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Canada Health Act

Annual Report 2005 – 2006

2005 – 2006

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Minister of Health Ministre de la Santé

The Honourable/L'honorable Tony Clement

Ottawa, Canada K1A 0K9

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

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year that ended March 31, 2006.

Tony Clement

Canada

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

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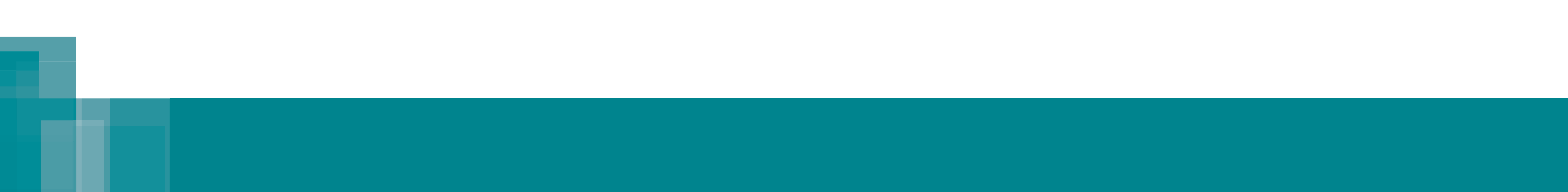

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Introduction

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

The Canadian health insurance system evolved into its present form over more than five decades. Saskatchewan was the first province to establish universal, public hospital insurance in 1947 and, 10 years later, the Government of Canada passed the *Hospital Insurance and Diagnostic Services Act* (1957) to share in the cost of these services. By 1961, all the provinces and territories had public insurance plans that provided universal access to hospital services. Saskatchewan again pioneered in providing insurance for physician services, beginning in 1962. The Government of Canada adopted the *Medical Care Act* in 1966 to cost-share the provision of insured physician services with the provinces. By 1972, all provincial and territorial plans had been extended to include physician services.

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

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

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

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

Health Canada's approach to the administration of the Act emphasizes transparency, consultation and dialogue with provincial and territorial health care ministries. The application of financial penalties through deductions under the Canada Health Transfer is considered only as a last resort when all options to resolve an issue collaboratively have been exhausted. Pursuant to the commitment made by premiers under the 1999 Social Union Framework Agreement, federal, provincial and territorial governments agreed through an exchange of letters, in April 2002, to a Canada Health Act Dispute Avoidance and Resolution (DAR) process. The DAR process was formalized in the First Ministers' 2004 Accord. Although the DAR process includes dispute resolution provisions, the federal Minister of Health retains the final authority to interpret and enforce the *Canada Health Act*.

For the most part, provincial and territorial health care insurance plans not only meet the criteria and conditions of the *Canada Health Act*, in many cases they restate the principles of the Act in provincial and territorial laws and regulations.

Currently, the most prominent concerns with respect to compliance under the *Canada Health Act* relate to accessibility issues, especially patient charges and queue jumping for medically necessary health services at private clinics. Health Canada has made these concerns known to the provinces that allow these charges.

Chapter 1

Canada Health Act Overview

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

What is the Canada Health Act?

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

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

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

Key Definitions Under the Canada Health Act

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

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

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

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

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

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

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

Requirements of the Canada Health Act

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

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

The Criteria

1. Public Administration (section 8)

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

2. Comprehensiveness (section 9)

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

3. Universality (section 10)

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

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

4. Portability (section 11)

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

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

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

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

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

5. Accessibility (section 12)

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

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

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

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

The Conditions

1. Information (section 13(a))

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

2. Recognition (section 13(b))

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

Extra-billing and User Charges

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

Extra-billing (section 18)

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

User Charges (section 19)

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

Other Elements of the Act

Regulations (section 22)

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

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

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

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

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

Discretionary Penalty Provisions

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

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

Excluded Services and Persons

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

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

These exclusions are discussed below.

Non-insured Health Services

In addition to the medically necessary 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 that may be provided include pharmacare, ambulance services and optometric services.

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

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

Excluded Persons

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

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

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

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

Policy Interpretation Letters

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

Epp Letter

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

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

Marleau Letter — Federal Policy on Private Clinics

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

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

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

Dispute Avoidance and Resolution Process

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

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

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

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

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

Chapter 2

Administration and Compliance

Administration

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

Health Canada works with the provinces and territories to ensure that the principles of the Act are respected. Our preference is always to work with provinces and territories to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

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

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

Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC)

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee and provides a secretariat for the Committee. The Committee was formed in 1991 to address issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the *Canada Health Act*.

The within-Canada portability provisions of the Act are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives hospital or physician services in another

province or territory. The province or territory providing the service will then directly bill the patient's home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and signing them is not a requirement of the Act.

Compliance

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

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

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

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

Compliance Issues

For the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the *Canada Health Act*. However, some issues and concerns remain. The most prominent of these relate to accessibility issues, especially patient charges and queue jumping for medically necessary health services at private clinics.

The Act requires that all medically necessary physician and hospital services be covered by the provincial and territorial health insurance plans, whether the services are provided in a hospital or in a facility providing hospital care. There are concerns about queue jumping and charges to insured persons at private surgical clinics in Quebec and British Columbia, for services that are covered under their respective provincial health insurance plans. Patient charges and queue jumping at private diagnostic clinics also remains an issue in five provinces (British Columbia, Alberta, Manitoba, Quebec and Nova Scotia). where private clinics are charging patients and allowing them to jump the queue for insured health services.

During 2005–2006, Health Canada was successful in reaching an agreement with Manitoba to address patient charges for medical surgical supplies, known as "tray fees."

Also during 2005–2006, the federal Health Minister notified his counterpart in New Brunswick of his intent to refer the province's refusal to provide coverage for medically necessary abortion services performed in clinics to a panel review under the Canada Health Act Dispute Avoidance and Resolution process.

Canada Health Transfer Deductions in 2005–2006

Deductions were taken from the March 2006 Canada Health Transfer (CHT) payments to British Columbia in respect of extra-billing and user charges at surgical clinics that occurred during fiscal year 2003–2004, in the amount of $29,019, on the basis of charges reported by the province to Health Canada.

A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT to reconcile amounts actually charged in respect of extra-billing and user charges at a private clinic with the penalties that had already been levied, based on provincial estimates reported for fiscal 2003–2004.

History of Deductions and Refunds Under the Canada Health Act

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

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

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

In January 1995, the federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the *Canada Health Act*. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

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

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

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

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

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

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

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

Deductions were taken from the March 2006 CHT payments to British Columbia in respect of extra-billing and user charges at surgical clinics that occurred during fiscal year 2003–2004, in the amount of $29,019, on the basis of charges reported by the province to Health Canada.

A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT to reconcile amounts actually charged in respect of extra-billing and user charges at a private clinic with the penalties that had already been levied, based on provincial estimates reported for fiscal 2003–2004.

Since the enactment of the *Canada Health Act*, from April 1984 to March 2006, deductions totalling $8,853,076 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the Act. This amount excludes deductions totalling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated.

Chapter 3

Provincial and Territorial Health Care Insurance Plans in 2005–2006

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* program criteria and conditions in 2005–2006.

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

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

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

To help provinces and territories prepare their submissions to the annual report, Health Canada provided them with the document *Canada Health Act Annual Report 2005–2006: A Guide for Updating Submissions* (User's Guide). This guide was developed through discussion with provincial and territorial officials and is designed to help provinces and territories meet the reporting requirements of Health Canada. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for the *2005–2006 Canada Health Act Annual Report* was launched late spring 2006 when letters were sent to all provinces and territories confirming the timetable for this year's annual report. An updated User's Guide was also sent to the provinces and territories at that time. Additionally, bilateral meetings were held this year with provincial and territorial officials from Ontario and Prince Edward Island to review the process and reporting requirements.

Insurance Plan Descriptions

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

Provincial and Territorial Health Care Insurance Plan Statistics

In 2003–2004, the section of the annual report containing the statistical information submitted from the provinces and territories was simplified and streamlined following feedback received from provincial and territorial officials, and based on a review of data quality and availability.

The format remains the same for the 2005–2006 report. The supplemental statistical information can be found at the end of each provincial or territorial narrative, except for New Brunswick and Quebec.

The purpose of the statistical tables is to place the administration and operation of the *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 federal Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental by province and territory for five consecutive years ending on March 31, 2006. All information was provided by provincial and territorial officials.

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

Organization of the Information

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

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

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

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

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

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

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

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

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

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

Newfoundland and Labrador

Introduction

The reorganization of the province's 14 health boards into four new regional health authorities occurred in 2005–2006. The new structure will achieve greater integration of services on a regional basis. The four new regional authorities will focus on the full continuum of care including public health, community services and acute and long-term care services. By the end of fiscal year 2005–2006, new Boards of Trustees and senior executive teams were in place and restructuring of administrative and support services were underway.

The provincial government appoints Boards of Trustees who serve as volunteers. These boards are responsible for delivering health and community services to their regions and, in some cases, to the province as a whole, interact. Regional authorities interact with the public and stakeholders to determine health needs. The boards 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 March 2006 the department released the Provincial Wellness Plan. The first phase of the plan will be implemented over the next three years and will focus on key areas including healthy eating, physical activity, tobacco control and injury prevention.

Other key initiatives during the year included:

- The appointment of the province's first Chief Nurse.
- A new *Medical Act* which will increase accountability and public protection. Under this legislation, the Newfoundland Medical Board is renamed the College of Physicians and Surgeons of Newfoundland and Labrador.
- *Working Together for Mental Health*, a new provincial policy for mental health and addictions services, was released.
- The Province reached a new four-year Memorandum of Agreement with physicians.
- Design and some site work began on new long-term care sites in the Eastern and Western regions.
- Budget 2005 continued Government's development of an Electronic Health Record through an investment of $4 million to expand and enhance the Picture Archiving and Communications System (PACS). This allows diagnostic images including X-rays and CT scans to be digitally captured, viewed, stored and transmitted electronically from one facility to another. By 2007 there will be 27 PACS sites in Newfoundland and Labrador making it the first province in Canada to have a province-wide system.
- A Provincial Wait Time Coordinator was hired in September 2005 to coordinate improved monitoring and reporting of wait times for select health services. Regional Wait Times coordinators were put in place to assist with this initiative. In December 2005, Government announced the implementation of pan-Canadian wait times for five select procedures and committed to quarterly reporting.
- Budget 2005 allocated $2.6 million to implement another three primary health care teams (Port aux Basques, Deer Lake/White Bay, Springdale/Green Bay) and expand some of the existing networks, with funding provided to four more areas (Grand Falls-Windsor/Botwood, New-Wes-Valley, St. John's downtown and Burin Peninsula) to develop proposals for PHC changes in their areas.
- In spring 2005, a Chronic Disease Prevention and Management Collaborative program, with diabetes as the first collaborative, was funded provincially and initiated in eight PHC team areas.
- In winter 2005, funding was provided to develop a provincial Telehealth Plan.

The Department continues to address the challenges of delivering quality health and community services to the people of the province while recognizing the challenges of an aging population, fiscal resource constraints, diverse geography and human resource issues.

In Newfoundland and Labrador, almost 19,000 health care providers and administrators provided health services to 510,000 residents.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department include the Hospital Insurance Plan and the Medical Care Plan. Both plans are non-profit and publicly administered.

The *Hospital Insurance Agreement Act*, amended in 1994, is the legislation that enables the Hospital Insurance Plan. The Act gives the Minister of Health and Community Services the authority to make regulations for providing insured services on uniform terms and conditions to residents of the province under the conditions specified in the *Canada Health Act* and Regulations.

The *Medical Care Insurance Act* (1999) which came into force on April 1, 2000, empowers the Minister to administer a plan of medical care insurance for residents of the province. It allows for developing regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to administering the Medical Care Plan.

The Medical Care Plan facilitates the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures and systems that permit appropriate compensation to providers for rendering insured professional services. The Medical Care Plan operates in accordance with the provisions of the *Medical Care Insurance Act* (1999) and Regulations, and in compliance with the *Canada Health Act*.

There were no legislative amendments to the *Medical Care Insurance Act* (1999) or the *Hospital Insurance Agreement Act* in 2005–2006.

1.2 Reporting Relationship

The Department is mandated with administering the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes, e.g. Public Accounts and the Estimates Committee of the House of Assembly.

The Department will be tabling its 2005–2006 Annual Report in the House of Assembly in fall 2006. The four regional health authorities, on behalf of predecessor boards, and some health agencies will also table their reports.

The Department's Annual Report highlights the accomplishments of 2005–2006 and provides an overview of the initiatives and programs that will continue to be developed in 2006–2007. The report is a public document and is circulated to stakeholders. It will be posted on the Department's website at: www.health.gov.nl.ca/health.

1.3 Audit of Accounts

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

The four regional health authorities are subject to Financial Statement Audits, Reviews and Compliance Audits. Financial Statement Audits were performed by independent auditing firms that are selected by the health authorities under the terms of the *Public Tendering Act*. Review engagements, compliance audits and physician audits were carried out by personnel from the Department under the authority of the *Newfoundland Medical Care Insurance Act* (1999). Physician records and professional medical corporation records were reviewed to ensure that the records supported the services billed and that the services are insured under the Medical Care Plan.

Beneficiary audits were performed by personnel from the Department under the *Medical Care Insurance Act* (1999). Individual providers are randomly selected on a bi-weekly basis for audit.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (as amended) and the Hospital Insurance Regulations 742/96 (1996) provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 36 facilities (14 hospitals and 22 community health centres) and 14 nursing stations. Insured services include: accommodation and meals at the standard ward level; nursing services; laboratory, radiology and other diagnostic procedures; drugs, biologicals and related preparations; medical and surgical supplies, operating

room, case room and anaesthetic facilities; rehabilitative services (e.g. physiotherapy, occupational therapy, speech language pathology and audiology); out-patient and emergency visits; and day surgery.

The coverage policy for insured hospital services is linked to the coverage policy for insured physician services. The Department of Health and Community Services manages the process of adding or delisting a hospital service from the list of insured services based on direction from the Minister. There were no services added or de-listed in 2005–2006.

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* includes:

- 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 by the Newfoundland Medical Board (now named the College of Physicians and Surgeons of Newfoundland and Labrador) to practice in the province.

An insured service is defined as one that is: listed in section 3 of the Medical Care Insurance Insured Services Regulations; medically necessary; and/or recommended by the Department of Health and Community Services. There are no limitations on the services covered, subject to these criteria.

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.

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

(1) Where a physician providing insured services is not a participating 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.

(2) Where a physician who is not a participating physician provides insured services through a professional medical corporation, the professional medical corporation is not, in relation to those services, 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 and the professional medical corporation and the physician providing the insured services shall comply with subsection (1).

As of March 31, 2006, there were no physicians who had opted out of the Medical Care Plan.

Ministerial direction is required to add to or to de-insure a physician service from the list of insured services. This process is managed by the Department in consultation with various stakeholders, including the provincial medical association and the public. There were no services added or deleted during the 2005–2006 fiscal year to the list of insured physician services.

2.3 Insured Surgical-Dental Services

The provincial Surgical-Dental Program is a component of the Medical Care Plan. Surgical-dental treatments provided to a beneficiary and carried out in a hospital by a dentist are covered by Medical Care Plan if the treatment is specified in the Surgical-Dental Services Schedule.

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

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

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

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

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 before admission or upon discharge; private duty nursing arranged by the patient; non-medically required x-rays or other services for employment or insurance purposes; drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital; bedside telephones, radios or television sets for personal, non-teaching use; fibreglass splints; services covered by 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 Medical Care Plan are also 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 dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for, or on behalf of, or any communication to, or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosing the illness proposed to be treated by acupuncture;
- examinations not necessitated by illness or at the request of a third party except as specified by the 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 determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age; excision of xanthelasma;
- circumcision of newborns;
- hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the province at a facility not approved by the Newfoundland Medical Board;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;

- *in vitro* fertilization and ovarian stimulation and sperm transfer (OSST); 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.

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

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

Surgical-dental and other services not covered by the Surgical-Dental Program include the dentist's fee and the oral surgeon's or general practitioner's fees for routine dental extractions in a hospital.

3.0 Universality

3.1 Eligibility

Residents of Newfoundland and Labrador are eligible for coverage under the *Medical Care Insurance Act* (1999) and the *Hospital Insurance Agreement Act* (as amended).

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 (Regulation 20/96) identify those residents eligible to receive coverage under the plans. The Medical Care Plan has established rules to ensure that the Regulations are applied consistently and fairly in processing applications for coverage.

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 Forces and Royal Canadian Mounted Police (RCMP) personnel; inmates of federal prisons; and armed forces personnel from 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 to access insured services. New residents are advised to apply for coverage as soon as possible on arriving 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 Medical Care Plan number. A birth or baptismal certificate will be required where the child's surname differs from either parent's surname.

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

3.3 Other Categories of Individual

Foreign workers, clergy and dependants of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Holders of Minister's permits are also eligible, subject to MCP approval. There are approximately 500 beneficiaries covered under a work permit, only one under a Minister's permit and approximately 15 dependents of NATO personnel. Clergy are included under the work permit or other category and numbers are not readily available.

4.0 Portability

4.1 Minimum Waiting Period

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

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Forces, the RCMP 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 authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

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

Sections 12 and 13 of the Hospital Insurance Regulations (1996) define portability of hospital coverage during temporary absences both within and outside Canada. Portability of medical coverage during temporary absences both within and outside Canada is defined in departmental policy.

Eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services, although there is no formalized process.

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

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

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and Medical Care Plan 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:

- Before leaving the province for extended periods, a resident must contact the Medical Care Plan to obtain an out-of-province coverage certificate.
- Beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months. Upon return, beneficiaries are required to reside in the province for a minimum of four consecutive months. Thereafter, certificates will only be issued for up to eight months of 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 coverage up to 12 months. Verification of employment may be required;
- Persons must not establish residence in another province, territory or country while maintaining coverage under the Newfoundland MCP;
- For out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request;
- For out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the province.

Failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay 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. Hospital services are considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the Government's hospitalization plan for out-of-country in-patient hospital care is $350 per day, if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and 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 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 where 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. 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 Medical Care 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 insured hospital services and no extra-billing by physicians in the province.

5.2 Access to Insured Hospital Services

In Newfoundland and Labrador there is a health care workforce of nearly 19,000 individuals. Half of this workforce belongs to regulated professional groups.

The supply of health professionals is a high-priority issue in the province, especially in rural areas.

In 2005–2006, the Department continued with its commitment to health human resource planning in the province. The Physician Resource Planning Committee was formed in March 2005 to develop a human resource plan for physicians in the province and is continuing work in this regard. The Department participates in the Provincial Nursing Network, which was formed to develop human resource strategies for registered nurses and licensed practical nurses. The Department also created a Chief Nurse position.

The Atlantic Health Human Resources Planning Study was completed in 2005–2006. The study's deliverables include comparative analysis of the previous provincial studies and roll-up of data, inventories of health education programmes, an environmental scan, reusable simulation modelling software and recommendations. The study's executive summary is available at www.ahhra.ca.

Five health human resource projects were completed, including: 1) developing province-wide standards related to HHR data; 2) developing best practices for the recruitment and retention of physicians; 3) implementing a system in one organization to establish the collection of nursing workload data; 4) provision of community mental health services in the province; and 5) assisting regional health authorities to develop and sustain quality professional practice environments for registered nurses and licensed practical nurses to positively impact nurse retention and client outcomes. These projects were funded by Health Canada.

The department continued to offer recruitment incentives for physicians, registered nurses, audiologists, speech language pathologists, pharmacists and other health professionals in 2005–2006.

Insured hospital services are provided by 36 hospitals and health centres across Newfoundland and Labrador. All facilities provide 24 hour emergency services, out-patient clinics, laboratory and x-ray services. The other services vary by facility and range from general surgery, internal medicine and obstetrics to specialized services such as cardiology and neurology. Quaternary care is not offered in Newfoundland and Labrador and provincial residents travel to other jurisdictions to access services.

Federal funding through the 2004 Health Accord enabled Newfoundland and Labrador to invest $23.2 million in 2005–2006 to improve access to key services by purchasing new medical equipment, modernizing diagnostic and medical equipment and expanding select services in all of the province's major health care centres. These monies will allow the delivery of 43,344 additional MRI, CT, cardiac and other key diagnostic procedures, surgeries, as well as cancer treatments to reduce wait times for provincial residents. The new equipment includes a second MRI in St. John's, replacement of aging CT scanners with multi-slice scanners, new and replacement ultrasound equipment at four sites and four new mammography machines. The MRI, CT scanners, ultrasound and mammography equipment at the St. John's tertiary sites became operational in late 2005–2006. Ultrasound and mammography in other health regions will be available in 2006–2007. Expanded select services include increased cardiac surgeries, increased surgical capacity for joint replacement and cancer, and extended hours of operation to give cancer patients greater access to chemotherapy and radiation. Progress was made in increasing the number of surgeries performed and cancer treatments delivered in 2005–2006.

Newfoundland and Labrador is making progress in reducing wait times for select health services. The province is already at or near the national benchmarks in the five priority areas identified in the 2004 Health Accord. The Department hired a provincial wait times coordinator in 2005–2006 and is completing baseline assessment of wait times in the province. Government is working in partnership with health authorities and health care professionals in improving access to insured hospital services.

In late 2005–2006, Newfoundland and Labrador announced a $14.5 million investment in a province wide Picture Archiving and Communications System (PACS) by 2007. This amount includes a contribution of $10.5 million by Canada Health Infoway Inc. and a provincial investment of $4 million. PACS will benefit patients, health care providers and managers through improved access to diagnostic imaging services in rural areas, reduced wait time for patients in physicians' offices, improved access to specialist consultations due to improved image portability, and improved test-to-results time. A combined investment of $14.5 million by government and Infoway will result in the implementation of the PACS project in the Western and Labrador-Grenfell regions of the province allowing these regions to link into existing sites in Central and Eastern regions.

The provincial Primary Health Care framework, *Moving Forward Together: Mobilizing Primary Health Care* is providing direction for remodelling primary health care in Newfoundland and Labrador through population-health based approach to service delivery, and using a voluntary and incremental approach. PHC services include all the health services delivered in a geographic area (minimum population 6000 to maximum population of 25,000) from primary prevention through to and including acute and episodic illness at the primary health care service delivery level.

The framework supports four goals: (1) enhanced access to, and sustainability of, primary health care; (2) an emphasis on self-reliant and healthy citizens and communities; (3) promotion of a team-based, interdisciplinary and evidence-based approach to services provision; and (4) enhanced accountability and satisfaction of health professionals. Provincial

supports have included an Office of Primary Care, the Primary Health Care Advisory Council, linkages with local college and university programs and professional associations, and developing provincial working groups to support learning/problem-solving and provider capacity-building.

Eight interdisciplinary, team-based, primary health care team areas have initiated changes to service delivery based on the provincial framework, including the development of Community Advisory Committees and enhanced activities support health promotion and illness prevention. In addition, three PHC team areas have completed proposals and provided with funding for implementation, and four other areas have been provided funds for proposal development. Registration processes for primary health care services have commenced in one of the team areas. Formal evaluation of these changes is ongoing by external evaluators, and a report will be available in fall 2006.

Primary health care working groups, with associations, university, PHC team area and other partnerships, have developed processes and tools for scope of practice shifts, physician funding and payment models, and information management. Scope of practice processes have been implemented in the eight initial primary health care team areas, with the development of action plans to assist in shifting scope of practices.

A discussion document has been developed for physician funding and payment models, and a research project has been initiated at Memorial University regarding a funding and payment model. Physician networks are in development in the initial eight primary health care team areas, and a physician network contract (for signing by the Department of Health and Community Services, the region, and the physician network for medical services to the PHC team area) is in the later stages of completion.

In spring 2005, a Chronic Disease Prevention and Management Collaborative program, with diabetes as the first collaborative, was funded provincially on an operational basis, and initiated in eight PHC team areas. These collaboratives will support CDPM from primary prevention through to management, and include provincial learning sessions to promote professional development regarding chronic diseases. In addition, a software application is being supported through Eastern Health Authority that will provide information regarding adherence to clinical practice guidelines, and also for service planning at the individual client, PHC team area, regional and provincial levels. There are plans in the early stages to move forward with collaboratives for mental health and arthritis.

Newfoundland and Labrador is currently involved in two Atlantic Canada projects. Building a Better Tomorrow Initiative has been supporting team and inter-professional development and change management in primary health care team areas through a variety of training modules (team development, conflict resolution, adult learning, understanding primary health care, community development and program planning and evaluation).

In partnership with New Brunswick, a Memorandum of Understanding is being completed for a 24/7 nurse health advice telephone, and plans are in place for implementation, including identification of a site for the call center.

5.3 Access to Insured Physician and Surgical-Dental Services

The number of physicians practicing in the province has been relatively stable, with an upward trend since 2003. The Department is committed to working with regional health boards to develop a provincial human resource plan for physicians based on the principle of access to services.

As of March 31, 2006, there were 471 general practitioners and 500 specialists in practice, compared with 460 general practitioners and 494 specialists as of March 31, 2005. This represents a two percent increase in general practitioners and a one percent increase in specialists.

The Department initiated several measures to ensure access for insured physician services. Some of these included:

- funding for the Provincial Office of Recruitment;
- retention bonuses for salaried physicians based on geography and years of service;
- annual bursary program valued at $1.2 million for medical residents and students (matched to FP in CaRMS) willing to commit to provide medical services in areas of need within the province. During fiscal year 2005–2006, 39 bursaries and travelling fellowships were funded.

5.4 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act* (1999).

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

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), on behalf of all physicians. Representatives from the regional health authorities play a significant role in this process.

In 2005, a four-year agreement was negotiated with the provincial medical association effective October 1, 2005. The award provides for agreed-to increases to fees and salaries during the life of the agreement, additional payments for on-call and recognition of on-call services by salaried physicians. The current methods of remuneration to compensate physicians for providing insured health services are fee-for-service (63% of physicians); salaried (35% of physicians); and alternate payment plans (2% of physicians) such as block funding and new case payments.

5.5 Payments to Hospitals

The Department is responsible for funding regional health authorities for ongoing operations and capital purchases. Funding for insured services is provided to the regional health authorities as an annual global budget. Payments are made in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act*. As part of their accountability to the Government, the health authorities are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility and accountability to all appointed boards in the discharge of their mandates.

Throughout the fiscal year, the regional health authorities forwarded additional funding requests to the Department for any changes in program areas or increased workload volume. These requests were reviewed and, when approved by the Department, funded at the end of each fiscal year.

Any adjustments to the annual funding level, such as for additional approved positions or program changes, were funded based on the implementation date of such increases and the cash flow requirements.

Regional health authorities are continually facing challenges in addressing increased demands when costs are rising, staff workloads are increasing, patient expectations are higher and new technology introduces new demands for time, resources and funding. Regional health authorities continue to work with the Department to address these issues and provide effective, efficient and quality health services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) has been recognized and reported by the Government of Newfoundland and Labrador in the annual provincial budget, through press releases, government websites and various other documents. For fiscal year 2005–2006, these documents included:

- the 2005–2006 Public Accounts;
- the Estimates 2005–2006; and
- the Budget Speech 2005.

