincial/territorial medical insurance plans, in force July 1, 1968.

1968
Saskatchewan and British Columbia create medical insurance plans with federal cost sharing, July 1.

1969

Newfoundland, Nova Scotia and Manitoba create medical insurance plans with federal cost sharing, April 1.

Alberta creates medical insurance plan with federal cost sharing, July 1.

Ontario creates medical insurance plan with federal cost sharing, October 1.

1970

Québec creates medical insurance plan with federal cost sharing, November 1.

Prince Edward Island creates medical insurance plan with federal cost sharing, December 1.

1971

New Brunswick creates medical insurance plan with federal cost sharing, January 1.

Northwest Territories creates medical insurance plan with federal cost sharing, April 1.

1972

Yukon creates medical insurance plans with federal cost sharing, April 1.

1981

Provincial/territorial reciprocal billing agreement for in-patient hospital services provided out-of-province/territory.

1982

Federal EPF amended; revenue guarantee removed, funding formula amended.

1983

Royal Commission on Hospital and Nursing Home Costs,Newfoundland, begins April, reports February 1984.

Comite d'étude sur la promotion de la santé, Quebec, begins, ends 1984.

La Commission d'énquête sur les services de santé et les services sociaux, Quebec, begins January, reports December 1987.

...

Federal Task Force on the Allocation of Health Care Resources begins June, reports 1984.

1987

Premier's Council on Health Strategy, Ontario, begins, ends in 1991.

Royal Commission on Health Care, Nova Scotia, begins August 25, reports December 1989.

Advisory Committee on the Utilization of Medical Services, Alberta, begins September, reports September 1989.

All provinces and territories in compliance with the *Canada Health Act* by April 1.

1988

Provincial/territorial governments (except Québec) sign reciprocal billing agreement for physicians' services provided out-of-province/territory.

Commission on Directions in Health Care, Saskatchewan, begins July 1, reports March 1990.

Premier's Commission on Future Health Care for Albertans, Alberta, begins December, reports December 1989.

Commission on Selected Health Care Programs, New Brunswick, begins November, reports June 1989.

1989 to 1994

Further reductions in federal transfer payments.

1990

Royal Commission on Health Care and Costs, British Columbia, begins, reports 1991.

1977

Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF) federal cost-sharing shifts to block funding.

1979

Federal government creates Health Services Review; Emmet M. Hall appointed Special Commissioner to re-evaluate publicly funded health care system.

1980

Health Services Review report released August 29; recommends ending user fees, extra billing, setting national standards.

1984

The *Canada Health Act*, federal, passes (Royal Assent April 17), combines hospital and medical acts; sets conditions and criteria on portability, accessibility, universality, comprehensiveness, public administration; bans user fees and extra billing.

Provincial/territorial reciprocal billing agreement for out-patient hospital services provided out-of-province/territory.

1985

Health Services Review Committee, Manitoba, begins, reports November.

1986

Federal transfer payments rate of growth reduced.

Health Review Panel, Ontario, begins November, reports June 1987.

1991

National Task Force on Health Information, federal, reports; leads to creation of Canadian Institute of Health Information.

Task Force on Health, Prince Edward Island, begins June, reports March 1992.

1994

National Forum on Health, federal, created to discuss health care with Canadians and recommend reforms, begins October, reports 1997.

1995

Federal EPF and CAP merged into block funding under the Canada Health and Social Transfer (CHST), to support health care, post-secondary education and social services.

1996

Federal CHST transfers begin April 1.

1998

Health Services Review, New Brunswick, begins, reports February 1999.

1999

Social Union Framework Agreement (SUFA) in force; federal, provincial and territorial governments (except Québec) agree to collective approach to social policy and program development, including health.

Minister's Forum on Health and Social Services, Northwest Territories, begins July, reports January 2000.

2000

First ministers' Communiqué on Health, announced September 11.

Commission of Study on Health and Social Services (Clair Commission), Québec, created June 15, reports December 18.

Saskatchewan Commission on Medicare (Fyke Commission), Saskatchewan, begins June 14, reports April 11, 2001.

Premier's Advisory Council on Health for Alberta (Mazankowski Council), Alberta, established January 31, reports January 8, 2002.

Premier's Health Quality Council, New Brunswick, begins January, reports January 22, 2002.

2001

Standing Senate Committee on Social Affairs, Science and Technology review (Kirby Committee), federal, begins March 1, publishes recommendations October 2002.

Commission on the Future of Health Care in Canada (Romanow Commission), federal, begins April 4, reports November 2002.

British Columbia Select Standing Committee on Health (Roddick Committee), begins August, reports December 10.

Northwest Territories Action Plan, begins November, reports January 2002.

[Health] Consultation Process, Ontario, begins July, results released January 21, 2002.

Health Choices – A Public Discussion on the Future of Manitoba's Public Health Care Services, Manitoba, begins January, reports December.

2003

First ministers' Accord on Health Care Renewal, announced February 5.

Health Council of Canada established to monitor and report on progress of Accord reforms, December 9.

2004

Federal CHST split into two transfers: the Canada Health Transfer (CHT) and the Canada Social Transfer (CST), April 1.

First ministers' *A 10-Year Plan to Strengthen Health Care,* September 16.

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ON-LINE RESOURCES

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Aboriginal Canada Portal: www.aboriginalcanada.gc.ca

Canada's Parliament: www.parl.gc.ca

Canadian Health Network: www.canadian-health-network.ca

Canadian Health Services Research Foundation: www.chsrf.ca

Canadian Healthcare Association: www.cha.ca/

Canadian Hospice Palliative Care Association: www.chpca.net

Canadian Institute for Health Information: www.cihi.ca

Canadian Institutes of Health Research: www.cihr-irsc.gc.ca

Canadian Medical Association: www.cma.ca

Canadian Nurses Association: www.cna-aiic.ca

Commission on the Future of Health Care in Canada: www.hc-sc.gc.ca/english/care/romanow/index1.html

Health Canada: www.hc-sc.gc.ca

Health Information (general) - see Canadian Health Network, above

International Monetary Fund: www.imf.org

Organisation for Economic Co-operation and Development: www.oecd.org

Population Health: www.phac-aspc.gc.ca/ph-sp/phdd/index.html

Provincial/Territorial Ministries of Health: www.hc-sc.gc.ca/hcs-sss/delivery-prestation/ptrole/ptmin/index_e.html

Senate Standing Committee on Social Affairs, Science and Technology: www.parl.gc.ca (follow the Committee Business link)

Social Union Framework Agreement: www.socialunion.gc.ca

United States. Centers for Disease Control and Prevention: www.cdc.gov

United States. National Center for Health Statistics: www.cdc.gov/nchs

World Health Organization: www.who.int