The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available to Newfoundland and Labrador residents and have been shared with Health Canada for information purposes.

7.0 Extended Health Care Services

Newfoundland and Labrador has established long-term residential and community-based programs for persons discharged from hospital, seniors, and persons with disabilities. These programs are provided by the regional health authorities. Services include the following:

- Long-term residential accommodations are provided for residents requiring high levels of nursing care in 21 community health centres and 20 nursing homes. There are approximately 2,800 beds located in these 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.
- Persons requiring supervised care or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,750 beds located in 94 homes across the province. These homes are operated by the private for-profit sector. Residents are subsidized to a maximum of $1,138.10 per month, based on an individual client assessment using standardized financial criteria.

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 as well as some rehabilitative programs. These services are publicly funded and delivered by staff employed by the four regional health authorities. Non-professional services include personal care, household management, respite and behavioural 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 monthly ceiling for home support services (fiscal 2005–2006) is $2,707 for seniors and $3,875 for persons with disabilities.

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 equipment.

Drug Programs

The Senior Citizens' Drug Subsidy Program is provided to residents over 65 years of age who receive the Guaranteed Income Supplement and who are registered for Old Age Security benefits. Eligible individuals are given coverage for the ingredient portion of benefit prescription items. Any additional cost, such as dispensing fees, is the client's responsibility. Income support recipients are eligible for the Income Support Drug Plan, which covers the full cost of benefit prescription items, including a set mark-up amount and dispensing fee.

Other Programs

The Department administers the Emergency Air and Road Ambulance Programs.

The Road Ambulance Program provides quality pre-hospital emergency and routine treatment, care and transportation. It also includes the transfer of patients between facilities and return of patients to their place of residence. Road ambulances are operated by 56 organizations — 30 private companies, 22 community or volunteer groups, and four regional health authorities.

The Air Ambulance Program provides air transport for patients requiring emergency care who could not be transported by a commercial airline or by road ambulance because of urgency or time, or remoteness of location. This program uses two fixed-wing aircraft and five chartered helicopters. These helicopters are also used for routine transportation of doctors and nurses to remote communities for clinics. A third fixed-wing aircraft is used in Labrador for regional medical services transports, including routine appointments by coastal residents in Happy Valley/Goose Bay, Labrador.

Residents who travel by commercial air to access medically insured services that are not available within their area of residence or within the province, may qualify for financial assistance under the Medical Transportation Assistance Program. This program is administered by the Department. Kidney donors and bone marrow/stem-cell donors are eligible for financial assistance, as administered by Eastern Health, when the recipient is a Newfoundland and Labrador resident eligible for coverage under the provincial Hospital Insurance and Medical Care Plans.

The Dental Health Plan incorporates a children's dental component and an income support component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at six-month intervals; cleanings at 12-month intervals; fluoride applications at 12-month intervals for children aged 6 to 12; x-rays (some limitations); fillings and extractions; and some other specific procedures that require approval before treatment. Services are available to recipients of income support who are 13 to 17 years of age: examinations (every 24 months); x-rays (with some limitations); routine fillings and extractions; emergency extractions, when the patient is seen for pain, infection or trauma.

Adults receiving income support are eligible for emergency care and extractions. Beneficiaries covered under the Dental Health Plan must pay a variable amount directly to the dentist for each service provided (e.g., fillings, extractions, etc.). In circumstances where the beneficiary is receiving income support, a $5 co-payment is paid by the Dental Health Plan.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	565,000	560,644	599,907	569,835	545,160 [1]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number: [2]					
a. acute care	36	36	36	36	36
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	36	36	36	36	36
3. Payments:					
a. acute care	619,884,087	666,472,833	666,773,382	679,024,717	764,301,116
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. other	0	0	0	0	0
e. total	619,884,087	666,472,833 [3]	666,773,382 [3]	670,024,717 [3]	764,301,116 [3]
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	1	1	1	1	1
b. diagnostic imaging facilities	0	0	0	0	0
c. total	1	1	1	1	1
5. Number of insured hospital services provided:					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	0	0	0	0	0
c. total	not available	not available	not available	not available	not available
6. Payments:					
a. surgical facilities	338,200	286,425	280,250	264,575	285,475
b. diagnostic imaging facilities	0	0	0	0	0
c. total	338,200	286,425	280,250	264,575	285,475

1. Number of registered persons exceeds number of residents. Re-registration of residents commencing in 2006.
2. Restated number of hospital and health centres providing acute care services (rather than only those with acute care beds.
3. New Methodology for 2002–2003. 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.

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians: [4]					
a. general practitioners	421 [5]	437 [5]	451 [5]	460 [5]	471 [5]
b. specialists	465 [5]	477 [5]	499 [5]	494 [5]	500 [5]
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	886 [5]	914 [5]	950 [5]	954 [5]	971 [5]
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	not available	not available	not available	not available	not available
b. total payments	not available	not available	not available	not available	not available
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	2,263,000	2,147,000	2,109,987	2,145,000	2,222,000
b. specialists	2,218,000	2,206,000	1,843,902	1,874,000	2,012,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,481,000	4,353,000	3,953,889	4,019,000	4,234,000
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	42,751,000	50,961,000	62,613,000	72,225,000	75,475,000
b. specialists	75,177,000	78,157,000	90,739,000	103,685,000	104,788,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	117,928,000	129,118,000	153,352,000	175,910,000	180,263,000
13. Number of services provided through fee for service, by category:					
a. medical	2,728,000	2,607,000	3,170,000	3,195,000	3,358,000
b. surgical	398,000	379,000	270,000	270,000	282,000
c. diagnostic	1,345,000	1,367,000	480,000	502,000	540,000
d. other	not applicable	not applicable	34,000	52,000	49,000
e. total	4,481,000	4,353,000	3,954,000	4,019,000	4,234,000
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	not available	not available	96,261,000	105,090,000	114,468,000
b. surgical	not available	not available	26,456,000	27,946,000	30,649,000
c. diagnostic	not available	not available	12,430,000	14,611,000	15,894,000
d. other	not applicable	not available	18,205,000	28,263,000	19,252,000
e. total	117,928,000	129,118,000	153,352,000	175,910,000	180,263,000

4. Excludes inactive physicians.
5. Total salaried and fee-for-service.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	1,681	1,588	1,640	1,699	1,809
16. Total number of claims, out-patient.	26,155	26,464	25,762	26,467	29,628
17. Total payments, in-patient ($).	10,312,515	10,817,595	12,397,072	12,248,758	15,130,363
18. Total payments, out-patient ($).	3,213,978	3,488,186	3,232,235	4,321,173	5,132,112
19. Average payment, in-patient ($).	6,135.00	6,812.00	7,559.00	7,209,00	8,364.00
20. Average payment, out-patient ($).	123.00	132.00	125.00	163.00	173.00
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	116,000	116,000	139,000	113,000	136,000
22. Total payments ($).	4,082,000	4,231,000	4,518,000	4,770,000	5,197,000
23. Average payment per service ($).	35.19	36.47	32.50	42.21	38.21

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	62	61	62	50	54
25. Total number of claims, out-patient.	258	278	283	301	261
26. Total payments, in-patient.	123,692	269,963	363,153	76,981	112,039
27. Total payments, out-patient.	22,567	18,432	167,588	60,159	24,265
28. Average payment, in-patient.	1,995.00	4,426.00	5,857.00	1,540.00	2,075.00
29. Average payment, out-patient.	87.00	66.00	592.00	200.00	93.00
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	1,700	2,400	1,800	2,400	2,300
31. Total payments.	67,000	172,000	199,000	136,000	135,000
32. Average payment per service.	39.41	71.67	110.56	56.67	58.70

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of participating dentists.	26	33	25	31	26
34. Number of services provided.[6]	3,319	3,522	3,609	3,022	2,633
35. Total payments.	409,000	419,000	462,000	329,000	313,000
36. Average payment per service.	123.35	118.88	127.87	108.97	117.80

6. Number of surgical-dental services has been revised to coincide with changes in the way data is compiled for total payments.

Prince Edward Island

Introduction

The Ministry of Health is a large and complex system of integrated services whose aim is to protect, maintain and improve the health and well-being of Prince Edward Islanders. The role of the Department is to provide sound leadership in innovation and ongoing improvement, quality administration and regulatory services, and delivery of client-centred health services consistent with community needs.

The ministry is responsible for a variety of health services to promote and help foster the optimal health of Islanders, including public health services, primary care, acute care, community hospital and continuing care services. These services are delivered by a staff of over 4,000 dedicated professionals through a large number of facilities and programs across the province. Among them are acute care facilities, community hospitals, provincial manors, an in-patient mental health facility, provincial addictions treatment facilities and programs, family health centres, public health, home care, community addictions programs and community mental health.

In spring 2005, a major reorganization of the health and social service system was undertaken. As a result of the reorganization, the Department of Health and Social Services was divided into the Department of Health, and the Department of Social Services and Seniors. All regional health authorities were disbanded, and health services were brought together under a centralized management model.

In addition to creating two new departments and the attendant realignment of services, the restructuring also resulted in a number of administrative and systemic changes. Some of the most significant include the following:

- The role of the Department of Health changed from responsibility for quality of advice and assistance to line services to a responsibility for direct service delivery.
- Administrative and support services for line services moved from a regional to a departmental model, in line with the dissolution of the health authorities.
- Under the previous organizational structure, each of the five regional health authorities had governing boards. Under the new organizational model, each of the five community hospitals has a governing board.

Overview of the Health 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*.

A Minister of the Crown is ultimately accountable to the rest of government and the citizens of Prince Edward Island for the Department of Health and its performance and results. The Department is managed by a Departmental Management Committee comprised of the Deputy Minister and eight senior directors whose responsibility it is to direct the overall departmental management and day-to-day operations. A summary of the principal division of roles is outlined below.

Acute Care: Provides regional and provincial secondary, specialty services and in-patient mental health services to residents of Prince Edward Island. Facilities include Prince County Hospital (PCH), the Queen Elizabeth Hospital (QEH) and Hillsborough Hospital. Administratively, one Executive Director is responsible for PCH and one Executive Director is responsible for QEH / Hillsborough Hospital, each of whom is a member of the Departmental Management Committee.

Community Hospitals and Continuing Care: Provides acute care services to rural communities and support services to adults and seniors in need of continuing care on Prince Edward Island. Programs and facilities include the five rural community hospitals, provincial manors, home care, palliative care, dialysis and adult protection. Administratively, the Director of Community Hospitals and Continuing Care is responsible for this division and is a member of the Departmental Management Committee.

A governing board has been put in place for each of the five community hospitals. Each board is accountable to the minister, and is responsible for ensuring the completion of annual business plans and reporting on facility performance and results.

Primary Care: Provides primary health services to citizens of Prince Edward Island. Programs and facilities include: Community Mental Health and Addictions which encompasses the Provincial Addictions Treatment Facility, seven Family Health Centres, Public Health Nursing and Chronic Disease Prevention. The Director of Primary Care has the administrative responsibility for this division and is a member of the Departmental Management Committee

Population Health: Provides public health and regulatory services to the citizens of Prince Edward Island. The programs and services include the Office of Chief Health Officer, Emergency Health Services, Communicable Disease Control and Immunization, Epidemiology, Environmental Health, Vital Statistics, Community Care / Nursing Home Inspection, and Dietetic Services. The Director of Population Health has administration responsibility for this division and is a member of the Departmental Management Committee.

Facilities

Prince Edward Island has two referral hospitals and five community hospitals, with a combined total of 463 beds. Along with nine government manors (and facilities) that house 558 (plus 10 respite) long-term care nursing beds, Islanders have access to an additional 389 (plus 11 temporary beds) in nine private nursing homes. The system also operates several addictions and mental health facilities, 1,146 seniors' housing units and 468 family housing units.

A $50 million health facility, the Prince County Hospital, was opened in April 2004 in Summerside. Computed Tomography (CT) scanning and a wide range of diagnostic imaging, surgical and other specialty services are available at the referral hospitals. Phase I of a multi-phase redevelopment plan to upgrade the 23-year-old Queen Elizabeth Hospital was recently announced and construction will begin in 2007.

Human Resources

The public sector health workforce has approximately 4,000 employees. There is ongoing recruitment to address vacancies in the physician complement in this province, although enticing new physicians to the province and retaining the appropriate number of required physicians to meet the needs of Islanders is challenging. These challenges are being met by developing a long-term physician resource plan, by providing salary options to new graduates and existing physicians, and with more communication with Prince Edward Island students and residents through the Medical Education Program. A coordinator has been hired for the Physician Recruitment and Medical Education Programs who will be responsible for their administration as well as establishing a centralized locum support program.

The following vacancies currently exist in the physician complement: Family Medicine, Internal Medicine, Emergency Medicine, Psychiatry, Radiology, Pathology, Hospitalists, Ophthalmology and Plastic Surgery. Recruitment to find suitable placements for these positions is ongoing.

In addition to the aforementioned programs, there are other current and planned initiatives such as the Nurse Recruitment Strategy, Provider Registry, Supports for Other Health Care Providers, and the Musco-skeletal Injury Prevention Program (workplace safety).

In the 2005–2006 provincial budget, the government announced that the Registered Nurse Recruitment and Retention Strategy would be delayed for 2005–2006. However, 32 third-year Bachelor of Nursing students who received sponsorships during the 2004–2005 year were eligible to receive sponsorship for their final year of study. On March 30, 2006, the Government announced in the 2006–2007 provincial budget that this strategy would be reinstated.

The Physician Master Agreement is effective until March 31, 2007 and ensures Prince Edward Island remains competitive with other jurisdictions and that Islanders continue to access a quality health care system. The government has also made investments intended to make the health system more competitive in order to maintain services and increase the success of recruitment and retention efforts for physicians.

Financial Resources

The 2005–2006 budget estimate for the Department of Health amounts to $312 million. Prior to the reorganization of the health and social service system, the 2005–2006 combined budget for the Department of Health and Social Services totalled $422 million. The remaining $110 million represents the budget of the new Department of Social Services and Seniors.

Major health expenditures are allocated as following: Provincial Acute Care, 36 percent; Medical Programs, 27 percent; Community Hospitals and Continuing Care, 24 percent; Primary Care, eight percent; and other services such as Corporate Services, Financial Services and Population Health, five percent.

In 2005–2006, funding for the Oncology Centre increased by $275,000. Approval was given for the development and implementation of a $14 million Clinical Information System within the seven acute care hospitals and four community health centres. Funding in the amount of $2.2 million was made available to create a fourth orthopaedic surgeon position in an effort to alleviate wait times for procedures such as hip and knee replacements.

Critical Issues

Health Care in Small Communities

Prince Edward Island is a rural province where a large segment of the population resides outside the main service centres. Local access to health services, including acute services delivered through community hospitals, is important to small communities. Rural hospitals have historically played an important role in health care delivery and serve vital and central roles in their respective communities. Rural hospitals and other health services delivered in these areas face a number of challenges, such as the recruitment and retention of health care providers and keeping pace with evolving standards of care and quality. To enhance health care service delivery in rural areas, family health centres will be established. The planned Clinical Information System / Integrated Electronic Health Record will link all hospitals in the province to electronic patient information.

Access to Care

In Prince Edward Island, as across Canada, access to care is a significant public concern, whether from the perspective of ensuring appropriate wait times for services, access to specialty services, or access to services which are delivered in the official language of choice and or in a culturally sensitive way for linguistic and ethnic minorities. A variety of local initiatives have been undertaken to address these and other access related issues.

Current and/or Planned Initiatives

- A part of the Wait Times Strategy, the staffing complement at the Prince Edward Island Cancer Treatment Center was increased in the area of Radiation Oncology; a fourth Orthopedic Surgeon has been added; and an Oncology Associate has been put in place at PCH.
- Family Health Centres have initiated a variety of specialized clinics (i.e. influenza vaccination).
- Ambulatory Care, currently in place at the new PCH, and enhancements planned as part of the QEH redevelopment allow patients to receive many hospital treatments on an out-patient basis. This would previously have required admission.
- Health Human Resource Recruitment Strategies and other initiatives help ensure that an adequate number of health professionals are in place to deliver services to Islanders.
- New information technology systems, such as the Clinical Information System/Integrated Electronic Health Record will improve timeliness and the availability of patient information for health care providers.

Functional or Community Needs

The health service delivery system is large and complex. Issues or decisions in one area typically affect components elsewhere in the system. For instance, elderly patients or adults with special requirements may not be able to return home upon discharge from hospital and may require admission to long term care. When long term care beds are not available, they may need to remain in the hospital until a long term care bed becomes available. This is a problem for these patients, since they require the kind

of care provided by a manor B not a hospital. This is also a problem for people who need access to hospital care, since an occupied hospital bed is not available for other patients. Inconsistent availability of community supports, including drugs and supplies for home care/ambulatory patients, further challenges the ability to provide the right service at the right place by the right provider.

The provincial hospitals undertook a number of initiatives to help improve patient flow from acute to long term care. A "First Available Bed Policy" was put in place for QEH and PCH and a transition unit was put in place at the QEH.

Initiatives such as the QEH Redevelopment and the new PCH with their emphasis on ambulatory care; the PCH Restorative Care Unit; and the Primary Care Redesign all help the frail elderly and adults with special functional or community needs to live in the community as long as possible, if that is best choice for them. The Provincial Palliative Care Program helps ensure continuity of care for individuals at end of life and their care givers, by the provider and at the location most appropriate to their needs.

Chronic Diseases

The rate of chronic diseases continues to rise. As the population ages, so too will the number of people affected by chronic disease. Several initiatives are planned or underway which could directly or indirectly address current and future levels of chronic disease, including:

- Primary care redesign, including establishment of family health centers.
- Innovations and improvements in areas of pharmacare, home care and wait times are being developed and implemented.
- The Clinical Information System / Electronic Health Record will improve health care provider access to timely and accurate information.

Furthermore, models of service delivery and health care provider roles continue to evolve. Increased adoption of collaborative/inter-disciplinary approaches as well as enhancements in the areas of ambulatory care (including the QEH Redevelopment Project) and primary health care will contribute to chronic disease prevention, treatment, and management. A number of other targeted strategies have been adopted or are planned, such as the Cancer Control Strategy, the Healthy Living Strategy and the Diabetes Education and the Stroke Strategy.

Emerging Technologies

The exponential rate of growth of societal knowledge translates into new technologies, standards and procedures which render previous technologies, standards and procedures obsolescent. New MRI and linear accelerator technology was recently installed at the Cancer Treatment Center; a Provincial RIS/PACS system was recently implemented; and new CT Scan equipment was recently installed at PCH and QEH. There has been an increased adoption of laparoscopic surgical techniques and the use of less-invasive devices. Finally, Clinical Information Systems/Electronic Patient Health Record systems are under development.

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, is the vehicle for delivering 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*.

As a result of the reorganization of the Department and the dissolution of the former health authorities, the Department of Health is now responsible for service delivery, operates hospitals, health centres, manors and mental health facilities. The Public Service Commission hires physicians, nurses and other health related workers.

Under Part I of the *Hospital and Diagnostic Services Insurance 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 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; and
- 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;
- 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 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 to purchase 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 the Act to a hospital that does not comply with regulations relating to purchasing 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 the Act to a hospital that does not comply with the regulations relating to using such aids and procedures.

The Health Ministry, through the Department, 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 provincial hospitals and community hospital authority boards comply with regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the provincial hospitals and the community hospital authority boards;
- 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.

Health care services will continue to be subject to the accreditation process. The next scheduled accreditation is to take place in 2007.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister responsible who tables it in the Legislative Assembly. The Report provides information 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.

The community hospital authority boards are accountable to the Minister pursuant to the *Community Hospital Authorities Act* and must submit annual business plans and provide information to the Minister as and when required.

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.

The provincial Auditor General, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program specific basis. Community hospital authorities are reporting entities under the *Financial Administration Act*.

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- and out-patient hospital services 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 2006, there were seven acute care facilities participating in the province's insurance plan. In addition to 427 acute care beds, these facilities house 20 rehabilitative beds and 20 day surgery beds, as defined under the *Hospitals Act* (1988), for a total of 467 beds.

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, 2006, was 211.

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 physicians advise patients that they are not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of 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 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, 2006, 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, with prior approval that they be performed in a hospital; sterilization procedures, both female and male; treatment of fractures and dislocations; and certain insured specialist services, when properly referred by an attending physician.

The process to add a physician service to the list of insured services involves negotiation between the Department and the Medical Society.

2.3 Insured Surgical-Dental Services

Dental services are not insured in the Health Care Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital or in an office with prior approval as confirmed by the attending physician.

A surgical-dental service (post-operative removal of mandibular wires in an office setting) has been added as a result of negotiations between the Dental Association and the Department.

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, e.g. employment, insurance, education;
- 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;
- travel clinic and expenses;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- 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
- other services that the Department may, upon the recommendation of the negotiation process between the Department and the Medical Society, declare 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.

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

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

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

3.0 Universality

3.1 Eligibility

The *Health Services Payment Act* and Regulations, section 3, define eligibility for the 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 Forces, Royal Canadian Mounted Police (RCMP), inmates of federal penitentiaries and those 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 certain circumstances. Members of the Canadian Forces or RCMP become eligible on discharge or completion of rehabilitative leave. Penitentiary inmates become eligible upon release. In such cases, the province where the individual in question was stationed at the time of discharge or release, or release from rehabilitative leave, would provide initial coverage during the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged 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 before renewal.

The number of residents registered for the Health Care Insurance Plan in Prince Edward Island as of March 31, 2006, was 144,159.

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.

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 before leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement. The total amount paid under these agreements was $24,465,674.

The payment rate currently ranges from $717 at the community hospitals to $724 at Prince County Hospital and $959 at the Queen Elizabeth Hospital per day for hospital stays. The standard interprovincial outpatient rate is $158. The methodology used to derive these rates is as if the patient had the services provided in 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 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 Canada in 2005–2006 was $86,475.

4.4 Prior Approval Requirement

Prior approval is required from the Department before receiving non-emergency, out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a Prince Edward Island 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 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 new Prince County Hospital in Summerside was completed and occupied in April 2004.

As of March 31, 2006 the Department has agreements with five private ambulance operators in the province who provided emergency and non-emergency ground ambulance services on a 24-hour, seven day per week basis. The Department provides operating subsidies to operators who deliver service as per the requirements and standards contained within these agreements.

The Out-of-Province Medical Transport Support Program subsidizes the user fee for patients who require ground ambulance services to access specialized medical care outside the province.

There is activity underway with Health Infostructure Atlantic to further develop an Electronic Health Record within Atlantic Canada. The major focuses of these activities include the overall Electronic Health Record, Health Surveillance and Telehealth activities.

5.3 Access to Insured Physician and Surgical-Dental Services

Physician services are accessible throughout the province except for specialties where there are vacancies. Recruitment processes have been undertaken for family physicians, anaesthetists, radiologists, radiation and medical oncologists, psychiatrists, and a pathologist and plastic surgeon.

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 interests in the process.

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. Alternate payment modalities are growing and seem to be the preference for new graduates. Currently almost 50 percent of physicians are compensated under salary or sessional payments.

5.5 Payments to Hospitals

The community hospital authorities are responsible for delivering hospital services in the province under the *Community Hospital Authorities Act*. The budgetary requirements are established annually through annual business plans approved by the Minister and are subject to approval by the Legislative Assembly through the annual budget process.

Advance payments to provincial hospitals and the community hospital authorities for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

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

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health Transfer in its 2005–2006 Annual Budget and related budget documents and its 2004–2005 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, except for the insured chronic care beds noted in section 2.1.

Nursing Home Intermediate Care and Adult Residential Care Services

Nursing home services are available on approval from regional admission and placement committees for placement into public manors and licensed private nursing homes. There are currently 18 long-term care facilities in the province, nine public manors and nine licensed private nursing homes, with a total of 968 beds, including respite and temporary beds. Nursing home admission is for individuals who require 24-hour registered nurse supervision and care management. The standardized Seniors Assessment Screening Tool is used to determine service needs of residents for all admissions to nursing homes. Payment for long-term care is the responsibility of the individual. When a resident of a facility or someone coming into a facility does not have the financial resources to pay for their own care, they can apply for financial assistance under the Social Assistance Act Regulations, Part II. The Province subsidizes 72 percent of residents in nursing homes. The federal government subsidizes approximately 8.7 percent of nursing home residents through Veterans Affairs Canada. The remaining 18.4 percent finance their own care.

In addition to nursing home facilities, there are 38 licensed community care facilities in Prince Edward Island. As of March 31, 2006, the total number of licensed community care facility beds was 938. A Community Care Facility is a privately operated, licensed establishment with five or more residents. These facilities provide semi-dependent seniors and semi-dependent physically and mentally challenged adults with accommodation, housekeeping, supervision of daily living activities, meals and personal care assistance for grooming and hygiene. Care needs are

assessed using the Seniors Assessment Screening Tool and are at Level 1, 2 or 3. Residents are eligible to apply for financial assistance under the Social Assistance Act Regulations, Part I. It should be noted that payment to community care is the responsibility of the individual. Clients lacking adequate financial resources may apply for financial assistance under the Prince Edward Island *Social Assistance Act.*

Home Care Services

Home Care and Support provides assessment and care planning to medically stable individuals, and defined groups of individuals with specialized needs, who, without the support of the formal system, are at risk of being unable to stay in their own home, or are unable to return to their own home from a hospital or other care setting. Services provided through Home Care and Support include nursing, personal care, respite, occupational and physical therapies, adult protection, palliative care, home and community based dialysis, assessment for nursing home placement and community support. The Seniors Assessment Screening 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. Visiting homemaker services are subject to a sliding fee scale based on an individual's income assessment, which is generally waived for palliative care clients.

Ambulatory Health Care Services

Prince Edward Island has public adult day programs that provide services such as recreation, education and socialization for dependent elders. Individuals who require this service are assessed by regional home care staff. The overall purpose of adult day programs is to allow clients to remain in their homes as long as possible, provide respite for care givers, monitor client's health and provide social interaction. There are adult day programs located across Prince Edward Island.

The Prince Edward Island dialysis program is a community-based service that operates under the medical direction and supervision of the nephrology team at the Queen Elizabeth II Health Sciences Centre in Halifax.

There are five hemodialysis clinics in the province. This is a publicly-funded service. Prince Edward Island also offers a hemodialysis service to out-of-province/country visitors from the existing clinic locations. The provision of this service is based on the capacity within the clinics and the availability of human resources to provide this treatment at the time of the request. Cost of the service is covered through reciprocal billing if from another Canadian jurisdiction and by the visitor if from out of Canada.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	140,001	141,031	142,022	143,261	144,159

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
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. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	7	7	7	7	7
3. Payments:					
a. acute care	109,128,000	115,697,000	121,944,000	125,118,252	129,976,900
b. chronic care	900	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
e. total	109,128,900	115,697,000	121,944,000	125,118,252	129,976,900 [1]
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
5. Number of insured hospital services provided:					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments:					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

1. Figures are budget estimates, not actuals.

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	101	97	96	98	113
b. specialists	75	92	94	96	98
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	176	189	190	194	211
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	1,642,832	1,264,991	1,330,946	2,504,320	1,387,070 [2]
b. total payments	35,337,086	36,475,710	36,732,119	40,012,026	40,027,386 [2]
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	816,197	716,597	783,632	787,557	665,499
b. specialists	358,600	362,619	397,916	410,378	386,668
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,174,797	1,079,216	1,181,548	1,197,935	1,052,167
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	16,588,900	16,537,250	16,234,598	16,502,193	16,742,162
b. specialists	15,559,600	16,446,970	17,054,737	17,921,200	18,484,053
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	32,148,500	32,984,220	33,289,335	34,423,393	35,226,215
13. Number of services provided through fee for service, by category:					
a. medical	107,683	96,152	111,896	111,043	92,544
b. surgical	140,020	150,036	162,577	169,954	159,071
c. diagnostic	110,897	116,431	123,443	129,381	125,053
d. other	816,197	716,597	783,632	787,557	665,499
e. total	1,174,797	1,079,216	1,181,548	1,197,935	1,052,167
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	5,061,000	4,892,997	4,845,230	4,937,461	4,922,883
b. surgical	8,703,600	9,509,720	9,880,089	10,095,966	10,456,374
c. diagnostic	1,795,000	2,044,253	2,329,418	2,887,773	3,104,796
d. other	16,588,900	16,537,250	16,234,598	16,502,193	16,742,162
e. total	32,148,500	32,984,220	33,289,335	34,423,393	35,226,215

2. Reflects payments made through claim submissions.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	2,220	2,059	2,006	2,163	2,187
16. Total number of claims, out-patient.	17,572	16,790	15,638	14,368	15,547
17. Total payments, in-patient ($).	9,417,000	11,713,751	14,208,471	15,325,267	16,463,548
18. Total payments, out-patient ($).	2,930,100	2,879,064	2,578,895	2,667,968	3,225,803
19. Average payment, in-patient ($).	4,242.00	5,689.00	7,083.00	7,085.00	7,528.00
20. Average payment, out-patient ($).	167.00	171.00	165.00	186.00	207.00
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	67,435	48,369	45,255	48,928	54,269
22. Total payments ($).	3,871,900	3,778,171	3,795,244	4,122,725	4,674,004
23. Average payment per service ($).	57.00	78.00	84.00	84.00	86.13

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	26	23	37	30	25
25. Total number of claims, out-patient.	85	152	130	93	91
26. Total payments, in-patient ($).	123,127	79,577	155,922	95,719	69,391
27. Total payments, out-patient ($).	13,702	25,954	24,366	16,304	17,084
28. Average payment, in-patient ($).	4,736.00	3,459.00	4,214.00	3,191.00	2,775.00
29. Average payment, out-patient ($).	161.00	171.00	187.00	175.00	188.00
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	677	521	706	627	534
31. Total payments ($).	33,995	30,076	37,100	21,849	15,844
32. Average payment per service ($).	50.00	58.00	53.00	35.00	30.00

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of participating dentists.	2	2	2	2	3
34. Number of services provided.	176	312	393	410	303
35. Total payments ($).	60,989	88,443	90,851	96,490	115,918
36. Average payment per service ($).	347.00	283.00	231.00	235.00	382.00

Nova Scotia

Introduction

The Nova Scotia Department of Health's mission is to ensure, through leadership and collaboration, an appropriate, effective and sustainable health system that promotes, maintains and improves the health of Nova Scotians. This requires that health care services in Nova Scotia be integrated, community-based and sustainable.

In February 2006, the Government of Nova Scotia created a new Department of Health Promotion and Protection that brought together two areas in the Department of Health: the Office of the Chief Medical Officer of Health and the Public Health Branch.

The *Health Authorities Act*, Chapter 6 of the Acts of 2000, established the province's nine District Health Authorities (DHAs) and their community-based supports, the Community Health Boards (CHBs). DHAs are responsible for governing, planning, managing, delivering, monitoring and funding health services within each respective district and for providing planning support to the CHBs. Services delivered by the DHAs include acute and tertiary care, public health, mental health and addictions.

The province's 37 CHBs develop community health plans with primary health care and health promotion as their foundation. District Health Authorities draw two-thirds of their board nominations from CHBs. Their community health plans are part of the DHAs annual business planning process. In addition to the nine DHAs, the IWK Health Centre (Women and Children's Tertiary Care Hospital) continues to have separate board, administrative and service delivery structures.

The Department of Health is responsible for setting strategic direction and standards for health services which are meant to ensure the availability of quality health care; for, monitoring, evaluating and reporting on performance and outcomes and for funding health services. The Department of Health is directly responsible for physician and pharmaceutical services, emergency health, continuing care, and many other insured and publicly funded health programs and services.

Under the *Health Authorities Act*, the DHAs are required to provide the Minister of Health with monthly and quarterly financial statements and audited year-end financial statements. They are also required to submit annual reports, which provide updates on implementing DHA business plans. These provisions ensure greater financial accountability. The sections of the *Health Authorities Act* related to financial reporting and business planning came into effect on April 1, 2001.

Pursuant to the *Provincial Finance Act* (2000) and government policies and guidelines, the Department of Health is required to release annual accountability reports outlining outcomes against its business plan for that fiscal year. The 2005–2006 accountability report will be available in late 2006.

The spending of Nova Scotia's 2005–2006 health care dollars was consistent with commitments in *Your Health Matters* — a report released by the Department of Health in March 2003 outlining its multi-year plan for better health care. This plan focuses on five key areas:

- helping people stay healthy;
- training, recruiting, and keeping more doctors, nurses, and health professionals;
- shortening wait lists for tests, treatment, and care;
- caring for our seniors; and
- accessing health services close to home.

This report can be viewed at:
http://www.gov.ns.ca/health/your_health_matters.htm

As part of the commitments contained in Your Health Matters, Nova Scotia publishes annual reports on progress made, which account for how the year's activities matched plans. It reports specifically on issues such as quality, access and efficiency, as well as progress in primary or community-based health care, home care and drug coverage. The report for 2005–2006, *Working Together Toward Better Health: Ministers' Report to Nova Scotians* can be viewed at:
http://www.gov.ns.ca/health/reports.htm#MinisterReport

Nova Scotia faces a number of challenges in the delivery of health care services. Nova Scotia's population is aging. Currently, 14.1% of the Nova Scotia Population is sixty-five or over and this figure is expected to nearly double by 2026. Aging populations increase the pressure to expand the basket of publicly-insured services to include home care, long-term care and enhanced pharmaceutical coverage. The burden of illness resulting from much higher than average rates of chronic diseases such as cancers and diabetes are major contributors to the rising costs of health care delivery in Nova Scotia. Other major cost drivers are a highly competitive labour market for health human resources, the increasing costs of pharmaceuticals and aging facility infrastructure.

Despite these ever-increasing pressures and challenges, Nova Scotia continues to be committed to the delivery of medically necessary services consistent with the principles of the *Canada Health Act.*

Additional information related to health care in Nova Scotia may be obtained from the Department 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 and 35.

The MSI is administered and operated by an authority consisting of the Department of Health and Medavie Blue Cross (formerly called Atlantic Blue Cross), under the above-mentioned act (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32 and 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. As well, all residents of the province are insured on uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. 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.

The Department of Health and Medavie Blue Cross entered into a new service level agreement, effective August 1, 2005. This new ten-year agreement replaced the 1992 Memorandum of Agreement between Medavie and the Department of Health. Under the agreement, Medavie is responsible for operating and administering programs contained under MSI, Pharmacare Programs and Health Card Registration Services.

There were no changes to the *Health Services and Insurance Act* or regulations under this act in 2005–2006.

1.2 Reporting Relationship

Medavie is obliged to provide reports to the Department under various Statement of Requirements for each Business Service Description as listed in the contract.

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

1.3 Audit of Accounts

The Auditor General's office audits all expenditures of the Department of Health. A contract is in place to have an annual audit performed on the Insured Prescription Drug Plan Trust Fund. The Department of Health has a new service level agreement in place with Medavie Blue Cross, effective August 1, 2005. An audit plan is under development for this agreement, including Medicare payments, which has been recommended by the Auditor General's office.

All long-term care facilities, home care and home support agencies are required to provide the Department with annual audited financial statements.

Under section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health by July 1st each year, an audited financial statement for the preceding fiscal year.

The June, 2006 Report of the Auditor General of Nova Scotia contained audits with respect to:

- District Health Authorities — Colchester East Hants and Cumberland & Pictou County
- Payments to Physicians

1.4 Designated Agency

Medavie Blue Cross Care administers and has the authority to receive monies to pay physician accounts under a new service level agreement with the Department of Health, effective August 1, 2005. Medavie Blue Cross Care receives written authorization from the Department for the physicians to whom it may make payments. The rates of pay and specific amounts depend on the physician contract negotiated between Doctors Nova Scotia and the Department of Health.

All Medavie Blue Cross Care system development for MSI and Pharmacare is controlled through a joint committee. All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Nine DHAs and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in-patients and out-patients in Nova Scotia in a total of 35 facilities.

Accreditation is not mandatory, but all facilities are accredited at a facility or district 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. 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 Clinics; ultrasonic diagnostic procedures; home parenteral nutrition; and haemodialysis and peritoneal dialysis.

In order to add a new hospital service to the list of insured hospital services, DHAs are required to submit a New and/or Expanded Program Proposal to the Department of Health. This process is carried out annually by request through the business planning process. A Department-developed process format is forwarded to the DHAs for their guidance. A departmental working group reviews and prioritizes all requests received. Based on available funding, a number of top priorities may be approved by the Minister of Health.

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.

The *Health Services and Insurance Act* was amended in 2002–2003 to include section 13B stating that: "Effective November 1, 2002, any agreement between a provider and a hospital, or predecessors to a hospital, stipulating compensation for the provision of insured professional services, for the provider undertaking to be on-call for the provision of such services or for the provider to relocate or maintain a presence in proximity to a hospital, excepting agreements to which the Minister and the Society are a party, is null and void and no compensation is payable

pursuant to the agreement, including compensation otherwise payable for termination of the agreement."

Under the *Health Services and Insurance Act*, persons who can provide insured physician services include:

- general practitioners, who are persons who engage in the general practice of medicine;
- physicians, who are not specialists within the meaning of the clause; and
- specialists, who are physicians and are recognized as specialists 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 2005–2006, 2,220 physicians and 33 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 his or her billing number. Patients who pay the physician directly due to opting out are reimbursed for these services by MSI. As of March 31, 2006, 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 2005–2006. On a quarterly, ongoing basis, new specific fee codes are approved that represent 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 Doctors 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 Doctors Nova Scotia and the 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 Medavie Blue Cross 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 Nova Scotia *Health Services and Insurance Act*, a dentist is defined as a person lawfully entitled to practice dentistry in a place where that person carries on such practice.

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association 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, 2006, no dentists had opted out. In 2005–2006, 33 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 Insured Dental Services Tariff Regulations. 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 a surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth and oral and maxillary facial surgery. Routine extractions services are provided for cardiac patients, transplant patients, immunocompromised patients and radiation patients when these patients are undergoing active treatment in a hospital setting and the attendant medical procedure requires the removal of teeth. Other approved services include coverage for all precancerous or cancerous dental surgical biopsies.

Requests for an addition to the list of surgical-dental services are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health to add 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.

Major third-party agencies purchasing medically necessary health services in Nova Scotia include Workers Compensation, the Canadian Armed Forces and the Royal Canadian Mounted Police (RCMP).

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as foldable intraocular lens or a fiberglass cast can be purchased, it is required to fully inform patients about the cost. They 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 Doctors Nova Scotia and 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 de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

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

A person is considered to be "ordinarily present" in Nova Scotia if the person:

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

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. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the province, provided they are Canadian citizens or hold "Permanent Resident" status as defined by Citizenship and Immigration Canada.

Members of the RCMP, members of the Canadian Forces, federal inmates and members of the North Atlantic Treaty Organization (NATO) are ineligible for MSI coverage. When their status changes, they immediately become eligible for provincial Medicare.

There were no changes to eligibility requirements in 2005–2006.

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. Once eligibility has been determined, an application form is generated. The applicant (and spouse if applicable) must sign the form before it can be processed. The applicant must indicate on the application the name and mailing address of a witness. The witness must be a Nova Scotia resident who can confirm the information on the application. The applicant must include proof of Canadian citizenship or provide a copy of an acceptable immigration document.

When the application has been approved, health cards will be issued to each family member listed. MSI registration information is maintained as a family unit. Each health card number is unique and is issued for the lifetime of the applicant. Health cards expire every four years. The health card number also acts as the primary health record identifier for all health service encounters in Nova Scotia for the life of the recipient. Proof of eligibility for insured services is required before residents are eligible to receive insured services. Renewal notices are sent to most cardholders three months before the expiry date of the current health card. Upon return of a signed renewal notice, MSI will issue a new health card.

There is no legislation in Nova Scotia forcing residents of the province to apply for MSI. There may be residents of Nova Scotia who, therefore, are not members of the health insurance plan.

In 2005–2006, there were 933,259 residents registered with the health insurance plan.

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 moving from another country to live permanently in Nova Scotia are eligible for health care on the date of arrival. They must possess a landed permanent residency document. These individuals, formerly called “landed immigrants”, are now referred to as “Permanent Residents”.

Convention Refugees and Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required) who possess any other document and who have applied within Canada for Permanent Resident status, will be eligible on the date of application for permanent residency, provided they have a letter from the Immigration Department stating that they have applied for Permanent Residence.

Non-Canadians married to Canadian Citizens/ Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied outside Canada for Permanent Resident status, will be eligible on the date of arrival, provided they have a letter from the Immigration Department stating that they have applied for Permanent Residence.

In 2005–2006, there were 22,098 Permanent Residents registered with the health care insurance plan.

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

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

In 2005–2006, there were 1,230 individuals with Employment Authorizations covered under the health care insurance plan.

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

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

In 2005–2006, there were 943 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either a work permit or study permit.

4.0 Portability

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory are eligible for MSI on the first day of the third month following the month of their arrival.

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.

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, and their dependants, who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI a letter directly from the educational institution, which states that they are registered as full-time students. MSI coverage will be extended on a yearly basis pending receipt of this letter.

Workers who leave Nova Scotia to seek employment elsewhere will still be covered by MSI for up to 12 months, provided they do not establish residence in another province, 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 and the Medical Reciprocal Billing Agreement. Quebec is the only province that does not participate in the medical reciprocal agreement. Nova Scotia pays for services provided by Quebec physicians to Nova Scotia residents at Quebec rates if the services are insured in Nova Scotia. The majority of such claims are received directly from Quebec physicians. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amounts paid by the plan in 2005–2006, for in- and out-patient hospital services received in other provinces and territories were: $16,285,032 for out-of-province, in-patient services and $7,345,702 for out-of-province, out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

There were no changes made in Nova Scotia in 2005–2006 regarding in-Canada portability.

4.3 Coverage During Temporary Absences Outside Canada

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

Students and their dependants who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI, a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Persons who engage in employment (including volunteer/missionary work/research) outside Canada, which does not exceed 24 months, are still covered by MSI; providing the person has already met the residency requirements.

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 in 2005–2006 for insured in-patient services provided outside Canada was $1,495,313.

There were no changes made in Nova Scotia in 2005–2006 regarding out-of-Canada portability.

4.4 Prior Approval Requirement

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

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 the plan.

Nova Scotia continually reviews access situations across Canada to ensure that it is not falling behind. In areas where improvement is deemed necessary, depending on the Province's financial situation, extra funding is generally allocated to that area.

In 2005–2006 Nova Scotia Department of Health invested $650,000 to increase the number of community-based, multi-disciplinary teams available to serve the primary health-care needs of Nova Scotians.

To address the access needs of its culturally diverse population, the Nova Scotia Department of Health produced *Guidelines for Diversity and Social Inclusion in Primary Health Care* with plans to begin implementation of these guidelines in 2006–2007.

5.2 Access to Insured Hospital Services

The Government of Nova Scotia continues to emphasize the provision of sustainable, quality health care services to its citizens. In December 2005, Nova Scotia Department of Health released the Health Human Resources Action Plan as a first step in the development of a comprehensive health human resources strategy for the province which will ensure that the supply of health care professionals in Nova Scotia is sufficient, has the right mix of health professionals, and has the right geographical distribution.

In 2005–2006, there were a total of 2,220 physicians operating in Nova Scotia, 53 more than in the previous year. This includes 948 general practitioners and 1,270 specialists. As in previous years, all were participating in the health insurance plan.

Nova Scotia has a nursing strategy, which was introduced in 2001. It is a multi-year plan that provides a comprehensive and coordinated approach to enhancing the quality of work life for nurses, retaining experienced nurses in the system, and creating an environment in which recruitment efforts will be successful. Nova Scotia invests approximately $10 million annually on the strategy and on training more nurses.

Nova Scotia has a Telehealth Network (NSTHN), which connects DHAs and the IWK Health Centre with a sophisticated videoconferencing communications network. The network allows patients in rural areas to consult with specialists in large health centres. The NSTHN enhances access to health services closer to home for patients and their families. The NSTHN also provides health professionals across Nova Scotia with access to educational opportunities without leaving their communities.

In October of 2005, Nova Scotia officially launched its wait times website (see: www.gov.ns.ca/health/waittimes/default.htm)

This site provides Nova Scotians with information to help them, and their health-care providers, make decisions about their testing and treatment options. It provides provincial health-care wait times for tests, treatments and services by the various choice locations in Nova Scotia.

In 2005–2006, Nova Scotia announced a number of investments that will improve access to health care services for Nova Scotians. Some of these included:

- A $2 million renovation project at the Lillian Fraser Memorial Hospital to improve access to community health care services
- More than $1 million in the Picture Archive and Communication System expansion project.
- $3 million investment in a PET scans.
- Establishment of a new primary health care clinic at Yarmouth Regional Hospital.
- $78 million commitment to replace Colchester Regional Hospital.
- $9.3 million investment in St. Martha's Hospital.
- Plans to establish a provincial renal care program.
- The completion of the Nova Scotia Hospital Information System with implementation in 34 hospitals with over 1 million patients on file.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2005–2006, 2,220 physicians and 33 dentists actively provided insured services under the *Canada Health Act* or provincial legislation.

According to the 2005 Canadian Community Health Survey, 95.1 percent of Nova Scotians have a regular family physician. The Canadian average is 86.4 percent.

Innovative funding solutions for physicians, such as block funding and personal services contracts, have enhanced recruitment. A five-year incentive program is offered in 21 rural communities to recruit doctors. The program provides an annual bonus for each completed year of service, moving expenses, continuing medical education funding and guaranteed minimum billing (income) for the year.

Other provincial programs include: start-up contracts for family doctors, alternative payment plans, a debt assistance program, and a physician recruitment office that maintains a recruitment website and co-ordinates site visits, advertising, and c.v. distribution within the province.

The Province has increased the capacity for medical education 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 Doctors Nova Scotia and the Nova Scotia Department of Health. Doctors Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from Doctors Nova Scotia and the Department of Health negotiate the total funding and other terms and conditions. The current master agreement is effective from April 1, 2004 through March 31, 2008. The agreement lays out what the medical services unit value will be for physician services and addresses other issues such as Canadian Medical Protective Association, membership benefits, emergency department payment, on-call funding, specific fee adjustments, dispute resolution processes, and other process or consultation issues.

Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of alternative payment arrangements in place in Nova Scotia.

Over the past number of years, we have seen a significant shift toward alternative payment. In the 1997–1998 fiscal year, about nine percent of our doctors were paid solely through alternative funding. In 2005–2006 over 30 percent of physicians are remunerated through alternative funding. They can be broken down into three groups:

- Academic Specialists (these physicians are mainly located in Halifax at the QEII and the IWK centres). Most of the Academic Specialist groups are on alternate funding arrangements with the exception of Urology and Ophthalmology.
- District Specialists (Obstetrics/Gynecology, Anaesthesiology, Pediatrics).
- General Practice (including General Practice/Nurse Practitioner Contracts).

There are also a number of physicians who receive a portion of their remuneration through alternative funding. These alternative funding mechanisms include Sessional, Psychiatry, Remote Practice, Facility On-Call and Emergency Room funding. In total, over 60 percent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms.

In 2005–2006 total payments to physicians for insured services in Nova Scotia were $540,495,196. The Department paid an additional $6,619,938 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 Nova Scotia Dental Association and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement, which was reached in April 2004, expires on March 31, 2008.

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 DHAs, the IWK Health Centre and other non-DHA organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* instituted the nine DHAs that replaced the former regional health boards. 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. Under section 20 of the *Health Authorities Act*, the DHAs are responsible 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 2005–2006, there were 2,891 hospital beds in Nova Scotia (3.0 beds per 1,000 population). Department of Health direct expenditures for insured hospital services operating costs were increased to $1.13 billion.

6.0 Recognition Given to Federal Transfers

In Nova Scotia, the *Health Services and Insurance Act* acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware of ongoing federal contributions to Nova Scotia health care through the Canada Health Transfer (CHT) as well as other federal funds through press releases and media coverage.

The Government of Nova Scotia also recognized the federal contribution under the CHT in various published documents including the following documents released in 2005–2006:

- Public Accounts 2004–2005; and
- Budget Estimates 2005–2006.

7.0 Extended Health Care Services

The Nova Scotia Department of Health's Continuing Care branch offers home care and long-term care services. These services promote independence, fairness, equity, and choice for people with care needs. The Department of Health provides a Single Entry Access to its continuing care services. Nova Scotians can connect with Continuing Care through a single toll-free number.

In 2006, the Department of Health released a broad based, multi-year Continuing Care strategy that will see the addition of long-term care beds and the expansion and enhancement of community and home based services over the ensuing five to ten years.

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

The Department of Health provides residentially based long-term care services in the following facility types:

- **Nursing Homes & Homes for the Aged** which provide a range of personal care and/or skilled nursing care to individuals who require the availability of a registered nurse on-site at all times;
- **Residential Care Facilities** which provide supervisory care and/or personal care in a residential setting; and
- **Community Based Options** which provide accommodation, minimal supervision and the development of self-care skills for three or less residents.

Residents who live in nursing homes, residential care facilities, and community-based options under the Department of Health's mandate have the costs of their health care services covered by the provincial government. Residents pay the accommodation cost portion of the long-term care services they receive. Long-term care accommodation charges are based on the type of facility and the resident's income, up to a daily maximum. For more information please see: www.gov.ns.ca/health/ccs/ltc.htm

7.2 Home Care Services

Broad-based, provincially funded home care services are available to Nova Scotians of all ages and help individuals to reach and maintain their maximum level of health and to prolong independent living in the community. Both chronic care services over the longer term and short-term acute services are provided through home care. Home care services can be provided to people who are chronically ill, convalescent, palliative, disabled or to individuals with an acute illness. The services available to individuals through home care include professional nursing care, assistance with personal care, nutritional care, aid with home making activities, home oxygen services and respite care. The program also provides referrals to and linkages with other services such as adult day programs, volunteer services, meals on wheels and community rehabilitation services.

In December 2005, the Department of Health introduced a Self-Managed Care service component to assist physically disabled Nova Scotians to increase control over their lives. The program provides funds to eligible individuals so that they may directly employ caregivers to meet their home support and personal care needs.

In addition to the services outlined above, the following services and programs are provided to Nova Scotians outside the requirements of the *Canada Health Act*.

- **Nova Scotia Seniors' Pharmacare Program** — This provincial drug insurance plan helps seniors manage their prescription drug costs. Eligible persons include all residents aged 65 years or older and who do not have prescription drug coverage through Veterans Affairs Canada, First Nations and Indian Health, or a private drug plan. The program provides access to prescription drugs, and diabetic and ostomy supplies listed as benefits in the Nova Scotia Formulary. Persons using this program are responsible for user charges of 33 percent of the total cost to a maximum of $30 for each drug and supply with an annual maximum of $360. General information regarding Pharmacare can be found at: www.gov.ns.ca/health/pharmacare/default.htm
- **Special Funding for Drugs for Specific Disease States** — The Province provides special funding for drug therapies for a few specific disease states including cystic fibrosis, diabetes insipidus, cancer and growth hormone deficiency. There are no user charges for this coverage. General information regarding Drug Programs and Funding can be found at: www.gov.ns.ca/health/pharmacare/default.htm
- **Diabetes Assistance Program.** In 2005–2006, $2.5 million was allocated to design and start this program. This program helps cover the cost of most diabetes medications and supplies and is available to Nova Scotians under 65 years of age who have no other drug coverage. General information on this program is available at: http://www.gov.ns.ca/health/pharmacare/dap/default.htm
- **Emergency Health Services** — Pre-hospital Emergency Care — Emergency Health Services Nova Scotia (EHS) is responsible for the continual development, implementation, monitoring and evaluation of pre-hospital emergency health services in Nova Scotia. EHS integrates various pre-hospital services and programs into one system to meet the needs of Nova Scotians. These services include: EHS ground ambulance system, EHS LifeFlight (the provincial air medical transport system), EHS Communications Centre, Medical Oversight (Management and Direction), the EHS NS Trauma Program, EHS Atlantic Health Training and Simulation Centre and the EHS Medical First Response

program. This integrated province-wide systemhas been rated in the top 10 percent of systems in North America. Residents in Nova Scotia are levied a user charge of $120, to be transported to hospital by ambulance (regardless of distance). There is no charge for transport from hospital to hospital.

- **Children's Oral Health Program (COHP)** — This program has two components: 1) the Insured Services Treatment component provides diagnostic, preventative and restorative services; and 2) the Public Health Services component provides prevention-oriented activities through the application of public health initiatives. Children are eligible for services up to the end of the month in which they turn 10 years of age. All eligible children are entitled to one dental examination and two radiographs per year.
- **Special Dental Plans** — The program covers all dental services required, including prosthetics and orthodontics required by persons diagnosed as having a cleft palate cranofacial disorder; in-hospital dental services provided to the severely mentally challenged who, because of their condition, require the services to be provided in hospital; and a full range of diagnostic, preventive and restorative procedures to residents of the Nova Scotia School for the Blind. There are no user charges for these services. Eligible residents include the following: 1) patients registered with the Cleft Palate Cranofacial Clinic at the IWK Health Centre; 2) registered students at the School for the Blind; and 3) patients with a signed statement to the effect that they are severely mentally challenged and require hospitalization for dental treatment.
- **Community Mental Health Program** — All of the DHAs and the IWK Health Centre offer acute psychiatric treatment. Services are provided across the life span of a person. Specialized services are offered and are in-patient, day treatment, and community-based (e.g. forensic, eating disorders, psychogeriatrics and psychosocial rehabilitation). There are early intervention programs for children with Autism Spectrum Disorder (0–6 yrs). Intensive Community Based Treatment teams in two DHAs and one provincial mental health residential/rehabilitation program for children and youth exists to enhance the continuum of mental health services. Youth Forensic services, including a treatment program for sexually aggressive youth, exist under the authority of the IWK Health Centre. There are no user charges for these services. They are available to all residents in the province.
- **Nova Scotia Addiction Services** — A range of treatment and rehabilitation options are provided, including withdrawal management (detoxification and treatment orientation) programs and community-based structured treatment, out-patient and extended care services. Treatment options are tailored to individual needs and are based on an ongoing assessment. Short-term and long-term treatment goals are identified with each client. Programs and services may be available on a residential, day or out-patient basis, and may include individual, group and/or family programming. Targeted programming is offered where appropriate and may include programming for adolescents, women, families or impaired drivers. There are no user charges for these services except for the program for "Driving While Impaired Offenders".
- **Optometric Benefit** — This benefit provides insurance for visual analysis carried out by optometrists. Vision analysis is defined as: "... an examination that includes the determination of: 1) the refractive status of the eye; 2) the presence of any observed abnormality in the visual system, and all necessary tests and prescriptions connected with such determination." Coverage is limited to one routine vision analysis every two years for those under 10 years of age and those 65 and over. Those between 10 and 65 are not covered for routine analyses, but are covered where medical need is indicated.
- **Prosthetic Services** — All insured residents of the province are eligible for financial assistance in acquiring and replacing standard arm and leg prostheses prescribed by a qualified physician and repairs on such prostheses as required. Patients are responsible for all costs over and above stated coverage.
- **Interpreter Service Program** — This program guarantees equal access to government services, offered to the general public, to eligible deaf and hard of hearing residents of Nova Scotia.

- **Speech and Language Pathology Program** — The service options of this program include: 1) one-to-one therapy; 2) small-group therapy; and 3) consultations (e.g. classroom, day-cares, developmental preschools, and residential facilities for individuals with special needs). The Nova Scotia Hearing and Speech Centres provide specialized services such as dysphagia (swallowing) programs and pervasive developmental delay programs at limited locations in the province. There are no user charges. Eligible persons include children from birth to school age and individuals when they leave school through their adult lifespan. Provincial school boards service children in the public school system.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	953,385	955,475	956,820	961,089	933,259

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	35	35	35	35	35
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
e. total	35	35	35	35	35
3. Payments ($):[1]					
a. acute care	926,797,569	1,021,934,504	1,095,584,706	1,133,215,533	1,230,549,093
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	926,797,569	1,021,934,504	1,095,584,706	1,133,215,533	1,230,549,093
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	1	1	1	0	0
b. diagnostic imaging facilities	0	0	0	1	1
c. total	1	1	1	1	1
5. Number of insured hospital services provided:					
a. surgical facilities	81	83	38	0	0
b. diagnostic imaging facilities	0	0	0	not available	not available
c. total	0	0	38	not available	not available
6. Payments ($):					
a. surgical facilities	10,926	11,714	5,531	0	0
b. diagnostic imaging facilities	0	0	0	not available	not available
c. total	0	0	5,531	not available	not available

1. Dollars are paid to acute care facilities/District Health Authorities.

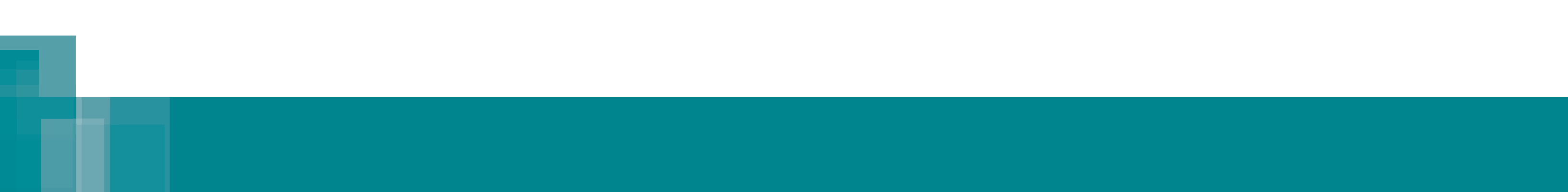
Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	865	875	904	905	948
b. specialists	1,128	1,142	1,198	1,235	1,270
c. other	10	9	14	27	2
d. total	2,003	2,026	2,116	2,167	2,220
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	7,905,797	9,023,272	9,199,462	9,290,207	9,599,128
b. total payments	359,193,862	398,328,665	434,000,386	464,685,571	540,495,196
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	4,521,991	4,563,449	4,629,753	4,706,554	4,916,485
b. specialists	1,650,685	1,677,973	1,924,079	1,629,835	1,636,464
c. other	2,999	2,512	7,098	16,993	825
d. total	6,175,675	6,243,934	6,560,930	6,353,382	6,553,774
12. Total payments to physicians paid through fee for service, by type ($):[2]					
a. general practitioners	102,555,964	113,507,874	120,455,816	124,586,294	133,168,106
b. specialists	118,414,434	127,688,914	133,964,947	121,524,641	121,365,556
c. other	162,779	165,984	250,201	613,173	87,992
d. total	221,133,176	241,362,772	254,670,965	246,724,107	254,621,655
13. Number of services provided through fee for service, by category:					
a. medical	5,124,398	5,163,027	5,262,750	5,312,025	5,527,154
b. surgical	1,009,997	1,034,307	1,054,059	993,621	975,434
c. diagnostic	34,036	39,099	41,161	45,191	50,042
d. other	7,244	7,501	2,960	2,545	1,144
e. total	6,175,675	6,243,934	6,360,930	6,353,382	6,553,774
14. Total payments to physicians paid through fee for service, by category ($):[2]					
a. medical	149,555,510	163,116,603	172,722,629	172,581,326	181,786,160
b. surgical	69,173,647	75,601,138	79,322,814	71,375,047	69,832,367
c. diagnostic	2,007,251	2,184,138	2,413,712	2,638,998	2,895,304
d. other	396,769	460,894	211,844	128,736	107,824
e. total	221,133,177	241,362,772	254,670,999	246,724,107	254,621,655

2. Discrepancies may exist between data presented here and the Nova Scotia Annual Statistical Tables due to methodological differences.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	2,050	2,300	2,368	2,335	2,252
16. Total number of claims, out-patient.	30,749	34,425	32,968	34,166	37,811
17. Total payments, in-patient ($).	8,536,691	12,685,659	15,859,930	15,795,451	16,285,032
18. Total payments, out-patient ($).	4,009,667	4,447,816	4,303,236	6,107,316	7,345,702
19. Average payment, in-patient ($).	4,115.45	5,515.50	6,697.61	6,764.65	7,231.36
20. Average payment, out-patient ($).	130.39	129.20	130.58	178.75	194.27
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	179,833	187,390	180,897	188,118	198,262
22. Total payments ($).	5,078,794	5,562,125	5,747,516	5,866,887	6,619,938
23. Average payment per service ($).	28.24	29.68	31.77	31.19	33.39

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	not available	not available	not available	not available	not available
25. Total number of claims, out-patient.	not applicable	not applicable	not applicable	not applicable	not available
26. Total payments, in-patient ($).	1,000,023	938,092	623,896	678,205	1,495,313
27. Total payments, out-patient ($).	not applicable	not applicable	not applicable	not applicable	not available
28. Average payment, in-patient ($).	not available	not available	not available	not available	not available
29. Average payment, out-patient ($).	not applicable	not applicable	not applicable	not applicable	not available
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	2,421	2,748	2,667	3,111	2,981
31. Total payments ($).	109,484	121,780	120,977	151,175	151,414
32. Average payment per service ($).	45.22	44.32	45.36	48.59	50.79

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of particpating dentists.	35	36	28	25	33
34. Number of services provided.	4,497	5,188	3,780	4,343	5,169
35. Total payments ($).	884,506	939,004	904,283	995,966	1,060,006
36. Average payment per service ($).	196.69	181.00	239.23	229.33	205.07



New Brunswick

Introduction

New Brunswick's ongoing commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility in health care services — the principles that form the foundation of the *Canada Health Act* — was reaffirmed during the 2005–2006 fiscal year as the Government of New Brunswick implemented its Provincial Health Plan.

The Provincial Health Plan, released in June 2004, sets key goals, principles, strategies and priorities to guide health care investments and improvements. It set out a vision of a single, integrated, patient-focused, community-based health services system, accessible to all New Brunswickers in both official languages and managed in a fiscally sustainable manner. It sets out strategies to improve health care services through investments in health promotion, primary health care, recruitment and retention of health human resources, and enhanced accountability and evidence-based decision making.

The goals set out in the Provincial Health Plan are in line with the priorities agreed to by First Ministers in the *10-Year Plan to Strengthen Health Care*. The New Brunswick plan includes initiatives to improve patient access to health care services, provide access to needed drug therapies, increase the supply of valued health professionals, and promote wellness and healthy living.

A number of initiatives to implement aspects of the Provincial Health Plan were undertaken during the 2005–2006 fiscal year.

On February 14, 2006 the Department was renamed the Department of Health, as responsibility for wellness moved to another ministry.

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. The public authority responsible for operating and administering the plan is the Minister of Health, 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 type of agreements 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 confidentiality and privacy issues as they relate to the administration of the Act.

The Minister of Health is responsible for establishing a medical services plan that identifies beneficiaries, 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* and Regulations. The Minister also has the authority to recover the cost of entitled services from a person who is negligent.

1.2 Reporting Relationship

The Medicare Branch of the Department of Health has a mandate to administer the Medical Services Plan. The Minister reports to the Legislative Assembly through the Department's annual report and through regular legislative processes.

The *Regional Health Authorities Act*, which came into force on April 1, 2002, sets out the relationship between the eight RHAs and the Department. Under the Act, RHAs must prepare regional health and business plans that are in harmony with the Provincial Health Plan developed by the Department. The business and affairs of the RHA are to be controlled and managed by a board of directors, appointed or elected in accordance with the Act and its regulations. The chief executive officer of each RHA reports to the Deputy Minister of Health. Under sections 7(1) and 7(2) of the Act, the Minister of Health shall establish an accountability framework, drafted in consultation with RHAs, to specify the responsibilities that each party has to the other in the provincial health system.

1.3 Audit of Accounts

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

The Office of the Auditor General

In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which includes the financial records of the Department of Health. For 2005–2006, all financial transactions of the Department were subject to audit. These procedures are completed on a routine basis each year. Following the audit, the Auditor General issues a management letter or report to identify errors and control weaknesses. The Auditor General also conducts management reviews on programs as he or she sees fit and follows up on prior years' audits

The Office of the Comptroller

The Comptroller is the chief internal auditor for the Province of New Brunswick and provides accounting, audit and consulting services in accordance with responsibilities and authority set out in the *Financial Administration Act*. The Comptroller's internal audit objectives cover 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 and the audit objectives. During 2005–2006, the Office of the Comptroller continued to gather risk assessment data on programs offered by the Department and reviewed common services in the Department and other selected departments.

Department of Health Internal Audit Branch

The Department's Internal Audit Branch 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 Branch also performs program audits to report on the efficiency, effectiveness and economy of programs in meeting departmental objectives.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, 1973, and section 9 of Regulation 84-167 and the *Hospital Act*, assented to on May 20, 1992, and its Regulation 92-84.

There are eight RHAs, established under the authority of the *Regional Health Authorities Act*. Each RHA includes a regional hospital facility and a number of smaller facilities, all of which provide insured services for both in- and out-patients. Each RHA has other health facilities or health centres, without designated beds, that provide a range of services to entitled persons.

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

In-patient services in a hospital facility operated by an approved regional health authority as follows:

- accommodation and meals at the standard ward level;
- necessary nursing service;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability;

- drugs, biologicals and related preparations, as provided for under Schedule 2; 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 therefore from the RHA.

Out-patient services in a hospital facility operated by an approved RHA as follows:

- laboratory and diagnostic procedures, together with the necessary interpretations, when referred by a medical practitioner or nurse practitioner, when approved facilities are available;
- laboratory and diagnostic procedures, together with the necessary interpretations, where approved facilities are available, when performed for the purpose of a mammography screening service that has been approved by the Minister of Health;
- the hospital component of available out-patient services when prescribed by a medical practitioner or nurse practitioner and provided in an out-patient facility of an approved RHA for maintaining health, preventing disease and helping diagnose and treat any injury, illness or disability, excluding the following services:
  - the provision of any proprietary medicines;
  - the provision of medications for the patient to take home;
  - diagnostic services performed to satisfy the requirements of third parties, such as employers and insurance companies;
  - visits solely for the administration of drugs, vaccines, sera or biological products; and
  - any out-patient service that is an entitled service under the *Medical Services Payment Act.*

2.2 Insured Physician Services

The enabling legislation providing for insured physician services is the *Medical Services Payment Act.*

The Act was given Royal Assent on December 6, 1968. Regulation 84-20 was filed on February 13, 1984. Regulation 93-143 was filed on July 26, 1993. Regulation 96-113 was filed on November 29, 1996, since repealed and replaced with 2002-53 filed on June 28, 2005, and Schedule 4 (surgical-dental services) Regulation 84-20 was filed on April 13, 1999.

No changes, pertaining to physician services, to this Act and regulations were introduced during 2005–2006.

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

- maintain current licensure with the New Brunswick College of Physicians and Surgeons;
- maintain membership in the New Brunswick Medical Society;
- hold privileges in a RHA; and
- have signed the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's Medical Services Plan as of March 31, 2006, was 1,461.

A total of 751 general or family practitioners, 844 specialists, seven dentists and five oral maxillofacial surgeons provided insured services in New Brunswick in 2005–2006. No orthodontists provided insured services in the same period.

Physicians in New Brunswick have the option to opt out totally for selected services. Totally opted-out practitioners are not paid directly by Medicare for the services they render and must bill patients directly in all cases. Patients are not entitled to reimbursement from Medicare.

The selective opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. Opted-in physicians wishing to opt out for a service 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 physician must advise the patient in advance and:

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

- If the charges will be in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:
  - they are opting out and charging fees above the Medicare 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 Medical Services Plan.

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

As of March 31, 2006, no physicians rendering health care services had elected to completely opt out of the New Brunswick Medical Services Plan.

The range of entitled services under Medicare includes the medical portion of all services rendered by medical practitioners that are medically required. It also includes certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital facility. The range of non-entitled services is set out under Schedule 2, Regulation 84-20, *Medical Services Payment Act.* No new services were de-insured during 2005–2006.

An individual, a physician or the Department may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and Canada. Considerations under the term "medically necessary" include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

Schedule 4 of Regulation 84–20 (filed June 23, 1998, under the *Medical Services Payment Act*) identifies the insured surgical-dental services that can be provided by a qualified dental practitioner in a hospital, if the condition of the patient requires services to be rendered in a hospital. In addition, a general dental practitioner may be paid to assist another dentist for medically required services under some conditions.

The conditions that 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).

As of March 31, 2006, there were 78 dentists registered with the plan.

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

New Brunswick expanded the role of Oral Maxillofacial Surgeons in New Brunswick by amending the *Medical Services Payment Act* and Regulations to provide payment for entitled services when they admit and discharge patients and perform physical examinations. The range of services and procedures was expanded and includes those done in an out-patient setting.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

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

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

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 New Brunswick Regulation 84-20 under the *Medical Services Payment Act* are specifically excluded from the range of entitled services under Medicare, namely:

- elective surgery or other services for cosmetic purposes;
- correction of inverted nipple;
- breast augmentation;
- otoplasty for persons over the age of 18;
- removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
- 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;
- surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in removing the cataract itself, due to the existence of an illness or other complication;
- medicines, drugs, materials, surgical supplies or prosthetic devices;
- vaccines, serums, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;
- advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
- examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
- dental services provided by a medical practitioner;
- services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
- services that are provided in conjunction with, or in relation to, the services referred to above;
- testimony in a court or before any other tribunal;
- immunization, examinations or certificates for travel, employment, emigration, insurance purposes, or at the request of any third party;
- services provided by medical practitioners to members of their immediate family;
- psychoanalysis;
- electrocardiogram (ECG) where not performed by a specialist in internal medicine or paediatrics;
- laboratory procedures not included as part of an examination or consultation fee;
- refractions;
- services provided within the province by medical practitioners or dental practitioners for which the fee exceeds the amount payable under this Regulation;
- the fitting and supplying of eyeglasses or contact lenses;
- transsexual surgery;
- radiology services provided in the province by a private radiology clinic; acupuncture;
- complete medical examinations when performed for a periodic check-up and not for medically necessary purposes;
- circumcision of the newborn;
- reversal of vasectomies;
- second and subsequent injections for impotence;
- reversal of tubal ligations;
- intrauterine insemination;
- gastric stapling or gastric by-pass; and
- venipuncture in order to take 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 service plans across the country and the previous use of the particular service. Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any change to the Regulation until the advice and recommendations of the New Brunswick Medical Society are received or until the period within which the Society was requested by the Minister of Health to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

No medical or surgical-dental services were removed from the insured service list in 2005–2006.

3.0 Universality

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and its Regulation 84–20, define eligibility for the health care insurance plan in New Brunswick.

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

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

Residents who are ineligible for Medicare coverage include:

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

Provisions to become eligible for Medicare coverage include:

- non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to, or in a common-law relationship with, 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 that they are residing in New Brunswick at the time, these persons are eligible for coverage on the date of their release. They must complete an application, provide the official date of release 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 dependents under the age of 19, on a 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 dependents are registered and a Medicare card with an expiry date is issued to the beneficiary and each dependent.

A Notice of Expiry form providing all family information currently existing on the Medicare files is issued to the beneficiary two or three months before the expiry date of the Medicare card or cards. 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 return the form to Medicare. Upon receiving the completed form, the file is updated and new card(s) are issued bearing a revised expiry date.

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

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

Residents may opt out of Medicare coverage if they choose. They are asked to provide written confirmation of their intention. This information is added to their files and benefits are terminated.

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 that they are legally married to, or living in a common-law relationship with, an eligible New Brunswick resident and still possess a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document.

4.0 Portability

4.1 Minimum Waiting Period

There is a three-month waiting period to obtain eligibility for Medicare coverage in New Brunswick. 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 that they do the following:

- provide proof of enrolment;
- contact Medicare once 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 temporarily employed in another province or territory are granted coverage for up to 12 months provided that they:

- do not establish residence in another province;
- do not receive coverage in another province; 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 receive coverage there on the first day of the thirteenth month.

New Brunswick has formal agreements with all Canadian provinces and territories for 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 residents are paid at Quebec rates if the service delivered is insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any paid claims submitted by the patient are reimbursed to the patient according to New Brunswick regulations.

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: Those 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 that they do the following:

- provide proof of enrollment;
- 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 Canada. Any absence over 182 days, whether it be for work purposes or vacation, would require the Director's approval. This approval can only be up to 12 months in duration and can only be granted once every three years. Families of workers temporarily employed outside Canada will continue to be covered, provided that they reside in New Brunswick.

Exception for 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:

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

- the Mobile Worker designation is assigned for a maximum of two years, after which the resident must re-apply and re-submit documentation to confirm his or her status.

Contract Workers: Any New Brunswick resident accepting an out-of-country employment contract must supply the following information and documentation:

- letter of request from the New Brunswick resident with his or her signature, detailing his or her absence, including Medicare number, New Brunswick address, date of departure, destination and forwarding address, reason for absence and date of return; and
- copy of the contractual agreement between employee and employer that defines a start date and end date of employment.

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

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 as follows: in-patient services $100 per day; and out-patient services $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.

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 the following requirements:

- the required service, or equivalent or alternate service, 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 services must be rendered by a medical doctor; and
- the service must be an accepted method of treatment recognized by the medical community and be regarded as scientifically proven in Canada. Experimental procedures are not covered.

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

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 of $220 per session; and
- allergy testing for environmental sensitivity: all tests sent outside the country will be paid at a maximum rate of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required to refer patients to psychiatric hospitals and addiction centres outside the province, because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received by Medicare from the Addiction Services or Mental Health branches of the Department of Health.

5.0 Accessibility

5.1 Access to Insured Health Services

New Brunswick charges no user fees for insured health services as defined by the *Canada Health Act*. Therefore, all residents of New Brunswick have equal access to these services.

5.2 Access to Insured Hospital Services

The New Brunswick Hospital Master Plan identifies the number of approved beds for each Regional Health Authority.

All facilities that provide insured services in accordance with the *Canada Health Act* have appropriate medical, surgical, rehabilitative and diagnostic equipment or systems corresponding to their designated levels of care. As of March 31, 2006, there were nine Computed Tomography (CT) scanners operating in New Brunswick — one in each of the eight RHAs, with a second unit operating in RHA 2. The Province also has two mobile Magnetic Resonance Imaging (MRI) units operating and three fixed-site MRI systems.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2006, there were 668 GPs, 715 Specialists, 78 Dentists (69 dentists, five oral maxillofacial surgeons, four orthodontists) registered with the plan.

In fiscal year 2005–2006, the Department continued to work on its recruitment and retention strategy, aimed at attracting newly licensed family practitioners and specialists. This strategy, announced in 1999–2000, included a contingency fund to allow the Department to more effectively respond to potential recruitment opportunities; the provision of location grants of $25,000 for family practitioners and $40,000 for specialists willing to practice in under-serviced areas of the province; and the purchase of five additional seats at the University of Sherbrooke's medical school, which began in September 2002. The recruitment and retention strategy also provides for increased government involvement in post-graduate training of family physicians; the maintenance of 300 weeks in summer rural preceptorship training for medical students; and moving physician remuneration toward relative parity with other Atlantic provinces.

5.4 Physician Compensation

Fiscal year 2004–2005 marked the third year of an agreement with fee-for-service physicians that provides for a 15 percent increase in fees over a three-year period (2002–2003 to 2004–2005). Discussions were held during the year with the New Brunswick Medical Society to implement the initiatives contained in that agreement.

On March 29, 2006, a tentative agreement was reached with the New Brunswick Medical Society for a new collective agreement.

There is no formal negotiation process for dental practitioners in New Brunswick.

Payments to physicians and dentists are governed under the *Medical Services Payment Act,* Regulations 84-20, 93-143 and 96-13.

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 legislative authorities 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. The *Regional Health Authorities Act*, which provides for the delivery and administration of health services in defined geographic areas within the province, came into force on April 1, 2002.

There were no changes during the 2005–2006 fiscal year affecting the hospital payment process.

The Department uses two components to distribute available funding to New Brunswick's eight RHAs.

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. addictions 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).

The CSL approach establishes base budgets for the eight RHAs 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 salary rates.

The population-based funding distribution formula, which was enhanced during fiscal year 2000–2001, was still in use in fiscal year 2005–2006. This methodology attempts to predict the appropriate distribution of available funding for the RHAs 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, RHAs are to 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 fiscal year. This information, along with the audited financial statements from the previous two fiscal years, are used to evaluate the expected funding level for each RHA.

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 RHA to its audited financial statements and reconciles budgeted revenues and expenses to actual revenues and expenses.

6.0 Recognition Given to Federal Transfers

New Brunswick routinely recognizes the federal role regarding its contributions under the Canada Health Transfer (CHT) in public documentation presented through legislative and administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on March 30, 2006;
- the Public Accounts presented by the Minister of Finance on December 20, 2005; and
- the Main Estimates presented by the Minister of Finance on March 30, 2006.

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 to the Department of Family and Community Services on April 1, 2000. Nursing home care, also a non-insured service, is offered through the Nursing Home Services program of the Department of Family and Community Services. 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

Nursing homes are private, not-for-profit organizations, except for one facility 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 and not-for-profit organizations. The number of available beds fluctuates constantly as private entrepreneurs open and close residential facilities. Clients are admitted after going through the same evaluation process used for nursing home admissions.

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

Ambulatory Health Care

In New Brunswick, ambulatory health care includes services provided in hospital emergency rooms, day or night care in hospitals and in clinics if it is available in hospitals, health centres and Community Health Centres. This is considered an insured service under the provincial Hospital Services Plan.

Extra-Mural Program

The New Brunswick Extra-Mural Program, also known as the hospital-at-home program, is an active treatment program of acute, palliative and long-term health care and rehabilitation services provided in community settings (an individual's home, a nursing home or a public school). Since 1996, this program has been delivered by New Brunswick's eight RHAs. Service providers include nurses, social workers, dieticians, respiratory therapists, physiotherapists, occupational therapists and speech language pathologists. These services, although not covered by the *Canada Health Act,* are considered an insured service under the provincial Hospital Services Plan.

Quebec

1.0 Public Administration

1.1 Health Insurance Plan and Public Authority

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

Quebec's health insurance plan, the Régime d'assurance maladie du Québec, is administered by the Régie de l'assurance maladie du Québec (RAMQ) [Quebec Health Insurance Board], a public body established by the provincial government and reporting to the Minister of Health and Social Services.

1.2 Reporting

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

1.3 Audit of Accounts

Both plans (the Quebec Hospital Insurance Plan and the Quebec Health Insurance Plan) are operated on a non-profit basis. All books and accounts are audited by the Auditor General of Quebec.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient services include: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anesthetic facilities; medications, prosthetic and orthotic devices that can be integrated with the human body; biologicals and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services rendered by hospital staff.

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

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

The MSSS administers an ambulance transportation program that is free-of-charge to persons aged 65 or older.

In addition to basic insured health services, the RAMQ also covers the following, with some limitations, for certain residents of Quebec, as defined by the *Health Insurance Act*, and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability; external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for people with a visual or auditory disability; and permanent ostomy appliances.

Since January 1, 1997, in terms of drug insurance, the RAMQ covers, over and above its regular clientele (employment assistance recipients and persons 65 years

of age or older), individuals who do not have access to a private drug insurance plan. The drug insurance plan covers 3.15 million insured persons.

2.2 Insured Medical Services

The services insured under this plan include medical and surgical services that are provided by physicians and are required from a medical standpoint.

2.3 Insured Surgical-Dental Services

Services insured under this plan include oral surgery performed in a hospital centre or university institution determined by regulation, by dental surgeons and specialists in oral and maxillo-facial surgery.

2.4 Uninsured Hospital, Medical and Surgical-Dental Services

Uninsured hospital services include: plastic surgery; *in vitro* fertilization; a private or semi-private room at the patient's request; televisions; telephones; drugs and biologics ordered after discharge from hospital; and services for which the patient is covered under the *Act Respecting Industrial Accidents and Occupational Diseases* or other federal or provincial legislation.

The following services are not insured:

- any examination or service not related to a process of cure or prevention of illness;
- psychoanalysis of any kind, unless such service is rendered in an institution authorized for this purpose by the Minister of Health and Social Services;
- any service rendered solely for aesthetic purposes;
- any refractive surgery, except in cases where there is documented failure in astigmatism of more than 3.00 diopters or for 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 his or her spouse or children;
- any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than one who has received an insured service, except in certain cases;
- any visit made for the sole purpose of obtaining the renewal of a prescription;
- any examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes;
- any service rendered by a professional on the basis of an agreement or a contract with an employer, an association or an organization; any adjustment of eye glasses or contact lenses;
- any surgical ablation of a tooth or tooth fragment performed by a physician, except where the service is provided in a hospital in certain cases;
- all acupuncture procedures;
- injection of sclerosing substances and the examination done at that time;
- mammography used for screening purposes, unless this service is delivered on a doctor's orders in a place designated by the Minister, in either case, to a recipient who is 35 years of age or older, on condition that such an examination has not been performed on the recipient in the previous year;
- thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides *in vivo* in humans, unless these services are rendered in a hospital centre;
- ultrasonography, unless this service is rendered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose;
- any radiological or anesthetic service provided by a physician if required with a view to providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of a radiology service, if required by a person other than a physician or dentist; any sex-reassignment surgical service, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and
- any services that are not associated with a pathology and that are rendered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim card, for colour blindness or a refraction problem, in order to provide or renew a prescription for eyeglasses or contact lenses.

3.0 Universality

3.1 Eligibility

Registration with the hospital insurance plan is not required. Registration with the RAMQ or proof of residence is sufficient to establish eligibility. All persons who reside or stay in Quebec must be registered with the RAMQ to be eligible for coverage under the health insurance plan.

3.2 Registration Requirements

Registration with the hospital insurance plan is not required. Registration with the RAMQ or proof of residence is sufficient to establish eligibility.

3.3 Other Categories of Individual

Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police (RCMP) and inmates of federal penitentiaries are not covered by the Plan.

Certain categories of residents, notably permanent residents under the *Immigration Act* and persons returning to live in Canada, become eligible under the Plan following a waiting period of up to three months. Persons receiving last resort financial assistance are eligible upon registration. Members of the Canadian Forces and RCMP who have not acquired the status of Quebec resident become eligible the day they arrive, and inmates of federal penitentiaries become eligible the day they are released. Immediate coverage is provided for certain seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the *Ministère de l'Éducation, du Loisir et du Sport* [Quebec Department of Education, Leasure and Sport], and refugees. Persons from outside Canada who have work permits and are living in Quebec for the purpose of holding an office or employment for a period of more than six months become eligible for the plan following a waiting period.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences Outside Quebec (in Canada)

If living outside Quebec in another province or territory for 183 days or more, students and full-time unpaid trainees may retain their status as residents of Quebec, In the first case, they retain it for four calendar years at most, and in the second, for two consecutive calendar years at most.

This is also the case for persons living in another province or territory who are temporarily employed or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons directly employed or working on contract outside Quebec in another province or territory, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

Status as a resident of the province is also maintained by persons who remain outside the province for 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years and provided they notify the RAMQ of the absence.

The costs of medical services received in another province or territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the RAMQ for such 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 the specialized services provided are not offered in the Outaouais region. This agreement became effective

November 1, 1989. A similar agreement was signed in December 1991 between the Centre de santé Témiscamingue [Témiscamingue Health Centre] and North Bay, Ontario.

Costs of hospital services received in another province or territory of Canada are paid in accordance with the terms and conditions of the interprovincial agreement on reciprocal billing regarding hospital insurance agreed on by the provinces and territories of Canada. In-patient costs are paid at standard ward rates approved by the host province or territory, and out-patient costs or the costs of expensive procedures are paid at approved interprovincial/territorial rates. However, since November 1, 1995, Quebec reimburses a maximum of $450 per day of hospitalization when an Outaouais resident is hospitalized in an Ottawa hospital for non-urgent care or services available in the Outaouais.

Insured persons who leave Quebec to settle in another province or territory of Canada are covered for up to three months after leaving the province.

4.3 Coverage During Temporary Absences Outside Quebec (outside Canada)

Students, unpaid trainees, Quebec government officials posted abroad and employees of non-profit organizations working in international aid or cooperation programs recognized by the MSSS must contact the RAMQ to ascertain their eligibility. If the RAMQ 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.

Persons directly employed or working on contract outside Canada, for a company or corporate body having its headquarters or a place of business in Quebec, or employed by the federal government and posted outside Quebec, also retain their status as residents of the province, provided their families remain in Quebec or they retain a dwelling there.

As of September 1, 1996, hospital services provided outside Canada in case of emergency or sudden illness are reimbursed by the RAMQ, usually in Canadian funds, to a maximum of $100(CDN) per day if the patient was hospitalized (including in the case of day surgery) or to a maximum of $50(CDN) per day for out-patient services. However, hemodialysis treatments are covered to a maximum of $220(CDN) per treatment. In such cases, the RAMQ provides reimbursement for the associated professional services. The services must be dispensed in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the RAMQ to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. The cost of all services insured in the province are reimbursed at the Quebec rate, usually in Canadian funds, when they are incurred abroad.

Coverage is discontinued as of the day of departure for insured residents who move permanently to another country.

4.4 Prior Approval Requirement

Insured persons requiring medical services in hospitals abroad, in cases where those services are not available in Quebec or elsewhere in Canada, are reimbursed 100 percent if prior consent has been given for medical and hospital services that meet certain conditions. Consent is not given by the Plan's officials if the medical service in question is available in Quebec or elsewhere in Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

Everyone has the right to receive adequate health care services without any kind of discrimination. There is no extra-billing by Quebec physicians.

Improved telephone access to care: The Info-Santé telephone line will be centralized in each of the 15 regions where it exists, and a new Info-Social line will be developed in all regions. An Info-médicament line and a public health branch advisory module will be incorporated into Info-Santé. The plan is to have one communication centre in each region and to link all of these centres into a network, as well as to make them accessible to the general public through a single three-digit number.

New projects for seniors: In order to respect the wishes of seniors needing medical care who wish to remain in their own homes as long as possible, the MSSS has funded new projects that offer innovative ways to deliver services directly to these persons. In order to respect the wishes of seniors needing medical care who wish to remain in their own homes as long as possible, the MSSS has funded new projects that offer innovative ways to deliver services directly to these persons. Thirty-one projects were funded at a cost of $12M to subsidize the network. This will assist some 510 persons over the three phases of the programme entitled A New Partnership for Seniors (Pour un nouveau partenariat au services des aînés).

The results of an evaluation of the programme will provide an assessment and understanding of what is required to implement similar programmes throughout the province of Quebec. This innovative way of better serving seniors whose autonomy is severely impaired will be instrumental in offering an alternative to remaining in residential or long-term care facilities.

The vision of the MSSS is that, one day, spots in residential and long-term care centres will be limited to patients who for medical reasons must remain in these facilities.

5.2 Access to Insured Hospital Services

As of March 31, 2006, Quebec had 118 institutions operating as hospital centres for a clientele suffering from acute illnesses. There were 24,457 beds for persons requiring care for acute physical or psychiatric ailments allotted to these institutions. From April 1, 2004 to March 31, 2005, Quebec hospital institutions had nearly 699,735 admissions for short stays (including births) and close to 295,707 registrations for day surgeries. These hospitalizations and registrations accounted for more than 5,080,246 patient days.

Restructuring of the health network: In November 2003, Quebec announced the implementation of local service networks covering all of Quebec. At the heart of each local network is a new local authority, the health and social services centre. These centres are the result of the merger of the public institutions whose mission it was to provide CLSC (local community service centre) services, residential and long-term care, and, in most cases, neighbourhood hospital services. The health and social services centres also provide the people in their territory with access to other medical services, general and specialized hospital services, and social services. To do so, they have to enter into service agreements with other health sector organizations. The linking of services within a territory forms the local services network. Thus, the aim of integrated local health and social services networks is to make all the stakeholders in a given territory collectively responsible for the health and well-being of the people in that territory.

Management of waiting lists: In October 2003, the MSSS began publishing waiting lists for each hospital on its website. It now provides physicians and institutions with a computerized service access management system (SGAS). This tool is based on the concept of "access within a clinically acceptable period," as defined by committees of medical experts in certain fields. Once applied uniformly throughout the province of Quebec, these guidelines will ensure that all patients, regardless of their place of origin, will be treated under the same criteria. Once implemented, this system will supply the data for the new waiting lists site and will enable the concerned patients and professionals to obtain appropriate, reliable and up-to-date information on the activities of hospital centres and waiting periods for various services.

5.3 Access to Insured Medical and Surgical-Dental Services

In 2003–2004, family medicine groups (FMGs) were established. These groups work closely with the CLSCs and other network resources to provide services such as health assessment, case management and follow-up, diagnosis, treatment of acute and chronic problems, and disease prevention. Their services are available 24 hours a day, seven days a week, for some certain registered clients.

Quebec now has 114 FMGs. A new FMG has been accredited in the Mauricie region. The number of such groups has gone from 21 to 114 within three years.

The Conseil médical du Québec established a committee to develop the concept of the physician/population ratio because interprovincial comparisons suggest that Quebec has an adequate number of physicians.

5.4 Physician Compensation

While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawan from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and non-participating professionals practise outside the plan and neither they nor their patients are reimbursed by the RAMQ.

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

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient. The Minister may also provide for a different rate of compensation for general practitioners and medical specialists during the first years of practice, depending on the territory or the activity involved. These provisions are preceded by consultation with the organizations representing the professional groups.

In 2004–2005, the RAMQ paid an amount estimated at $3,276,500 million to doctors in the province, while the amount for medical services outside the province reached an estimated $9.95 million.

5.5 Payments to Hospitals

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

The payments made in 2005–2006 to institutions operating as hospital centres for insured health services provided to persons living in Quebec were more than $7.3 billion. Payments to hospital centres outside Quebec were approximately $97.2 million.

6.0 Extended Health Care Services

Intermediate care, adult residential care and home care services are available. Admission is coordinated on a regional level and based on a single assessment tool. The CLSCs receive individuals, evaluate their care requirements, and either arrange for provision of services such as day care centre programs or home care, or refer them to the appropriate agencies. The MSSS offers some home care services, including nursing care and assistance, homemaker services and medical supervision.

Residential facilities and long-term care units in acute-care hospitals focus on maintaining their clients' autonomy and functional abilities by providing them with a variety of programs and services, including health care services.

Ontario

Introduction

Ontario has one of the largest and most complex publicly funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care (MOHLTC), Ontario's health care system was supported by over $32.5 billion (including capital) in spending for 2005–2006.

MOHLTC is responsible for providing services to the Ontario public through such programs as: health insurance; drug benefits; assistive devices; mental health services; home care; community support services; and public health.

MOHLTC also regulates and funds hospitals and long-term care homes (nursing homes and homes for the aged); operates psychiatric hospitals and medical laboratories; and funds and regulates or directly operates emergency health services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by MOHLTC. 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.

1.2 Reporting Relationship

The *Health Insurance Act* provides that the Minister of Health and Long-Term Care is responsible in respect of the administration and operation of the Plan, and is the public authority for Ontario for the purposes of the Canada Health Act.

1.3 Audit of Accounts

MOHLTC is audited annually by the Office of the Auditor General. The Auditor General's 2005 Annual Report was released on December 6, 2005.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2005–2006 Public Accounts of Ontario were released on August 24, 2006.

1.4 Designated Agency

Local Health Integration Networks (LHINs) were established under the *Local Health System Integration Act*, 2006 to improve the health of Ontarians through better access to high-quality health services, coordinated health care, and effective and efficient management of the health system at the local level. LHINs are not-for-profit Crown Agencies that will plan, integrate and fund local health services that are delivered by hospitals, Community Care Access Centres, long-term care homes, community health centres, community support services, and mental health agencies.

The *Local Health System Integration Act*, 2006 requires the board of directors of each Local Health Integration Network to establish, by by-law, the committees of the board that the Minister specifies by regulation. Regulation 417/06, which came into force on September 16, 2006, prescribes two LHIN Board Committees and their responsibilities: an Audit Committee; and a Community Nominations Committee.

The Act requires LHINs to prepare an Annual Report for the Minister who is required to table the reports before the Legislative Assembly. The LHIN Annual Reports for 2005–2006 were tabled in the Legislature of Ontario on October 24, 2006.

For fiscal 2007–2008, the Ontario Ministry of Health and Long-Term Care will enter into an accountability agreement with each LHIN that will include performance

goals and objectives for the networks, and the allocations for health service providers. The Act also provides the LHINs with the authority to fund health service providers and to enter into service accountability agreements with these providers.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured in-patient and out-patient hospital services in Ontario are prescribed under the *Health Insurance Act*, and Regulation 552 under that Act.

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

Insured out-patient services include medically necessary: laboratory, radiological and other diagnostic procedures; use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available; use of diet counselling services; use of the operating room, anesthetic facilities, surgical supplies, necessary nursing service, and supplying of drugs, biologicals, and related preparations (subject to some exceptions), including vaccines, anti-cancer drugs, biologicals and related preparations (subject to some exceptions); provision of equipment, supplies and medication to haemophiliac patients for use at home; and the following drugs for take-home use: cyclosporine to transplant patients; zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection; bio-synthetic human growth hormone to patients with endogenous growth hormone deficiency; drugs for treating cystic fibrosis and thalassemia; erythropoeitins to patients with anaemia of end-stage renal disease; alglucerase to patients with Gaucher disease; clozapine to patients with treatment-resistant schizophrenia.

In 2005–2006, there were 152 public hospital corporations (excluding specialty mental health hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care homes) staffed and in operation in Ontario. This includes 134 acute care hospital corporations, 14 chronic care hospitals, and four general and special rehabilitation units. Hospitals are categorized by major activity, although they provide a mix of services. For example, many acute care hospitals offer chronic care services. A number of designated chronic care facilities also offer rehabilitation.

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*, MOHLTC provides funding through the payment of facility fees under the *Independent Health Facilities Act*. Facility fees cover the cost of the premises, equipment, supplies, and personnel used to render an insured service. Under the *Independent Health Facilities Act*, patient charges for facility fees are prohibited.

Facility fees are charged to the government only by facilities that are licensed under the *Independent Health Facilities Act*. Examples of facilities that are licensed under the *Independent Health Facilities Act*, include surgical/treatment facilities (e.g., those providing abortions, cataract surgery, dialysis and non-cosmetic plastic surgery) and diagnostic facilities (e.g., those 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

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

Under subsection 37.1(1) of Regulation 552 of the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary; contained in the Schedule of Benefits for Physician Services; and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits. Physicians provide medical, surgical and diagnostic services, including primary health care services. Services are provided in a variety of settings, including private physician offices, community health centres, hospitals, mental health facilities, licensed independent health facilities, and long-term care homes.

In general terms, insured physician services include: diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anaesthesia; radiology and

laboratory services in approved facilities; and immunizations, injections and tests.

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

During 2005–2006, physicians could submit claims for all insured services rendered to insured persons directly to the Ontario Health Insurance Plan Office (OHIP), in accordance with section 15 of the *Health Insurance Act*, or a limited number could bill the insured person, as specified in section 15 of the Act (see also Part II of the *Commitment to the Future of Medicare Act*). Physicians who do not bill OHIP directly are commonly referred to as having "opted-out". When a physician has opted out, the physician bills the patient (not exceeding the amount payable for the service under the Schedule of Benefits), and the patient is then entitled to reimbursement by OHIP. However, the number of physicians who may opt out was fixed (on a "grandparented" basis) following proclamation of the *Commitment to the Future of Medicare Act* on September 23, 2004.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario.

There were approximately 22,000 physicians who submitted claims to OHIP in 2005–2006.

2.3 Insured Surgical-Dental Services

Insured surgical-dental services are prescribed in the Dental Schedule of Benefits and section 16 under Regulation 552 of the *Health Insurance Act*. Ontario's health insurance plan covers certain dental services when hospitalization is medically necessary. The *Health Insurance Act* authorizes OHIP to cover a limited number of procedures contained in the Schedule of Benefits for services performed by a dentist on the staff of a hospital. All of the insured procedures in the dental schedule must be performed for medical reasons in a hospital by an appointed dental staff member of the hospital.

Approximately 330 dentists and dental/oral surgeons provided insured surgical-dental services in Ontario in 2005–2006.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services prescribed by and rendered in accordance with the *Health Insurance Act* and regulations under that Act are insured.

Uninsured hospital services include: additional charges for preferred accommodation unless prescribed by a physician, oral-maxillofacial surgeon or midwife; telephones and televisions; charges for private-duty nursing; provision of medications for patients to take home from hospital, with certain exceptions; and in-province, out-patient hospital visits solely for administering drugs, subject to certain exceptions.

Section 24 of Regulation 552 details those physician services that are specifically prescribed as uninsured.

Uninsured physician services include: services that are not medically necessary; toll charges for long-distance telephone calls; the preparation or provision of 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); the preparation and transfer of records at the insured person's request; a service that is received wholly or partly for producing or completing a document or transmitting information to a "third party" in prescribed circumstances; the production or completion of a document or transmitting information to any person other than the insured person in prescribed circumstances; provision of a prescription when no concomitant insured service is rendered; acupuncture procedures; psychological testing; and research and experimental survey programs.

3.0 Universality

3.1 Eligibility

To be considered a resident of Ontario for the purpose of obtaining Ontario health insurance coverage, a person must:

- hold Canadian citizenship or an immigration status as prescribed in Regulation 552 of the *Health Insurance Act*;

- make his or her permanent and principal home in Ontario;
- be physically present in Ontario for at least 153 days in any 12-month period; and
- in most cases, new and returning residents applying for health coverage must also be physically present in Ontario for 153 of the first 183 days following the date residency is established in Ontario (i.e., a person cannot be away from the province for more than 30 days in the first six months of residency).

With certain exceptions in which there is an exemption from the waiting period, residents of Ontario, as defined in Regulation 552 of the *Health Insurance Act*, are eligible for Ontario health insurance coverage subject to a three-month waiting period. MOHLTC will assess whether or not an individual is subject to the three-month waiting period at the time of their application for health coverage. Examples of those who are exempt from the three-month waiting period include newborn babies born in Ontario, children under the age of 16 adopted by an insured person, and insured residents from another province or territory who move to Ontario and immediately become residents of approved charitable homes for the aged, homes for the aged or nursing homes in Ontario.

In July 2006, MOHLTC amended section 3(4) of Regulation 552 of the *Health Insurance Act* to exempt Canadian citizens and Permanent Residents/Landed Immigrants from the three-month waiting period for OHIP coverage, if they arrive in Ontario after July 20th, 2006 from a foreign country where an evacuation effort is being undertaken or facilitated by the federal government.

Individuals who are not eligible for Ontario health insurance coverage are those who do not meet the definition of a resident including those who do not hold an immigration status that is set out in Regulation 552, such as tourists, transients, and visitors to the province. Other individuals such as federal penitentiary inmates, Canadian Forces and ranked Royal Canadian Mounted Police personnel do not require Ontario health insurance coverage as they have health insurance coverage under a federal health care plan.

Persons who were previously ineligible for Ontario health insurance coverage but whose status and/or residency situation has changed (e.g., change in immigration status) may be eligible, upon application, subject to the requirements of Regulation 552.

When it is determined that a person is not eligible or is no longer eligible for OHIP coverage, a request may be made to MOHLTC to review MOHLTC's decision. Anyone may request that MOHLTC review the determination of their OHIP eligibility simply by making the request in writing to the General Manager of OHIP.

3.2 Registration Requirements

Every resident of Ontario, who seeks Ontario health insurance coverage, is required to apply to MOHLTC.

A health card is issued to eligible residents upon applying to the General Manager of OHIP, pursuant to sections 2 and 3 of Regulation 552. Eligible persons should apply for coverage upon establishing their permanent and principal home 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 MOHLTC with original documents to prove their Canadian citizenship or eligible immigration status, their residency in Ontario and their identity. Eligible applicants over the age of 15.5 are generally required to have their photographs and signatures captured for their photo health cards.

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

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

Approximately 12.47 million Ontario residents were registered with OHIP and held valid and active health cards as of as of April 1, 2006.

3.3 Other Categories of Individual

MOHLTC provides health insurance coverage to residents of Ontario other than just Canadian citizens and Permanent Residents/Landed Immigrants. These residents are required to provide acceptable documentation to support their eligible immigration status, their

residency in Ontario, and their identity in the same manner as Canadian citizen or Permanent Resident/ Landed Immigrant applicants.

The individuals listed below, who ordinarily reside in Ontario, may be eligible for Ontario health insurance coverage in accordance with Regulation 552 and prevailing MOHLTC policy. Clients applying for coverage under any of these categories should contact their local OHIP office for further details.

Applicants for Permanent Residence/Applicants for Landing — These are persons who have submitted an application for Permanent Resident/Landed Immigrant status by Citizenship and Immigration Canada (CIC) and have passed CIC's medical requirements.

Convention Refugees and Protected Persons — These are persons who are determined to be Convention Refugees or Protected Persons under the terms of the *Immigration and Refugee Protection Act*. Members of this group are exempt from the three-month waiting period.

Holders of Temporary Resident Permits/Minister's Permits — Holders of a Temporary Resident Permit/ Minister's Permit with a case type of 80 (adoption only), 86, 87, 88 or 89 are eligible for Ontario health insurance coverage for the duration of their permit if they meet the residency requirements as defined in Regulation 552. Members of this group are exempt from the three-month waiting period. Holders of a Temporary Resident Permit/ Minister's Permit with a case type of 80 (except adoption), 81, 84, 85, 90, 91, 92, 93, 94, 95 and 96 are not eligible for Ontario health insurance coverage.

Clergy, Foreign Workers and their Accompanying Family Members — An eligible foreign clergy is a person who is sponsored by a religious organization or denomination and has finalized an agreement to minister full-time to a religious congregation in Ontario for a period of at least six consecutive months.

A foreign worker is a person who has a finalized contract of employment or an agreement of employment with a Canadian employer located in Ontario and has been issued a Work Permit/Employment Authorization by CIC that names the Canadian employer, states the person's prospective occupation, and has been issued for a period of at least six months.

Spouses, same sex partners and/or dependant children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker are also eligible for Ontario health coverage if the member of the clergy or the foreign worker is to be employed in Ontario for at least three consecutive years and if the family member will be ordinarily a resident of Ontario.

Live-in Caregivers — Eligible Live-in Caregivers are persons who hold a valid Work Permit/Employment Authorization under the Live-in Caregivers in Canada Program (LCP) or the former Foreign Domestic Movement (FDM) administered by CIC, and ordinarily resides in Ontario. The Work Permit/Employment Authorization for LCP or FDM workers does not have to list the three specific employment conditions required by all other foreign workers.

Migrant Farm Workers — Migrant farm workers are persons who have been issued a Work Permit/Employment Authorization under the Caribbean, Commonwealth and Mexican Seasonal Agriculture Workers Program administered by CIC. Due to the special nature of their employment, migrant farm workers are exempt from the 3-month waiting period, and may be a resident for less than the required five month period, not have a permanent home in Ontario, and still qualify for OHIP.

3.4 Premiums

There are no premiums payable as a condition of obtaining Ontario health insurance coverage. The Ontario Health Premium is collected through the income tax system and is not connected to OHIP registration or eligibility in any way. Responsibility for the administration of the Ontario Health Premium lies with the Ontario Ministry of Finance.

4.0 Portability

4.1 Minimum Waiting Period

In accordance with subsection 3(3) of Regulation 552 under the *Health Insurance Act*, individuals who move to Ontario are typically entitled to OHIP coverage, three months after establishing residency in the province, unless listed as an exception in section 3(4).

Persons moving permanently to Ontario from another Canadian province or territory will typically be eligible for OHIP coverage on the first day of the third month following the date residency is established.

4.2 Coverage During Temporary Absences in Canada

Insured out-of-province services are prescribed under sections 28, 29 to 32 of Regulation 552 of the *Health Insurance Act*.

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability; therefore, insured residents who are temporarily outside of Ontario can use their Ontario health cards to obtain insured health services.

An insured person who leaves Ontario temporarily to travel within Canada, without establishing residency in another province or territory, may continue to be covered by OHIP for a period of up to 12 months.

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

Insured students who are temporarily absent from Ontario, but remain within Canada, may be eligible for continuous health insurance coverage for the duration of their full-time studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide MOHLTC with documentation from their educational institution confirming registration as a full-time student. 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.

In accordance with MOHLTC policy, most insured residents who want to travel, work or study outside Ontario, but within Canada, must have been present for at least 153 days in the last 12-month period immediately prior to departure from Ontario.

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 Interprovincial Health Insurance Agreements Coordinating Committee.

Ontario also participates in reciprocal billing arrangements with all other provinces and territories, except Québec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services. Ontario residents who may be required to pay for doctors' services received in Québec can submit their receipts to MOHLTC for payment as an insured service.

4.3 Coverage During Temporary Absences Outside Canada

Health insurance coverage for insured Ontario residents during extended absences outside Canada is governed by sections 28.1 through 29 (inclusive) and section 31 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*, MOHLTC may provide insured Ontario residents with continuous Ontario health insurance coverage during absences outside Canada of longer than 212 days (seven months) in a 12-month period.

The Ministry requests that residents apply to MOHLTC for this coverage before their departure and provide documents explaining the reason for their absence outside Canada. In accordance with the regulations and MOHLTC policy, most applicants must also have been present in Ontario for at least 153 days in each of the two consecutive 12-month periods before their expected date of departure.

The length of time that MOHLTC will provide a person with continuous Ontario health coverage during an extended absence outside Canada varies depending on the reason for the absence. Please refer to the information below for further details:

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

Certain family members may also qualify for continuous Ontario health coverage while accompanying the primary applicant on an extended absence outside Canada and should contact their local OHIP office for details.

Out-of-country services are covered under sections 28.1 to 28.6 inclusive, and sections 29 and 31 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 (CDN) for in-patient services;
- a maximum $50 (CDN) for out-patient services (except dialysis); and
- the actual cost incurred by the patient per dialysis treatment.

During 2004–2005, emergency medically necessary out-of-country physician and other eligible practitioner services were reimbursed at the Ontario rates detailed in regulation under the *Health Insurance Act* or the amount billed, whichever is less. Charges for medically necessary emergency or out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed or approved hospital or a licensed health facility. Medically necessary out-of-country laboratory services when done on an emergency basis by a physician are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less, and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

In 2005–2006, payments for out-of-country emergency in-patient and out-patient insured hospital and medical services amounted to $23.3 million (Note: the categories of out-of-country services were realigned in 2005–2006 to provide a greater level of reporting accuracy).

4.4 Prior Approval Requirement

As set out in section 28.4 of Regulation 552 of the *Health Insurance Act*, prior approval from MOHLTC is required for payment for non-emergent health services provided outside of Canada. 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 funding for out-of-country health services.

Under section 28.5 of Regulation 552 of the *Health Insurance Act*, laboratory tests performed outside Canada are paid for, with prior approval from MOHLTC, if the following conditions are met:

- the kind of service or test is not performed in Ontario;
- the service or test is generally accepted in Ontario as appropriate for a person in the same circumstances as the insured person;
- the service or test is not experimental; and
- the service or test is not performed for research purposes.

In 2005–2006, total payments for prior-approved treatment outside Canada were $56.3 million.

There is no formal prior-approval process for services provided to Ontario residents outside the province, but within Canada. The Interprovincial Agreement on Eligibility and Portability includes a schedule for high-cost services.

5.0 Accessibility

5.1 Access to Insured Health Services

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

All insured persons are entitled to all insured hospital and physician services, as defined in the *Health Insurance Act*.

Accessibility to insured health care services is protected under the *Commitment to the Future of Medicare Act*. This Act prohibits any person or any entity from charging more, or accepting payment or other benefit for more than the amount payable by OHIP. In addition, the *Commitment to the Future of Medicare Act* also prohibits physicians, practitioners and hospitals from refusing to provide an insured service if an insured person chooses not to pay for an uninsured service. The Act further prohibits any person or entity from paying, conferring or receiving any benefit in exchange for preferred access to an insured service.

MOHLTC 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 MOHLTC 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

Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations because the person is not insured.

In 2005–2006, there were 152 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 6,764,626 acute patient days, 1,987,995 chronic patient days and 758,452 rehabilitation patient days delivered by public hospitals.

Priority services are designated highly specialized hospital-based services that deal with life-threatening conditions. These services are often high-cost and rapidly growing, which makes access a concern. Generally, these services are managed provincially, on a time-limited basis.

Priority services include: selected cardiovascular services; selected cancer services; chronic kidney disease; and organ and tissue donation and organ transplantation.

5.3 Access to Insured Physician and Surgical-Dental Services

Initiatives

- Underserviced Area Program (UAP): UAP is one of a number of supports that MOHLTC provides to help communities across the province access needed health care services. UAP provides a variety of integrated initiatives aimed at attracting and retaining health care providers. To be eligible for the UAP's recruitment and retention benefits, a community must be designated as underserviced. UAP works closely with underserviced communities to identify their need for health human resources. It provides financial incentives and practice supports, and enables community access to physician services by funding locums and outreach clinics. Currently, there are 137 communities in Ontario designated as underserviced for general/family practitioners and 14 northern Ontario communities designated as underserviced for medical specialists.
- Northern Physician Retention Initiative (NPRI): NPRI provides eligible family practitioners and specialists who maintain practices in northern Ontario for at least four years with a retention incentive as well as access to funding for continuing medical education.
- Northern Health Travel Grant Program (NHTGP): NHTGP helps defray transportation costs for residents of northern Ontario who must travel long distances to access insured non-emergency hospital and specialist medical services that are not locally available, and also promotes using specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.
- Primary Health Care: During 2005–2006, Ontario continued to align its new and existing primary care delivery models to help improve and expand access to primary care for all Ontarians by including elements such as 24-hour, seven days a week access through telephone health advisory services, increased after-hours coverage and preventive care initiatives that enhance chronic disease management and disease prevention. As of March 31, 2006, there were approximately 6.0 million patients rostered to physicians in the primary care models that have these features. New agreements were negotiated and signed for Health Service Organizations, Primary Care Networks, Rural and Northern Physician Groups and a number of other family physician groups working in high-needs practices. As part of transforming its health care system, Ontario committed to establish 150 Family Health Teams by 2007–2008 to further facilitate physicians working as part of a team with other health providers with a focus on keeping patients healthy.
- The 2004 Memorandum of Agreement between MOHLTC and the Ontario Medical Association provides for the alignment of the Primary Care Network and Health Service Organization models into one model. This new model, the Family Health Organization, is expected to be implemented in Fall 2006.

5.4 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Some physician payments are provided through fee-for-service arrangements. Remuneration is based on the Schedule of Benefits under the *Health Insurance Act*. Other physician payment models may include Alternate Payment Plans and new funding arrangements for physicians in Academic Health Science Centres.

Family physicians paid solely on a fee-for-service basis represent 49 per cent of Ontario's registered family physicians. The remaining family physicians in Ontario receive funding through one of the primary care initiatives such as Family Health Networks, Family Health Groups, Comprehensive Care Models, and Family Health Teams. Family Health Teams build upon existing primary care physician funded models by providing funding for inter-disciplinary health care professionals, who work as integral members of the team. Physicians participating in Family Health Teams are funded by one of three compensation options that include: blended salary, blended complement, or blended capitation. There are also models for physicians in Academic Health Science Centres where funding may include any combination of capitation, salary, special payments, and bonuses.

MOHLTC negotiates payment rates and other changes to the Schedule of Benefits for Physician Services with the Ontario Medical Association. A new Physician Services' Agreement with the Ontario Medical Association was negotiated for a four-year term, from April 2004 to March 2008. The Agreement provided for an across-the-board fee increase of 2 percent for specialists and 2.5 percent for general practitioners/family physicians, effective April 1, 2004. Further increases in specific fee codes are scheduled for implementation on various dates from October 1, 2005, through to January 1, 2008.

The Agreement eliminated payment thresholds effective April 1, 2005. This Agreement expands access to care in rural communities by introducing new funding to support hospital-based specialists in the north; enhances care for seniors by introducing new on-call fees in long-term care homes, home care and palliative care; supports hospital care by expanding hospital on-call coverage and in-hospital care fees for specialists and by introducing new fees for family doctors caring for their own patients in emergency departments; supports health promotion and disease prevention by introducing special fees for managing specific chronic diseases; invests in initiatives to recruit physicians to Ontario; and, makes quality of life improvements for physicians such as expanding pregnancy and parental leave benefits.

Under the Agreement, the parties have committed to begin meeting in April 2007, to undertake a performance review of the degree to which the objectives under the Agreement have been met.

With respect to insured surgical-dental services, MOHLTC negotiates changes to the Schedule of Benefits for Dental Services with the Ontario Dental Association. In 2002–2003, MOHLTC and the Ontario Dental Association agreed on a new multi-year funding agreement for dental services, which became effective on April 1, 2003, and will end on March 31, 2007.

5.5 Payments to Hospitals

The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority services, wait time strategies, 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.

Transfer payments to hospitals are based on historical global allocations and multi-year incremental increases that incorporate population growth and anticipated service demands within the available provincial budget.

Each year, public hospitals submit Hospital Annual Planning Submissions that are the result of broad consultations within the facilities (e.g., all levels of staff, unions, physicians and board) and within the community and region. Hospital Annual Planning Submissions are based on a multi-year budget and provide a corresponding multi-year planning forecast. The data submitted in the Hospital Annual Planning Submissions is used to populate schedules for service volumes and performance targets that form the contractual basis for the Hospital Accountability Agreement.

In the Hospital Accountability Agreement, hospital performance is measured through five key performance indicators: total margin; current ratio; percentage of

full-time nurses; relative risk of readmission; and chronic care patient quality indicators. A review of the targets in each of the schedules and a discussion of corresponding corridors for performance indicators in the Hospital Accountability Agreement is conducted between ministry staff and hospitals.

This year, members from the Local Health Integration Networks (LHINs) will be partners in the Hospital Annual Planning Submissions and Hospital Accountability Agreement process, attending training sessions and meetings with the ministry. In April 2007, LHINs are expected to take over funding authority for hospitals in Ontario.

MOHLTC reviews chronic care co-payment regulations and rates annually, accounting for changes in the Consumer Price Index and Old Age Security each year, and determines whether revisions to the regulations and rates are appropriate.

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 2005–2006 publications.

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care

Long-Term Care homes provide care and services for people who are no longer able to live independently and who require 24-hour supervision, personal care and support. The home-like environment is intended to foster the best possible quality of life. MOHLTC funds and regulates all Long-Term Care homes licensed or approved under three different Acts, including the *Homes for the Aged and Rest Homes Act*, the *Nursing Homes Act*, and the *Charitable Institutions Act*.

There are three types of Long-Term Care homes and each type is governed by a separate Act:

- Municipal Homes for the Aged by the *Homes for the Aged and Rest Homes Act*;
- Nursing Homes by the *Nursing Homes Act*; and
- Charitable Homes for the Aged by the *Charitable Institutions Act*.

Bill 140, the proposed new *Long-Term Care Homes Act*, 2006, received its first reading in the Legislature on October 3, 2006. The proposed Act provides a legislative framework to enable improved management of a growing and rapidly changing sector and to better plan for the needs of the population requiring the long-term care residential services provided in a Long-Term Care home.

As of April 2006, there are approximately 602 Long-Term Care homes with 75,008 beds including 252 not-for-profit homes (which consist of municipal, charitable and not-for-profit nursing homes), and 350 for-profit homes.

Long-Term Care homes provide both health care services and accommodation to residents, tailored to a range of care needs from light to heavy care. In general, Long-Term Care homes offer higher levels of personal care and support than those typically offered by either retirement homes or supportive housing. Retirement homes are neither regulated nor funded by the ministry.

MOHLTC also operates the Compliance Management Program which is designed to safeguard residents' rights, safety, security, quality of care and quality of life. Through the Compliance Management Program, MOHLTC monitors and inspects the compliance of Long-Term Care homes with legislation, regulation, standards and criteria, service agreements and, where necessary, uses enforcement measures to achieve compliance.

In January 2005, a new regulation ensured that each resident was offered a minimum of two baths per week, and that resident meal plans were reviewed and approved by dietitians. In October 2004, the ministry provided the additional funding of $191M to enable all Long-Term Care homes to hire 2000 new staff including 600 Registered Nurses. As of August 1, 2005, the ministry required all homes to provide around the clock coverage by Registered Nurses.

Effective January 1, 2006, all Long-Term Care homes were required to implement two new standards: Skin Care and Wound Management; and Continence Care. Ministry inspectors began monitoring compliance with the new standards effective April 1, 2006.

Home Care Services

Ontario home and community care programs provide a range of services that support people living in their homes or other community care settings. These services are available through Community Care Access Centres (CCACs) and Community Service agencies.

CCACs provide simplified access for eligible Ontario residents, of all ages, to home and community care; deliver, make arrangements for and coordinate the delivery of home care services to people in their homes, schools and communities; and, authorize admission to long-term care homes. There is no charge for services provided by CCACs.

The CCAC provides or purchases a range of community services on behalf of eligible clients. The range of services includes nursing, homemaking, personal support, physiotherapy, occupational therapy, speech-language pathology, social work, dietetics, medical supplies and dressings, hospital and sickroom equipment, assistance in obtaining a drug card, laboratory and diagnostic services, and transportation to medical appointments and hospitals.

The CCAC assesses an individual's requirements and determines their eligibility for professional health services, homemaking, and personal support services provided in people's homes and in the community. CCACs assess and determine eligibility for professional health and personal support services for children/youth in schools and receiving home schooling.

CCACs develop plans of service and also provide information and referral services for the public to home and community care related services. CCACs are responsible for admission to long-term care homes, and manage the Requests for Proposal process for purchased client services.

Legislation most relevant to CCACs include the *Long-Term Care Act*, 1994; *Health Insurance Act*; *Community Care Access Corporations Act*, 2001; *Nursing Homes Act*; *Charitable Institutions Act*; and *Homes for the Aged and Rest Homes Act*. Each CCAC must also be familiar with all other relevant laws, including but not limited to the *Health Care Consent Act*, 1996; *Substitute Decisions Act*, 1992; *Personal Health Information Protection Act*, 2004; and the *Ministry of Health Appeal and Review Boards Act*, 1998.

Community service agencies provide support services that include: respite, volunteer visiting hospices, services for persons with physical disabilities, Alzheimer services, homemaking, attendant care, adult day programs, caregiver support, meal services, home maintenance and repair, friendly visiting, security checks and reassurance, social and recreational services, and volunteer transportation. These services are also provided in programs which include acquired brain injury services and assisted living services in supportive housing. Community services are part of a continuum of in-home and other health services, and the assistance provided by family and friends. Community services are legislated under the *Long-Term Care Act*, 1994 and are delivered by community-based, not-for-profit agencies that rely heavily on volunteers, and are funded by the Ministry of Health and Long-Term Care.

The provincial End-of-Life Care Strategy helps replace hospitalizations, where appropriate, with home care services made possible through advances in treatment practices, collaborative planning between all health care sectors, and increased resources. The objectives of the strategy are to shift care of the dying from the acute setting to an appropriate alternate setting based on individual preference; to enhance/develop a client-centred and interdisciplinary end-of-life care service capacity; and to improve access to, and coordination/consistency of comprehensive end-of-life care services. End-of-Life care services are provided in home or the community by CCACs, Community Support Service agencies and residential hospices.

Ambulatory Health Care Services

Community Health Centres are transfer payment agencies governed by a community board of directors. The name "Community Health Centre" reflects the fact that the agency is established by the community and provides programs and services in response to needs identified in that community. Community Health Centres deliver services through inter-disciplinary teams including

physicians, nurses, counsellors, dietitians and health promoters. Services include comprehensive primary care as well as group and community programs, such as diabetes education, parent/child programs, community kitchens, and youth outreach services. Community Health Centres work within a population health framework that places an equal emphasis on providing comprehensive primary care, preventing illness, and health promotion.

Community Health Centres identify the priority populations that they will serve — traditionally people who have experienced barriers to access based on culture, language, literacy, age, socio-economic status, mental health status and homelessness. Community Health Centres also develop partnerships to improve access to care, promote effective service integration and build community capacity to address health risks.

Service is provided through 54 Community Health Centres operating from more than 80 full-service sites across Ontario. Of these, 27 are in large urban centres, 14 are in smaller urban centres, and 13 are in either northern or rural communities. There is no legislation specific to Community Health Centres.

Historically, Community Health Centres have been developed based on expressions of interest from sponsoring groups. This has resulted in an uneven distribution and some significant gaps in coverage across the province. Between 2004–2005 and 2007–2008, the government is expanding the network of Community Health Centres by adding 22 new Centres and 27 satellite Centres. This expansion will be targeted to communities with at-risk populations facing barriers to access. Once implemented, it is expected that many of the most critical gaps in coverage will be addressed.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	11,800,000	12,100,000	12,200,000	12,400,000	12,500,000[1]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	139	139	139	135	134
b. chronic care	11	11	11	13	14
c. rehabilitative care	4	4	4	4	4
d. other	3	3	3	3	4
e. total	157[2]	157[2]	157[2]	155[2]	156[2]
3. Payments:					
a. acute care	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
b. chronic care	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
c. rehabilitative care	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
d. other	not available[3]	not available[3]	not available[3]	not available[3]	not available[3]
e. total	9,200,000,000	10,300,000,000	10,300,000,000	12,300,000,000	12,700,000,000
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
b. diagnostic imaging facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
c. total	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
5. Number of insured hospital services provided:					
a. surgical facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
b. diagnostic imaging facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
c. total	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
6. Payments:					
a. surgical facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
b. diagnostic imaging facilities	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]
c. total	not available[4]	not available[4]	not available[4]	not available[4]	not available[4]

1. These estimates represent the number of individuals registered for Ontario health coverage with valid and active health numbers as of March 31, 2006.
2. Excludes the three Provincial Psychiatric Hospitals.
3. Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of bed. Separating by facility type gives a small sample size and significantly understates the amount actually spent on chronic and rehabilitative beds.
4. “Data are not collected in a single system in MOHLTC. Further, the MOHLTC is unable to categorize providers/facilities as “for-profit” as MOHLTC does not have financial statements detailing service providers' disbursement of revenues from the ministry.”

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	10,395	10,508	10,611	10,660	10,774
b. specialists	10,520	10,724	10,703	11,016	11,460
c. other	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
d. total	20,915	21,232	21,314	21,676	22,234
8. Number of opted-out physicians:					
a. general practitioners	22	17	15	14	12
b. specialists	165	134	114	62	39
c. other	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
d. total	187	151	129	76	51
9. Number of not participating physicians:					
a. general practitioners	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
b. specialists	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
c. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
d. total	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
10. Services provided by physicians paid through all payment methods:					
a. number of services	185,473,186 [7]	188,309,344 [7]	192,572,601 [7]	200,825,265 [7]	215,980,656 [7]
b. total payments	not available [7]	5,420,010,700 [7]	5,945,003,300 [7]	6,424,329,400 [7]	7,072,813,000 [7]
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	77,800,000	76,800,000	78,700,000	82,111,000	84,989,000
b. specialists	99,600,000	102,300,000	103,300,000	109,340,200	118,667,000
c. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
d. total	177,400,000	179,100,000	182,000,000	191,451,200	203,656,000
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	1,741,400,000	1,733,200,000	1,820,200,000	1,891,180,350	1,894,490,000
b. specialists	2,936,700,000	3,065,100,000	3,152,800,000	3,420,905,268	3,747,559,000
c. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
d. total	4,678,100,000	4,798,300,000	4,973,000,000	5,312,085,618	5,642,049,000
13. Number of services provided through fee for service, by category:					
a. medical	81,800,000	81,800,000	80,900,000	85,101,110	88,800,000
b. surgical	22,700,000	23,900,000	27,100,000	28,507,294	33,600,000
c. diagnostic	72,900,000	73,400,000	74,000,000	77,842,796	81,300,000
d. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
e. total	177,400,000	179,100,000	182,000,000	191,451,200	203,700,000
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	2,731,400,000	2,742,800,000	2,818,000,000	3,010,146,244	3,214,300,000
b. surgical	706,800,000	735,000,000	787,700,000	841,409,580	894,100,000
c. diagnostic	1,239,800,000	1,320,500,000	1,367,300,000	1,460,529,794	1,533,700,000
d. other	not available [8]	not available [8]	not available [8]	not available [8]	not available [8]
e. total	4,678,100,000	4,798,300,000	4,973,000,000	5,312,085,618	5,642,100,000

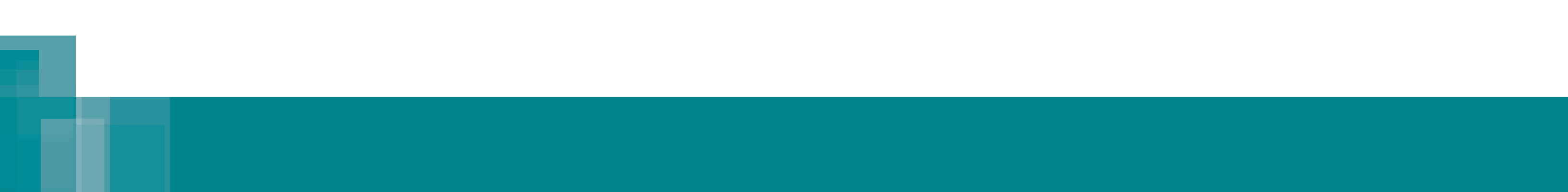
5. All physicians are categorized as general practitioner or specialist.
6. Ontario has no non-participating physicians, only opted-out physicians who are reported under item #8.
7. Number of services includes services provided by Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, and Academic Health Science Centres. Total Payments includes payments made to Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, and Academic Health Science Centres and the Hospital On Call Program. Services and payments related to Other Practitioner Programs, Out-of-Country/Out-of-Province Programs, and Community Labs are excluded.
8. All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	8,633	9,306	9,023	8,184	8,374
16. Total number of claims, out-patient.	144,831	140,692	167,143	154,460	174,848
17. Total payments, in-patient ($).	36,800,000	48,500,000	63,000,000	52,000,000	54,000,000
18. Total payments, out-patient ($).	18,000,000	16,500,000	20,000,000	23,000,000	29,100,000
19. Average payment, in-patient ($).	4,262.70	5,211.70	6,982.00	6,353.00	6,448.53
20. Average payment, out-patient ($).	124.30	117.30	119.66	129.48	166.43
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	469,146	497,880	557,720	534,179	573,830
22. Total payments ($).	15,500,000	17,700,000	18,600,000	20,300,000	21,164,600
23. Average payment per service ($).	33.00	35.00	33.34	38.00	36.89

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	18,542	23,295	21,458	21,710	23,845
25. Total number of claims, out-patient.	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
26. Total payments, in-patient ($).	19,300,000	27,200,000	32,000,000	42,466,826	66,916,271
27. Total payments, out-patient ($).	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]
28. Average payment, in-patient ($).	1,043.20	1,167.40	1,490.80	1,956.10	2,806.30
29. Average payment, out-patient ($).	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	157,191	200,428	180,395	179,410	200,723
31. Total payments ($).	8,200,000	10,200,000	9,900,000	11,635,998	13,211,381
32. Average payment per service ($).	51.90	51.00	55.10	64.86	65.82

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of participating dentists.	327	319	323	335	330
34. Number of services provided.	74,000	75,600	72,900	86,000	87,111
35. Total payments ($).	8,600,000	9,300,000	9,200,000	11,786,600	12,546,397
36. Average payment per service ($).	116.00	123.02	126.20	137.05	144.03

9. Included in #24.
10. Included in #26.
11. Included in #28.



Manitoba

Introduction

Manitoba Health and Healthy Living provides leadership and support to protect, promote and preserve the health of all Manitobans. The Department is organized into five distinct but related functional areas: Corporate and Provincial Program Support, Healthy Living and Health Programs, Health Workforce, Regional Affairs and Administration, Finance and Accountability. Their mandates are derived from established legislation and policy pertaining to health and wellness issues. The roles and responsibilities of Manitoba Health include policy, program and standards development, fiscal and program accountability and evaluation.

Manitoba Health and Healthy Living remains committed to sustaining our universal, comprehensive and accessible health care system and improving the health status of all Manitobans. In support of these commitments, a number of activities were initiated in 2005–2006.

The Ministry of Healthy Living undertook a province-wide consultation with Manitobans about ways to maximize the health of children and youth today and into their adult lives. A Chronic Disease Prevention initiative to address risk factors associated with preventable chronic diseases was implemented. A provincial physical activity strategy entitled *Manitoba in Motion* and public education campaigns such as *Protect Your Noggin*, which focuses on the use of bicycle helmets were also launched.

Manitoba introduced a $155 million Five Point Plan to improve access to quality care and reduce wait times in key areas. The plan involves more diagnostic testing, more surgeries, more health professionals, system innovation and better wait list management, prevention and health promotion.

The Manitoba Institute for Patient Safety which was established in 2004, undertook a variety of activities to promote, coordinate and stimulate research and initiatives that enhance patient safety and quality care. These included key stakeholder consultations, culture of safety surveys, Provincial Patient Safety Workshop and other forums.

Manitoba's Pharmacare Program has been enhanced by adding 220 new drugs and 43 new interchangeable categories.

A new Long Term Care Seniors' Strategy entitled *Aging in Place* will increase community living support for seniors and provide alternatives to institutional care.

Significant capital investments were also made in acute care facilities, such as the initiation of the Cardiac Care Centre at St. Boniface hospital and continued redevelopment of the Critical Services area in the Health Sciences Centre in Winnipeg; expansions or upgrades to the Swan Valley Health Centre; the St. Anne and Flin Flon hospitals; and a new a Health Centre in Wabowden.

The Role and Mission of Manitoba Health

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

Manitoba Health and Health Living's vision is healthy Manitobans through an appropriate balance of prevention and care.

It is the mission of Manitoba Health and Healthy Living to lead a publicly administered sustainable health system that meets the needs of Manitobans, and promotes their health and well-being. This 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 on behalf of Manitobans for insured health benefits related to the costs of medical, hospital, personal care, pharmacare and other health services.

It is also the role of Manitoba Health and Healthy Living to foster innovation in the health care system. This is accomplished by 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, 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[1] was significantly amended in 1992, dissolving the Manitoba Health Services Commission and transferring all assets and responsibilities to Manitoba 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 and other health services referred to in acts of the Legislature or regulations there under. The Act was amended on January 1, 1999, to provide insurance for out-patient services relating to insured medical services provided in surgical facilities.

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

- 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;
- 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;
- 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 that the Minister considers necessary to ensure that adequate standards are maintained;
- 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;
- 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, which are required by the Government of Canada, are submitted; and
- in cases where residents do not have available medical services and other health services, to take such measures that 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 he or she considers necessary for the purposes of the Act. The Minister may also make grants to any person or group for the purposes of the Act on such terms and conditions that are considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the regulations.

There were no legislative amendments to the Act or the regulations in the 2005–2006 fiscal year that affected the public administration of the Plan.

1 Where reference is made to “the Act” in the text, this refers to The *Health Services Insurance Act* as consolidated to March 31, 2006.

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 prepare an annual report, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it, if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the Act requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the Plan annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2005–2006 fiscal year and is contained in the Manitoba Health Annual Report, 2005–2006. It will also be available on the Province's website in late October 2006.

2.0 Comprehensiveness

2.1 Insured Hospital Services

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

As of March 31, 2006, there were 98 facilities, providing insured hospital services to both in- and out-patients. Hospitals are designated by the Hospitals Designation Regulation (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in- 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.

All hospital services are added to the list of available hospital services through the health planning process.

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 (M.R. 49/93) made under the 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, 2006, there were 2,169 physicians on the Manitoba Health Registry. This figure is taken from the Monthly Practitioner Registration Statistics and includes all physicians registered with Manitoba Health whether income was generated or not.

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 section 91 of the Act and section 5 of the Medical Services Insurance Regulation. 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.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or regulations. 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 that are not excluded under the Excluded Services

Regulation (M.R. 46/93) of the Act, rendered to an insured person by a physician.

During fiscal year 2005–2006, 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 those covered by Manitoba Health, physicians must put forward a proposal to their specific section of the Manitoba Medical Association (MMA). 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 (M.R. 48/93) under the Act. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist. As of March 31, 2006, 600 dentists were registered with Manitoba Health, however only 115 dentists were paid for providing dental services.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to or collect from an insured person a fee in excess of the benefits payable under the Act or regulations. No providers of dental services had opted out as of March 31, 2006.

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

The Excluded Services Regulation (M.R. 46/93) made under the Act sets out those services that are not insured. These include: examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third parties; group immunization or other group services except where authorized by 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 of sterilization procedures; and psychoanalysis.

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

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

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 2005–2006.

3.0 Universality

3.1 Eligibility

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

The Residency and Registration Regulation (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have a work permit of 12 months or more.

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 MHSIP excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Royal Canadian Mounted Police Act*; *Veteran's Rehabilitation Act*; or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The excluded are residents who are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP) and federal inmates. These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Forces, the RCMP, or if an inmate of a penitentiary has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health (Residency and Registration Regulation (M.R. 54/93, 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, and that they intend to be physically present in Manitoba for six months. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration card 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 medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for payment of all hospital services and for the provincial drug program.

As of March 31, 2006, there were 1,173,815 residents 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 (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit 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.

As of March 31, 2006, there were 4,475 individuals on work permits covered under the MHSIP.

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). No legislative amendments to the Act or the regulations in the 2005–2006 fiscal year affected universality.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation (M.R. 54/93 section 7(1)) defines the rules for portability of health insurance during temporary absences in Canada. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies.

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

Except for 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 2005–2006, Manitoba Health made payments of approximately $23.7 million for hospital services and $8.7 million for medical services provided in Canada.

4.3 Coverage During Temporary Absences Outside Canada

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

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 after completing 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 up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93). Hospital services received outside Canada due to an emergency or a sudden illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per-diem rate according to hospital 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 a specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at the equivalent Manitoba rate for similar services. Hospital services are paid at a minimum of 75 per cent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15–23).

Manitoba Health made payments of approximately $3,410,500 for hospital care provided in hospitals out-

side Canada in the 2005–2006 fiscal year. In addition, Manitoba Health made payments of approximately $1,074,000 for medical care outside Canada.

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

4.4 Prior Approval Requirement

Prior approval by Manitoba Health is not required for services provided in other provinces or territories or for emergency care provided outside Canada. 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 for coverage.

No legislative amendments to the Act or the regulations in the 2005–2006 fiscal year had an effect on portability.

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 Surgical Facilities Regulation (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

In July 2001, the *Health Services Insurance Act*, the *Private Hospitals Act* and the *Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

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

On February 10, 2004, Manitoba officially opened the expanded Health Links/Info Santé, a 35-seat, state-of-the-art call centre with a call capacity of 300,000 per year. Manitobans now have access to vital health information and assistance in 120 languages 24-hours a day, seven days a week.

Public demand for Health Links/Info Santé has increased steadily since it began as a six station call back service in 1994. Manitobans value the service. Providing this information source relieves pressure on other areas of the health care system, particularly emergency rooms.

Through the Primary Health Care Transition Fund, multi-jurisdictional envelope funds have been made available to implement a program to manage patients with congestive heart failure. Beginning in November 2004, this 17-month initiative will evaluate the benefits of using health lines to manage patients with chronic diseases.

5.2 Access to Insured Hospital Services

All Manitobans have access to hospital services including acute care, psychiatric extended treatment, mental health, palliative, chronic, long-term assessment/rehabilitation and to personal care facilities. There has been a shift in focus from hospital beds to community services, out-patients and day surgeries, which are also insured services.

Manitoba's nursing supply has improved significantly in Winnipeg, with a more gradual improvement noted in rural and northern regions. The increased supply of nurses is primarily due to an investment in nursing education. Enrolment in nursing education programs continues to be fully subscribed. The Nurses Recruitment and Retention Fund (NRRF) has also contributed significantly to improving nursing supply in Manitoba. The most recent NRRF initiative is the Conditional Grant Program that was implemented in July 2004 to encourage new graduates to work in rural and northern Manitoba regions (outside Winnipeg and Brandon).

In addition, Manitoba has a wide range of other health care professionals. Shortages in some of the technology fields persist, primarily in rural and northern areas of the Province. Shortages in some of the technology fields such as medical radiology technology, medical laboratory technology and sonography continue to be issues of concern, however recent expansions of training opportunities are expected to have positive impacts in the near future.

Manitoba currently has access to seven Magnetic Resonance Imaging (MRI) machines, six of which are used for clinical testing. The first unit was installed

in 1990 by the St. Boniface Research Foundation. In Winnipeg, there are three MRI machines located at St. Boniface General Hospital, and two located at the Health Sciences Centre. One of the MRIs at the Health Science Centre was a joint initiative with the National Research Council (NRC). The sixth MRI was opened at Brandon Regional Health Centre in June 2004. This was the first MRI machine to be located outside Winnipeg. The seventh and newest MRI opened at Pan AM Clinic and became operational November 21, 2005.

Manitoba has 17 Computerized Tomography (CT) scanners: three (one for paediatric patients) at the Health Sciences Centre, two at the St. Boniface General Hospital, one each at Victoria General Hospital, Misericordia Health Centre, Seven Oaks, Grace and Concordia Hospitals all located in Winnipeg. Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Bethesda Hospital, The Pas Hospital and Selkirk Regional Health Centre are all located throughout the province. As well, planning is underway to establish a CT scanner at Portage District General Hospital. Brandon is in the process of purchasing a 64 slice scanner and Dauphin is in the process of purchasing a 16 slice CT scanner.

There are 67 ultrasound scanners located in Winnipeg health facilities and 22 scanners in rural and northern health facilities. Concordia and Seven Oaks Hospitals are reviewing proposals for a new ultrasound for each facility. Bethesda Hospital is also purchasing an ultrasound scanner. Bone density testing is funded by Manitoba Health on two machines, one located in Winnipeg and one in Brandon.

In November 2004 new community cancer programs were established in Deloraine and Pinawa. These new cancer programs operate in conjunction with CancerCare Manitoba and focus on prevention, early detection and screening, diagnosis and treatment and rehabilitation. Services are delivered by health professionals specially trained in oncology and include the preparation and administration of chemotherapy.

The Manitoba Prostate Cancer Centre became operational in October 2004. It is located on the third floor of the new CancerCare building at 675 McDermot Avenue. The Prostate Centre includes a wide variety of services for Manitoba men including clinical assessment, information to help with patient decision-making, linkages with prostate cancer support groups and research conducted in the area of prostate disease.

Wait time funding has provided for additional hip and knee joint replacements at several sites in Winnipeg, Brandon Regional Health Centre and Boundary Trails Health Centre. Rehabilitation clinics have also been established in Winnipeg, Brandon and Boundary Trails to provide care to patients while they wait for their joint replacement surgery.

Additional cataract procedures to reduce wait lists have been added at Pan Am Clinic in Winnipeg and at Brandon Regional Health Centre.

In March 2005 the expansion of pediatric dental surgery services to Misericordia Health Centre (MHC) was initiated to reduce the waiting times. Further, 200 surgeries were added to Thompson General Hospital at the beginning of August 2005.

Services at the Pain Clinic at Health Sciences Centre had been impacted by a shortage of anesthesiologists and the lack of physical space in the clinic. Renovations to expand clinic size and increase capacity were completed in 2005. The Health Sciences Centre Pain Clinic has recruited two Geriatric Rehabilitation doctors (psychiatrists) and a psychologist who are part of the multi-disciplinary team treating patients.

The WRHA Emergency Care Task Force was initiated in January 2004. The Task Force was closed effective January 2006. During its two years of work, a total of 46 recommendations for short and long term improvements in emergency care in Winnipeg hospitals were identified and plans for implementation defined. While some recommendations have been fully implemented, work continues on others as many recommendations involve system issues. Highlights include enhanced diagnostic capabilities, enhanced education for Emergency Department staff, redevelopment of physical space and improved IT support.

The Wait Times Task Force was established in 2006 to improve access to quality care and reduce wait times. The Wait-Time Reduction Strategy targets the five priority areas identified by First Ministers in their 10-year plan to strengthen health care: cancer, cardiac, diagnostic imaging, joint replacement and sight restoration. In addition, Manitoba is targeting four other priority areas: children's

dental surgeries, mental health programs, pain management and treatment for sleep disorders.

A plan was developed in consultation with practitioners and stakeholders, which will increase the number of surgeries and procedures, invest in human resources, technology and capital, and provide regional health authorities with new wait-list management tools and resources.

The Wait Time Task Force established the Manitoba Patient Access Network which is charged with developing new approaches to patient navigation through better system integration and coordination, improving patient access to services and ensuring sustainability of initiatives.

5.3 Access to Insured Physician and Surgical-Dental Services

In 2005–2006, Manitoba Health continued to support initiatives to improve access to physicians in rural and northern areas of the province. One of the supported initiatives, implemented in the fall of 2005, was a co-ordinated process to assist Regional Health Authorities with the logistics of recruiting foreign-trained physicians. The co-ordinated process, administered through the Physician Resource Coordination Office (PRCO), is aimed at avoiding duplication of effort, while introducing future physician candidates to opportunities available in Manitoba.

The province supports many initiatives aimed at recruiting and retaining physicians. There is an initiative that facilitates the entry of eligible foreign medical graduates into the physician workforce. Through the program, foreign-trained physicians can achieve conditional licensure to practice family medicine in return for agreeing to work in a sponsoring rural Regional Health Authority. Another initiative assists in facilitating the assessment of physicians whose practice will be limited to a specialty field of training. Through this program clinical assessments are organized and facilitated in order for foreign trained physicians to meet the College of Physicians and Surgeons of Manitoba (CPSM) criteria for licensure.

Manitoba continues to experience increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province continued to provide a financial assistance grant, introduced in 2001, for students and residents. In return for financial assistance during their training, the student or resident agrees to work in Manitoba for a specific period after graduating. In 2005 the Practice Assistance Option of the Medical Student/Resident Financial Assistance Program was enhanced to provide two grants of $50,000 each to physicians re-entering training in an area of critical need in the Province, such as emergency medicine or anaesthesia. In addition five grants of $15,000 each have been made available to Family Physicians who have been working in an urban area and five grants of $25,000 each to Family Physicians working in a rural/northern area of the Province, subject to certain eligibility criteria. Since 2001, Manitoba has supported an expansion in medical school class sizes, which continues in 2006 with the first year enrolment for the fall of this year reaching 101 students.

The Manitoba Telehealth Network under the leadership of the Winnipeg Regional Health Authority has implemented the infrastructure to link 23 Telehealth sites across the province. This modern telecommunications link means patients can be seen by specialists and medical staff can consult with each other without having to endure the expense and inconvenience of travelling from the North to Winnipeg. In September 2002, Manitoba Health launched the new Manitoba Telehealth site at St. Boniface General Hospital, officially linking its medical specialists to patients and colleagues province-wide.

5.4 Physician/Dentist Compensation

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, salaried, sessional and blended.

The *Health Services Insurance Act* governs payment to physicians for insured services. There were no amendments to the *Health Services Insurance Act* (HSIA) related to physician compensation during the 2005–2006 fiscal year.

Fee-for-service remains the dominant method of payment for physician services. Notwithstanding, alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive either a salary (employer-employee relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods to top-up the wages of physicians whose fee-for-service income may not be competitive, yet whose

services remain vital to the province. As well, physicians may receive sessional payments for providing medical services, as well as stipends for on-call responsibilities.

Representatives from the Manitoba Medical Association (MMA) and Manitoba Health typically negotiate compensation agreements for physicians.

The June 27, 2005, settlement maintained the terms of the June 2, 2002, Arbitration Agreement, (subsequently entrenched in the 2003–2005 MMA- Manitoba Heath Agreement) including:

- the continuation of a Physician Retention Fund ($5 million per annum over the duration of this agreement as well as the subsequent agreement);
- the continuation of the Professional Liability Insurance Fund ($5 million per annum for 2006 through to 2011);
- the continuation of the Continuing Medical Education Fund ($1 million per annum from 2006 through 2011);
- the continuation of a Maternity/Parental Benefits Fund ($1 million per annum from 2005 through to 2011);
- a mechanism to initiate arbitration proceedings with respect to a subsequent agreement, if notice is given by either party by January 1, 2007;
- that physicians covered by the Agreement shall refrain from stopping work or curtailing services and to continue to provide services without interruption; and
- continuation of the Grievance Arbitration procedure set forth in the March 8, 1994, Fee-For-Service Agreement between the parties.

The highlights of the June 27, 2005, Negotiated Settlement include:

- a three-year term from April 1, 2005 to March 31, 2008;
- an overall increase of 7.5 per cent (non-compounded) to the Fee-For-Service Schedule of Benefits, as well as alternate-funded agreements and arrangements)
- 2.5 per cent effective April 1, 2005; 2.5 per cent effective April 1, 2006; and 2.5 per cent effective April 1, 2007.
- an additional $10 million was applied to the schedule of benefits through a Shoring Up Fund and an additional $5.5 million was applied to outstanding fee-for-service issues through the Exceptional Issues Fund;
- an additional $5 million was applied to alternate funding contracts though the alternate Funding Shoring Up Fund.
- an extension of maternity and parental benefits to all Manitoba physicians, including interns and residents continued;
- increased incentives for family doctors to provide full-service care and to maintain hospital privileges; and,
- increases to the rates for physicians under alternate funding agreements in the amount of 2.5 per cent effective April 1, 2005; 2.5 per cent effective April 1, 2006; and 2.5 per cent effective April 1, 2007 (non-compounded); were also applied over and above the fee-for-service increase.

5.5 Payments to Hospitals

Division 3.1 of Part 4 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 enables 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 that the Minister of Health appoint a mediator to help them resolve outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute. The Minister's resolution is binding on the parties.

There are three Regional Health Authorities which have hospitals operated by health corporations in their health regions. The Regional Health Authorities have concluded the required agreements with health corporations. The operating agreements enable a Regional Health Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities. In all other regions, the hospitals are operated by the *Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

The allocation of resources by Regional Health Authorities for providing 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 MHSIP for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the regulations in 2005–2006 had an effect on payments to hospitals.

6.0 Recognition Given to Federal Transfers

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health Transfer (CHT) in public documents.

7.0 Extended Health Care Services

Manitoba has established community-based service programs as appropriate alternatives to hospital services. These service programs are funded by Manitoba Health through the Regional Health Authorities. The services include the following:

Personal Care Home Services

Insured personal care services are provided pursuant to the Personal Care Services Insurance and Administration Regulation under the *Health Services Insurance Act*. In 2005, the Personal Care Homes Standards Regulation and Personal Care Homes Licensing Regulation were enacted under the same Act, linking licensing to compliance with a range of standards designed to ensure safe, quality care. Both proprietary and non-proprietary homes are licensed by Manitoba Health. Residents of personal care homes pay a residential charge towards accommodation costs, with the cost of care funded by Manitoba Health through the Regional Health Authorities. Total Manitoba Health operating funding for personal care services delivered in licensed personal care homes and in two long-term care centres during fiscal year 2005–2006 was $445,588,400. This funding supported the delivery of insured personal care services in a total of 9,830 personal care beds plus a total of 190 chronic care beds in two long-term care facilities, 30 palliative care beds and 136 rehab beds. In addition, Manitoba Health provided $13,054,100 in capital funding for approved capital projects, information technology projects, safety and security upgrades, and equipment.

Home Care Services

The Manitoba Home Care Program is the oldest comprehensive, province-wide, universal home care program in Canada. Manitoba Home Care provides 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. Home Care case co-coordinators conduct assessments and develop individual care plans, which may include self or family Managed Care, personal care assistance, household maintenance, professional health care, in-home family relief, facility-based respite care, some supplies and equipment, access to adult day programs, and/or access to support services to seniors' programs that coordinate volunteers, congregate meal programs, transportation, emergency response systems and other activities that support continued independent community living.

Mental Health and Addictions Services

All Regional Health Authorities provide community mental health services. Community Mental Health Workers provide assessment, service planning, short-term

counselling interventions, rehabilitation and recovery planning, crisis intervention, community consultation and in some cases education. In addition to Community Mental Health Workers, some regions have a variety of intensive and supportive programs such as Intensive Case Management, Supported Employment, Supported Housing and, in Winnipeg, the Program for Assertive Community Treatment and the Early Psychosis Prevention and Intervention Service.

Addictions services and supports are provided through provincially funded agencies. They include the Addictions Foundation of Manitoba (AFM), The Behavioural Health Foundation, Salvation Army — Anchorage, Native Addictions Council of Manitoba, Tamarack, Laurel Centre, Esther House and Addictions Recovery Inc. These agencies work to reduce the harm associated with alcohol and other drugs. AFM also offers a gambling program. Programs include education, prevention, rehabilitation and research. In addition to the provincially funded agencies, the Winnipeg Regional Health Authority funds to detox programs and the Norman Regional Health Authority funds a residential treatment agency.

Primary Health Care

One of Manitoba Health's strategic priorities is the need to address primary care renewal. One strategy includes the development of Physician Integrated Networks (PIN) which has been evolving under the guidance of an Advisory Committee with representation from the University of Manitoba; the Colleges of Registered Nurses and Physicians & Surgeons of Manitoba; the Manitoba Medical Association; the Winnipeg and Assiniboine Regional Health Authorities and other primary care stakeholders.

The Physician Integrated Network initiative focuses on the engagement of fee-for-service physician groups. The objectives of this initiative are to improve access to primary care, to improve primary care providers' access to and use of information systems, to improve the working environment for all primary care providers, and to demonstrate high quality care with a specific focus on chronic disease management.

A PIN resource team has been established to work with four demonstration sites during the development phase of the implementation plan. The project is scheduled to be operational early in 2007.

The federal government's Primary Health Care Transition Fund per capita grant funded twenty-two initiatives in Manitoba. Some initiatives received sustainable funding from their regional health authorities while others concluded as of March 31, 2006. The final reports and evaluations, submitted by the initiatives provided many insights for future strategic planning and enhancement of primary health care in the province.

Primary Health Care participated in a national initiative to develop multidisciplinary collaborative care in order to address human resource and quality issues in maternal newborn services. Primary Health Care, in partnership with MB Telehealth, held a workshop for regional health authorities to pilot the project's tool-kit, and assess its usefulness in the provincial environment. Implementation of the model begins with an environmental scan and gap-analysis, is flexible to address northern, rural and remote situations and is designed to begin with current resources. Regional Health Authority representatives found the model practical and useful, and plan to work with Primary Health Care in development of collaborative maternal/newborn services.

Midwifery, regulated in 2000, has now been introduced in seven of 11 Regional Health Authorities. In 2003–2004 only six RHAs employed midwives. Services are distributed across the province, with half provided outside the Winnipeg Region. Midwives provide primary care for women and newborns; now attending five per cent of Manitoba births, as well as providing well-woman care. Provincial direction has focused the service on priority populations, which represent over 65% of midwifery clients; including those at high social risk such as substance abusers. The program, providing comprehensive, community-based care, has significantly lower rates of pre-term birth, high and low birth weights. Development of human resources is being addressed through the introduction of the Aboriginal Midwifery Education Program at University College of the North.

The primary health care staff participated in a Pan-Canadian Primary Health Care Indicator Development Project also funded through the Primary Health Care Transition Fund. The purpose of the project was to develop a set of agreed-upon PHC indicators with which to compare and measure PHC at multiple levels within each jurisdiction across Canada.

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.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.[2]	1,152,982	1,156,217	1,159,784	1,169,667	1,173,815

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	96	92	92	98 [3]	98 [3]
b. chronic care	3	5	5	3 [4]	3 [4]
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not applicable	not available	not available	not available	not available
e. total	99	97	97	98	98
3. Payments ($):					
a. acute care	1,046,407,229	1,148,652,940	1,220,253,362	1,400,448,441	1,488,094,835
b. chronic care	70,872,152	107,840,132	117,642,127	96,364,992	71,117,677
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	not applicable	1	1	1	1
b. diagnostic imaging facilities	not applicable	0	0	0	0
c. total	not applicable	1	1	1	1
5. Number of insured hospital services provided:					
a. surgical facilities	not applicable	not available	not available	not available	not available
b. diagnostic imaging facilities	not applicable	0	0	0	0
c. total	not applicable	not available	not available	not available	not available
6. Payments ($):					
a. surgical facilities	not applicable	not available	1,252,657	1,290,989	1,305,132
b. diagnostic imaging facilities	not applicable	0	0	0	0
c. total	not applicable	not available	1,252,657	1,290,989	1,305,132

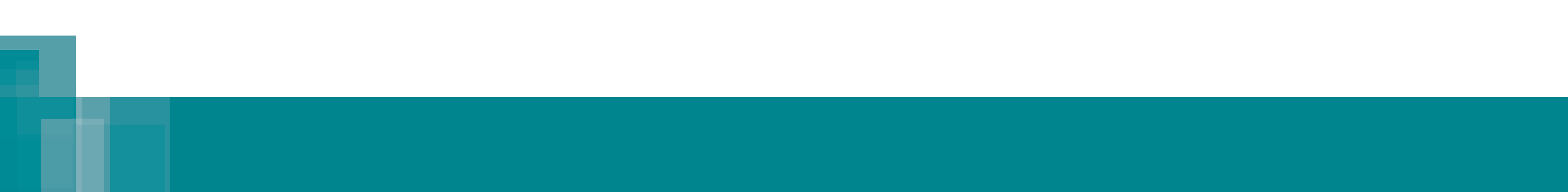
2. The population data is based on records of residents registered with Manitoba Health as of June 1.
3. Ninety-eight submitting acute facilities includes 22 nursing stations and 2 federal hospitals.
4. Three acute facilities have been given a chronic institution submitting number: Riverview Health Centre, Deer Lodge Centre and Brandon General Hospital.

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	not available	954	959	979	981
b. specialists	not available	1,010	980	1,008	1,035
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not available	1,964	1,939	1,987	2,016
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	not available	not available	not available	not available	not available
b. total payments	496,268,700	521,611,200	559,271,513	601,240,469	653,290,519
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	6,244,197	6,161,451	6,224,463	6,185,333	6,365,965
b. specialists	9,198,787	9,779,269	10,044,381	10,393,068	11,100,403
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	15,442,984	15,940,720	16,268,844	16,578,401	17,466,368
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	140,703,474	143,846,209	152,393,920	167,728,376	175,463,105
b. specialists	214,392,377	221,948,290	232,153,861	248,021,396	267,022,019
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	355,095,851	365,794,499	384,547,781	415,749,772	442,485,124
13. Number of services provided through fee for service, by category:					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	15,442,984	15,940,720	16,268,844	16,578,401	17,466,368
14. Total payments to physicians paid through fee for service, by category ($):					
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	355,095,851	365,794,499	384,547,781	415,749,772	442,485,124

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	2,892	2,714	2,928	3,036	2,995
16. Total number of claims, out-patient.	26,479	26,059	31,100	24,057	29,685
17. Total payments, in-patient ($).	11,427,627	12,918,117	16,290,426	15,393,378	19,153,208
18. Total payments, out-patient ($).	3,776,489	3,783,059	4,369,889	3,896,789	5,670,133
19. Average payment, in-patient ($).	3,951.50	4,759.81	5,563.67	5,070.28	6,395.06
20. Average payment, out-patient ($).	142.60	145.17	140.51	161.98	191.01
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	211,464	212,795	210,294	209,152	228,090
22. Total payments ($).	7,381,785	7,691,159	7,579,028	8,109,229	8,966,703
23. Average payment per service ($).	34.900	36.14	36.00	39.00	39.31

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	557	569	418	540	569
25. Total number of claims, out-patient.	6,676	6,025	6,069	6,170	6,690
26. Total payments, in-patient ($).	2,008,580	1,847,910	1,348,148	1,085,650	1,455,908
27. Total payments, out-patient ($).	3,267,764	914,251	1,216,073	1,112,466	1,325,062
28. Average payment, in-patient ($).	3,607.40	3,249.89	3,225.00	2,010.00	2,558.71
29. Average payment, out-patient ($).	489.00	151.73	200.00	180.00	198.07
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	6,345	5,826	5,324	5,714	6,138
31. Total payments ($).	529,029	607,066	519,782	426,937	608,524
32. Average payment per service ($).	83.40	104.20	98.00	75.00	99.14

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of particpating dentists.	not available	116	102	114	115
34. Number of services provided.	3,401	3,455	3,498	3,774	3,863
35. Total payments ($).	677,295	714,590	750,122	875,657	936,091
36. Average payment per service ($).	199.15	206.83	214.44	232.02	242



Saskatchewan

Introduction

In 2005–2006 Saskatchewan Health continued to base its work on *The Action Plan for Saskatchewan Health Care*, a blueprint and broad strategic plan for strengthening the health care system. Our vision for Saskatchewan remains unchanged:

"*Building a province of healthy people and healthy communities.*"

In 2005–2006 Saskatchewan Health made significant progress toward fulfilling its goals of:

- improved access to quality health services;
- effective health promotion and disease prevention;
- retaining, recruiting and training health providers; and
- a sustainable, efficient, accountable, quality health system

The following examples highlight several significant accomplishments by Saskatchewan Health during the 2005–2006 fiscal year.

- Saskatchewan achieved a significant increase in surgical capacity in 2005–2006 and a considerable drop in the number of patients waiting for surgery.
- Regina Qu'Appelle and Saskatoon Health Regions together completed about 2,000 more surgeries in 2005–2006. The number of patients waiting for surgery in those regions dropped by nearly 1,600 over the previous year.
- The total number of patients waiting for an MRI exam decreased provincially by 35.6 per cent since March 2004. With the implementation of Regina's second MRI, it is anticipated that wait times will be further reduced.
- Funding was provided to more than 500 new and continuing return service bursaries for health care providers.
- New International Medical Graduate residency seats were added at the University of Saskatchewan to allow more foreign-trained physicians to work in Saskatchewan.
- It released the comprehensive report *Working Together: Saskatchewan's Health Workforce Action Plan* — an action plan designed to improve health care in Saskatchewan by keeping and attracting health care professionals.
- It expanded immunization program to include free flu shots for children between the ages of 6–23 months.
- It announced the building of a new Provincial Laboratory to ensure we can even better identify, respond to and prevent illness and disease in our province.
- It expanded the Telehealth network to now include 26 sites across the province, and serve about 5,500 Saskatchewan residents and health care providers every year.

In August 2005, Premier Lorne Calvert announced the launch of the Premier's Project Hope, a comprehensive and integrated plan to prevent and treat alcohol and drug addiction in Saskatchewan. Funding for 2005–2006 included $10 million of new annual funding in addition to the $4.7 million increase in the 2005–2006 budget for addictions programming. This amounted to a 60 per cent increase in substance abuse prevention and treatment funding.

Saskatchewan has also made exciting progress in developing new electronic health record (EHR) technologies; we were successful in securing funding from Canada Health Infoway to launch a number of important new projects such as the Pharmaceutical Information Program (PIP). We will continue to work closely with our health delivery partners to introduce innovative technologies for improving the health of our citizens. The EHR program will ensure authorized front-line care providers have access to the information they need — improving the quality, access and effectiveness of health care services across the province into the future.

Saskatchewan Health and the health care system provide a wide range of services through a complex delivery system that includes Regional Health Authorities, the Saskatchewan Cancer Agency, affiliated health care organizations and a range of professionals many of whom are in private practice. The range and number of services provided are partially illustrated by the following examples of activity:

- 128,700 annual in-patient admissions or 2,100 (acute, psychiatric and rehabilitation) patients in hospital beds on any given day;
- 93,700 surgeries and select ambulatory procedures (e.g., endoscopies and biopsies) per year or 257 per day;
- 4.6 million visits per year or 12,600 family physician visits per day;
- 2,500 visits to specialists per day;
- 400,000 immunizations per year; and
- more than 40,000 mammograms per year.

The health system employs over 37,000 individuals, includes 26 self-regulated health professions, and operates 269 health facilities.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of *The Department of Health Act* authorizes that the Minister of Health may:

- pay part of, or the whole of, the cost of providing health services for any persons or classes of person who may be designated by the Lieutenant Governor in Council;
- make grants or loans or provide subsidies to regional health authorities, health care organizations or municipalities for providing and operating health services or public health services;
- pay part of or the whole of the cost of providing health services in any health region or part of a health region in which those services are considered by the Minister to be required;
- make grants or provide subsidies to any health agency that the Minister considers necessary; and
- make grants or provide subsidies to stimulate and develop public health research and to conduct surveys and studies in the area of public health.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* provide the authority for the Minister of Health to establish and administer a plan of medical care insurance for residents. The *Regional Health Services Act* provides the authority to establish 12 regional health authorities, replacing the former 32 district health boards.

Sections 5 and 11 of *The Cancer Foundation Act* provide for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Department of Health, regional health authorities and the Saskatchewan Cancer Agency for 2005–2006 are outlined in *The Department of Health Act*, *The Regional Health Services Act* and *The Cancer Foundation Act*.

1.2 Reporting Relationship

The Department of Health is directly accountable, and regularly reports, to the Minister of Health on the funding and administering the funds for insured physician, surgical-dental and hospital services.

Section 36 of The *Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit to the Legislative Assembly an annual report concerning the medical care insurance plan.

The *Regional Health Services Act* prescribes that a regional health authority shall submit to the Minister of Health:

- a report on the activities of the regional health authority; and
- a detailed, audited set of financial statements.

Section 54 of *The Regional Health Services Act* requires that the regional health authority shall submit to the Minister any reports that the Minister may request from time to time. All regional health authorities are required to submit a financial and health service plan to Saskatchewan Health.

The Cancer Foundation Act prescribes that the Cancer Foundation shall, in each fiscal year, submit a report about its business and a financial statement to the Minister of Health for the fiscal year immediately preceding.

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 regional health authorities, the

Saskatchewan Cancer Agency and to physicians and dental surgeons for insured physician and surgical-dental services.

Section 57 of *The Regional Health Services Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by the regional health authority, shall audit the accounts of a regional health authority at least once in every fiscal year. A detailed, audited set of financial statements must be submitted annually, by each regional health authority, 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 representative.

The most recent audits were for the year ended March 31, 2006.

The audits of the Government of Saskatchewan, regional health authorities and Saskatchewan Cancer Agency are tabled in the Saskatchewan Legislature each year. The reports are available to the public directly from each entity or are available on their websites.

The Provincial Auditor's Office of Saskatchewan also prepares reports to the Legislative Assembly of Saskatchewan. These reports are designed to assist government in managing public resources and to improve the information provided to the Legislative Assembly. They are available on the Provincial Auditor's website.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Regional Health Services Act was proclaimed on August 1, 2002, to replace The *Health Districts Act* as the authority to amalgamate the existing 32 health districts into 12 regional health authorities. Section 8 of *The Regional Health Services Act* (the Act) gives the Minister the authority to provide funding to a regional health authority or a health care organization for the purpose of the Act.

Section 10 of *The Regional Health Services Act* permits the Minister to designate facilities including hospitals, special-care homes and health centres. Section 11 allows the Minister to prescribe standards for delivering services in those facilities by regional health authorities and health care organizations that have entered into service agreements with a regional health authority.

The Act sets out the accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual operational and financial and health service plans for Ministerial approval (sections 50–51); establishing community advisory networks (section 28); and reporting critical incidents (section 58). The Minister also has the authority to establish a provincial surgical registry to help manage surgical wait times (section 12). The Minister retains authority to inquire into matters (section 59); appoint a public administrator if necessary (section 60); and approve general and staff practitioner by-laws (sections 42–44).

Funding for hospitals is included in the funding provided to regional health authorities.

As of March 31, 2006, the following facilities were providing insured hospital services to both in- and out-patients:

- 66 acute care hospitals provided in- 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.

A comprehensive range of insured services is provided by hospitals. These may include: public ward accommodation; necessary nursing services; the use of operating room and case room facilities; required medical and surgical materials and appliances; x-ray, laboratory, radiological and other diagnostic procedures; radiotherapy facilities; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all drugs, biological and related preparations required for hospitalized patients; and services rendered by individuals who receive remuneration from the hospital.

The *Action Plan for Saskatchewan Health Care* established new hospital categories and outlined a standard array of services that should be available in each hospital. Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals.

One of the elements of the Action Plan is to provide reliable, predictable hospital services, so people know what they can expect 24 hours a day, 365 days a year. While not all hospitals will offer the same kinds of services, reliability and predictability means:

- it is widely understood which services each hospital offers; and
- these services will be provided on a continuous basis, subject to the availability of appropriate health providers.

This service delivery framework will ensure quality, predictable hospital services and help guide decisions about where to invest new funds.

Regional health authorities have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs and available health professional funding resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, which takes into account such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. The process is initiated by a regional health authority and, depending on the specific service request, it could include consultations involving several branches within Saskatchewan Health as well as external stakeholder groups such as health regions, service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. Amendments were made in April and October 2005 to the Physician Payment Schedule of The Saskatchewan Medical Care Insurance Payment Regulations (1994) in accordance with an agreement reached with the Saskatchewan Medical Association. Those amendments provided for the addition of new insured physician services, changes in payment levels for selected services, and definition or assessment rule revisions to existing selected services with significant monetary impact. All new fee items for physicians can be found in the Physician's Newsletter at:

- www.health.gov.sk.ca./ic_pub_2005oct1_pps.html
- www.health.gov.sk.ca/ic_pub_2005apr1_pps.html

The *Saskatchewan Health Medical Services Branch 2005–2006 Annual Statistical Report* is available on the website: www.health.gov.sk.ca/mc_publications.html

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, 2006, there were 1,719 physicians licensed to practice in the province and eligible to participate in the medical care insurance plan.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, must fully opt out of all insured physician services. The "opted-out" physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2006, there were no "opted-out" physicians in Saskatchewan.

Insured physician services are those 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 Payment Regulations (1994) of *The Saskatchewan Medical Care Insurance Act*.

There were approximately 3,100 different insured physician services as of March 31, 2006.

A process of formal discussion between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services (modernization) with significant monetary impact. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service or significant revisions occur to the Physician Payment Schedule,

a regulatory amendment is made to the Physician Payment Schedule.

Although formal public consultations are not held, 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. As of March 31, 2006, 78 dental specialists were providing such services.

Amendments were made in April 2003, to The Saskatchewan Medical Insurance Branch Payment Schedule for Insured Services Provided by a Dentist. Those amendments provided for changes in payment levels for selected services.

Dentists may 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.

There were no “opted-out” dentists in Saskatchewan as of March 31, 2006.

Insured surgical-dental services are limited to: services in connection with maxillo-facial surgery required as a result of trauma; treatment services for the orthodontic care of cleft palate; extraction of teeth when medically required for the provision of heart surgery, services for chronic renal disease and services for total joint replacement by prosthesis when a proper referral has been made and prior approval obtained from the Medical Services Branch; and certain services in connection with abnormalities of the mouth and surrounding structures.

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 provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service.

Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

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 regional health authority; services provided by health facilities other than hospitals unless through an agreement with Saskatchewan Health; non-emergency cataract surgery, MRIs and bone densitometry 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; and services received under other public problems including *The Workers' Compensation Act*, the federal Department of Veteran Affairs and *The Mental Health Act*.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with regional health authorities, 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 regional health authorities, physicians and dentists.

Insured hospital services could be de-insured by the government if they were determined to be no longer medically necessary. The process is based on discussions among regional health authorities, practitioners and officials from the Department of Health.

Insured surgical-dental services could be de-insured if they were determined not to be medically necessary. 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 they were determined not to be 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 2005–2006.

3.0 Universality

3.1 Eligibility

The *Saskatchewan Medical Care Insurance Act* (sections 2 and 12) and The Medical Care Insurance Beneficiary and Administration Regulations define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage. The penalty provisions in section 11 of the Act (Duty to Register) provide for a fine of up to $50,000 for giving false information or withholding information necessary for registering an individual.

Eligibility is limited to residents. A "resident" means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor-in-Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following the establishing 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 insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police (RCMP), federal inmates and refugee claimants; visitors to the province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g. students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the RCMP, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

3.2 Registration Requirements

The following 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, 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 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 in December 2008.)

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 and over living in the parental home or on their own must self-register.

The number of persons registered for health services in Saskatchewan on June 30, 2005, was 1,021,080.

3.3 Other Categories of Individuals

Other categories of individuals who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, student permit 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 an employment/student permit, Minister's permit or permanent resident, that is, landed immigrant record.

On June 30, 2005, there were 5,439 such temporary residents registered with Saskatchewan Health.

4.0 Portability

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada. There were no changes to the in-Canada temporary absence provisions in 2005–2006.

Continued coverage during a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- employment of up to 12 months (no documentation required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority for paying in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of The Saskatchewan Medical Care Insurance Payment Regulations (1994) provides payment for physician services to Saskatchewan beneficiaries temporarily residing outside the province.

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. The reciprocal arrangement for physician services applies to every province except Quebec.

Payments/reimbursement to Quebec physicians, for services to Saskatchewan residents, are made at Saskatchewan rates (Saskatchewan Physician Payment Schedule). However, the physician fees may be paid at Quebec rates with prior approval. In recent years, the out-of-province reciprocal hospital per diem billing rates have increased significantly.

In 2005–2006, expenditures for insured physician services in other provinces were $20.54 million. Insured hospital services in other provinces were $44.72 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations 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 the expiration of the approved period as follows:

- education: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- contract employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations provides open-ended temporary absence coverage for persons whose principal place of residence is in Saskatchewan, but who are not able to satisfy the annual six months physical presence requirement because the nature of their employment requires travel from place to place outside Canada (e.g. cruise line workers).

Section 6.6 of *The 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.

In 2005–2006, $2.03 million was paid for in-patient hospital services and $1.49 million was spent on out-patient hospital services outside Canada. In 2005–2006, expenditures for insured physician services outside Canada were $695,900.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical out-of-province 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.

Prior approval from the Department must be obtained by the patient's specialist for alcohol and drug, mental health and problem gambling services; and cataract surgery services, bone densitometry and non-urgent MRI when provided out-of-province.

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 specialist must seek prior approval from the Medical Services Plan of Saskatchewan Health.
- The Saskatchewan Cancer Agency is consulted for out-of-country cancer treatment requests. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

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 providing 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, 2006, Saskatchewan had 3,073 staffed hospital beds in 66 acute care hospitals, including 2,537 acute care beds, 218 psychiatric beds and 325 other beds. The Wascana Rehabilitation Centre had 48 rehabilitation beds and 204 extended care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

Saskatchewan's Health Workforce Action Plan

In September 2004, Canada's First Ministers agreed to accelerate their work on health human resource (HHR) action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals. They agreed to make their action plans public by December 31, 2005, including targets for the training, recruitment and retention of professionals.

On December 14, 2005 *Working Together: Saskatchewan's Health Workforce Action Plan* was released. The Plan expanded on 2001 *Action Plan for Saskatchewan Health Care*. Extensive consultations took place with stakeholders while developing the plan, including a conference focused

on *Finding Common Ground*, hosted by the Canadian Policy Research Network (CPRN). The purpose of this event was to bring together the major partners to discuss the key elements of a provincial HHR plan. The CPRN facilitated a structured dialogue of the key issues to help achieve consensus on key elements of a framework, solutions and courses of action.

The Plan contains the following 5 goals:

- that the health care system have a sufficient number and effective mix of health care professionals who are used fully to provide safe, high-quality care;
- that the health system have safe, supportive and quality workplaces that help to retain and recruit health care professionals;
- that Aboriginal people fully participate in the health sector in all health occupations;
- that the education and training supply of Saskatchewan health care professionals be aligned with projected workforce requirements and health service needs; and
- that the health workforce be innovative, flexible and responsive to changes in the health system.

A copy of *Working Together: Saskatchewan's Health Workforce Action Plan* can be found at: www.health.gov.sk.ca. A copy of the CPRN conference documents can be found at www.cprn.org. These documents include a pre-conference report entitled: *Finding Common Ground: Consultations and Directions*, as well as the final conference report entitled: *Setting Priorities and Getting Direction.*

The Workforce Action Plan strives to improve Saskatchewan's self-sufficiency in training its own health professionals, within available resources. At the same time, it proposes employment opportunities for newly trained professionals, building a representative workforce, drawing upon the experience of veteran employees to mentor new graduates, better aligning education with health service needs, and establishing a steering committee to help implement the plan and guide continued planning efforts.

Saskatchewan's plan has been enjoying kudos from a number of groups at the national level. The Health Council of Canada noted the Saskatchewan plan for its innovative health care planning, and Saskatchewan ranked highest among all provinces and territories that reported health human resources action plans.

The plan identifies a number of initiatives/actions that will assist in recruiting and retaining nurses including:

- establishment of a provincial recruitment agency;
- enhanced clinical placement capacity;
- resources to support Occupational Health and Safety initiatives, training and research;
- working with our training and learning institutions, as well as our Aboriginal community to bridge our youth into health programs; and
- work related to recruitment of internationally educated health professionals.

Province-wide Employee Opinion Survey

Regional health authorities conducted a province-wide employee opinion survey in 2005–2006. The survey results were officially released on December 12, 2005. Health employers are using the survey results to develop more specific actions to improve workplaces, and help fulfil regional health authority accreditation requirements.

Based on the survey company's (NRC Picker) national database, Saskatchewan healthcare employees are more positive on average than their national counterparts within the NRC Picker database. Survey results showed that physical environment, and safety and respect were the highest positively rated topic areas. It also showed that the learning environment was the lowest positively rated topic area.

Bursary Program

Saskatchewan Health administers a Bursary Program, which is a recruitment and retention tool designed to improve the number of health professionals working in publicly funded organizations in the province.

Bursaries are awarded on a competitive basis based upon criteria that match the program goals. Those who are awarded a bursary agree to a return-service contract that commits them to work in a publicly funded facility in Saskatchewan upon graduation for a set period of time. Bursary amounts vary by discipline as well as the amount of return service. For each year of bursary assistance, students commit to one year if they accept a position in rural or northern Saskatchewan and two years if they work in the urban centres of Regina or Saskatoon. Failure to complete their return service means that they must repay the bursary assistance with interest.

The number of new bursaries awarded to health science (non-physician) students has been increased substantially from 2001–2002 when 27 bursaries were awarded, to

2005–2006 in which 305 new bursaries were awarded. Bursaries are awarded to a wide range of nursing and allied health disciplines, with 20 types of allied health bursaries and six categories of nursing bursaries.

Negotiations

During the 2005–2006 fiscal year, a 3-year collective agreement was reached with the Saskatchewan Union of Nurses and a 4-year collective agreement was reached with the provider unions.

Supply of Health Providers

In looking at the trend of selected health professionals, the majority of Saskatchewan's health professionals have increased between 1995 and 2004 (Table 1).

Regarding the availability of selected diagnostic, medical, surgical and treatment equipment and services in facilities providing insured hospital services, Saskatchewan Health notes the following:

- MRI machines are located in Saskatoon (2) and Regina (2). Regina Qu'Appelle Regional Health Authority's second MRI became operational in December, 2005.

Table 1. Selected Allied Health Professionals, Saskatchewan and Canada

Occupations	Total				Saskatchewan Per 100,000 Population, 2004
	Saskatchewan			Canada	
	1995	2000	2004	2004	
Audiologists	n/a	n/a	35	1,175	4
Dental Hygienists	131	162	182	6,892	18
Dieticians	182	222	251	7,783	25
Respiratory Therapists	92	93	103	7,274	10
Social Workers	449	930	1,019	28,689	102
Speech-Language Pathologists	n/a	n/a	218	6,062	22
Medical Laboratory Technologists	998	972	949	19,401	95
Medical Physicists	7	10	10	314	1
Medical Radiation Technologists	418	438	429	15,693	43
Occupational Therapists	136	203	214	10,984	22
Optometrists	106	109	113	3,941	11
Pharmacists	1,043	1,108	1,170	28,537	118
Physiotherapists	407	521	526	15,607	83
Psychologists	71	74	404	14,695	41

n/a — Data not available.

Source: Health Personnel Provincial Profiles 2004, Canadian Institute for Health Information (CIHI): Last updated June 2006.

Note: Comparing the number of professionals per 100,000 population may not provide a good comparison, as it does not recognize the different ways health services are delivered.

- CT scanners are available in Saskatoon (4), Regina (3), Prince Albert (1), Swift Current (1), Moose Jaw (1), Yorkton (1), North Battleford (1) and Lloydminster (1).
- Renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton, Swift Current, North Battleford, and Moose Jaw.
- Cancer treatment services are provided by the Saskatchewan Cancer Agency's two cancer clinics, the Saskatoon Cancer Centre and the Allan Blair Cancer Centre in Regina. In calendar year 2005, approximately 5,000 new patients began treatment for cancer. Both centres provided approximately 39,000 radiation therapy treatments and 17,500 chemotherapy treatments to cancer patients in Saskatoon and Regina.
- Sixteen (16) sites are involved in the Community Oncology Program of Saskatchewan (COPS) 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. In 2004, over 1,000 patients made approximately 6,400 visits to COPS centres for treatment.
- Approximately 73 per cent 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 per cent is provided in six mid-sized hospitals in Prince Albert, Moose Jaw, Yorkton, Swift Current, North Battleford and Lloydminster, with the remaining surgery performed in smaller hospitals across the province.
- Telehealth Saskatchewan links continue 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 2005–2006 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. In 2005–2006, approximately 19,600 MRI tests and approximately 105,000 CT tests were performed.
- Telehealth Saskatchewan has proven to be an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health continues to support the network. In 2005–2006 eight additional sites were added, which brings the number to 26 sites.
- The Chronic Renal Insufficiency (CRI) Clinics that were established in the Regina Qu'Appelle and Saskatoon regions in summer 2001 continue to grow. The goals of these clinics are to delay the need for dialysis and to better prepare patients in making their treatment choices: haemodialysis, peritoneal or home dialysis or transplant. The number of patients served by these clinics surpasses the number of patients on dialysis. (During the period December 31, 2004 to December 31, 2005, the number of CRI patients grew from 813 to 920, an increase of 13.2 per cent.)
- The Cancer Agency is responsible for the provincial Screening Program for Breast Cancer. The Screening Program has seven sites around the province and one mobile mammography unit that travels into communities not served by a stationary site. The Screening Program provides mammograms to between 34,000 and 37,000 women annually.
- The Prevention Program for Cervical Cancer is a Cancer Agency Program that has the goal of increasing participation in regular pap testing and tracking follow-up of unsatisfactory and abnormal test results. In 2005 the program sent out 115,000 result notices and 103,000 recall/reminder letters.
- The Provincial Malignant Hematology/Stem Cell Transplant Program continues to provide transplants to Saskatchewan residents. In 2005–2006, 38 patients with aggressive or advanced blood or other system cancers received stem cell or bone marrow transplants. The program also provides teaching as a formal part of the hematology clinic rotation for residents of Internal Medicine at the University of Saskatchewan.

Capital equipment purchases by regional health authorities is consistent with the criteria established under the February 2003 Health Accord. Regional health authority acquisitions are reviewed to ensure consistency with provincial health strategies and priorities and Health Accord principles. Capital equipment acquisitions in 2003–2004 supported enhanced access to diagnostic imaging and surgical services.

Saskatchewan Health continues to place priority on promoting surgical access and improving the province's surgical system. Saskatchewan Health, with advice from the Saskatchewan Surgical Care Network (SSCN), is leading the country in implementing key surgical care system initiatives.

Saskatchewan has already developed and implemented a Patient Assessment Process, a Surgical Patient Registry and Target Time Frames for Surgery as part of Saskatchewan Health's Action Plan.

The Patient Assessment Process will increase consistency and fairness by standardizing the factors physicians use to assess their patients' level of need for surgery. This will help to ensure those with the greatest need for surgery will receive it first.

The Surgical Patient Registry tracks patients needing surgery in the province. Information from this comprehensive database will allow the surgical care system to improve the management of surgical access, assist in determining system capacity and resource requirements, and reduce wait times for patients.

Target Time Frames for Surgery will allow the health regions to better monitor and track patients and to help ensure they receive care according to their level of need. In March 2004, Target Time Frames for Surgery were announced as "performance goals" for the surgical care system. On the recommendation of the Saskatchewan Surgical Care Network (SSCN), the number of Priority Levels for surgery was reduced from the initial six levels to four levels (plus emergency surgery which is to be recorded and reported separately) as of April 2006, to give surgeons and regions more flexibility in managing wait lists to shorten maximum wait times.

In January 2003, the Saskatchewan surgical website was launched. Located at www.sasksurgery.ca, this surgical access website provides a range of surgical care system information and wait list information including wait time and wait list data, and physician location and specialty. The web site also provides information on surgeries performed, patients waiting and waiting times, as well as how the system works and how to access surgical services in the Province.

Saskatchewan Health is currently working closely with members of the health regions, physicians and other health partners to maximize access to diagnostic imaging services in Saskatchewan. The focus is on improving access to diagnostic services (MRI, CT), while at the same time providing a basis for improved, sustainable health delivery in the future.

On January 31, 2005, the Minister of Health announced the establishment of a Diagnostic Imaging Network. This Network is a partnership among clinicians, service providers, regional health authorities, regulatory agencies, health training institutions, community and government that works toward the goal of ensuring equitable access to quality diagnostic imaging services in Saskatchewan. Through collaboration with participating partners, the Network acts as a provincial advisory body to assist in province-wide strategic planning and coordination of the diagnostic imaging system.

5.3 Access to Insured Physician and Surgical-Dental Services

As of March 31, 2006, there were 1,719 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 990 (57.6 per cent) were family practitioners and 729 (42.4 per cent) were specialists.

As of March 31, 2006, there were approximately 373 practising dentists and dental surgeons located in all major centres in Saskatchewan. Seventy-eight provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2005–2006 to recruit and retain physicians whereby enhancing access to insured physician services and reducing waiting times.

Specialist Programs:

- A Specialist Physician Enhancement Training Program provides grants of up to $80,000 per year to allow practicing specialists the opportunity to obtain additional training and requires a return service commitment.
- A Specialist Emergency Coverage Program compensates specialist physicians who make themselves available to provide emergency coverage to acute care facilities.
- The Specialist Resident Bursary Program offers 15 bursary spots per year to residents for a maximum of three years funding with a return-of-service commitment.

- The Foreign Certified Specialists' initiative implemented in 2004–2005 provides funding to ensure that these specialists are paid rates equivalent to Canadian certified specialists.

Rural and Regional Programs:

- A pilot Regional Practice Establishment Program provides grants of $10,000 to eligible family physicians who establish a practice in a regional centre for a minimum of 18 months.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program, which compensates physicians providing emergency room coverage in rural areas and helps those communities with fewer than three physicians gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Programs make grants of $18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Family Medicine Resident Bursary Program provides bursaries of $25,000 to family medicine residents to help them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $15,000 to medical students who sign a return service commitment to a rural community.
- The Rural Practice Enhancement Training Program 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 Care 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 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.
- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to help stabilize 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.

Other Programs:

- 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 Program.
- A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.
- The Parental Leave Program was developed in 2004 to provide benefits for self-employed physicians who take a maternity, paternity or adoption child care leave from clinical practice.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by section 48 of *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 begin discussing 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 select a third member; and
- the Board has the authority to make a decision binding on the parties.

The latest three-year agreement with the Saskatchewan Medical Association, which expires March 31, 2006, provided increases in the Physician Payment Schedule of 8.3 per cent effective October 1, 2003, and 6 per cent on April 1, 2004 and 2005. Similar increases were applied to non fee-for-service physicians. Additional improvements included a total of $11.2 million to bolster recruitment and retention programs and $3 million per year for new items and modernization of the Payment Schedule. Negotiations for a new agreement began in January 2006.

Section 6 of The Saskatchewan Medical Care Insurance Payment Regulations, 1994, 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. Total expenditures for in-province physician services and programs in 2005–2006 amounted to $547.6 million: $357.4 million for fee-for-service billings; $20.8 million for Emergency Coverage Programs of which about $6 million was paid through fee-for-service; $150.6 million in non-fee-for-service expenditures; and $18.8 million for Saskatchewan Medical Association programs as outlined in the agreement.

5.5 Payments to Hospitals

In 2005–2006, funding to regional health authorities was based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. Each regional health authority is given a global budget and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes.

Regional health authorities may receive additional funds for providing specialized hospital programs, e.g. renal dialysis, specialized medical imaging services and specialized respiratory services, or for providing services to residents from other health regions.

Payments to regional health authorities for delivering services are made pursuant to section 8 of *The Regional Health Services Act*. The legislation provides the authority for the Minister of Health to make grants to regional health authorities and health care organizations for the purposes of the Act and to arrange for providing services in any area of Saskatchewan if it is in the public interest to do so.

Regional health authorities provide an annual report on the aggregate financial results of their operations.

6.0 Recognition Given to Federal Transfers

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health Transfer(CHT)in the Department of Health 2005–2006 Annual Report, the 2005–2006 Annual Budget and related budget documents, its 2005–2006 Public Accounts, and the Quarterly and Mid-Year Financial Reports. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents.

Federal contributions have also been acknowledged on the Saskatchewan Health website, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums.

7.0 Extended Health Care Services

As of March 31, 2006, the range of extended health care services provided by the provincial government included long-term residential care services for Saskatchewan residents, certain community-based health services such as home care, as well as a wide range of other health, social support, mental health, addiction treatment and drug benefit programs.

Nursing Home Intermediate Care Services

Special-care homes provide institutional long-term care services to meet the needs of individuals, primarily 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 by Saskatchewan Health through regional health authorities and are governed by *The Housing and Special-care Homes Act* and regulations.

Public Health Services of regional health authorities provide immunization for 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. This applies to influenza and pneumococcal vaccines.

Home Care Services

The Home Care Program provides an option for people 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 with palliative, acute and supportive care needs. Services include assessment and care coordination, nursing, personal care, respite care, homemaking, meals, home maintenance, therapy and volunteer services. Individualized funding is an option of the Home Care Program. It provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is funded by Saskatchewan Health, delivered by the Regional Health Authorities, and governed by *The Regional Health Services Act*.

Ambulatory Health Care Services

Saskatchewan regional health authorities provide a full range of mental health and alcohol and drug services in the community which are governed by *The Mental Health Services Act*.

Regional health authorities offer podiatry services including assessment, consultation and treatment. The Chiropody Services Regulation of *The Department of Health Act* provides chiropodists and podiatrists with the ability to self-regulate their profession.

Regina Qu'Appelle and Saskatoon regional health authorities provide a Hearing Aid Program. Services under this program, governed by the *Hearing Aid Act* and regulations and the *Regional Health Services Act*, include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids.

Rehabilitation therapies such as occupational and physical therapies and speech and language pathology are offered by the regional health authorities to help individuals of all ages improve their functional independence. The services are provided in hospitals, rehabilitation centres, long-term care facilities, community health centres, schools and private homes and include assessment, consultation and treatment. The *Regional Health Services Act* and the Community Therapy Regulations, which are under the authority of *The Department of Health Act*, govern these programs.

Adult Residential Care Services — Mental Health Services

Apartment Living Programs and Group Homes, governed by the *Residential Services Act* provide a continuum of support and living assistance to individuals with long-term mental illnesses.

Saskatchewan Health, in partnership with the Heartland Regional Health Authority, offers a rehabilitation program for people and families struggling with eating disorders. BridgePoint Centre delivers this program and abides by the *Registered Charities* and *The Income Tax Act*, and *The Regional Health Services Act*.

Alcohol and Drug Services

The provision of Alcohol and Drug services generally falls under *The Regional Health Services Act*. Facilities that provide residential alcohol and drug services are licensed as listed below. Saskatchewan Health or the regional health authorities contract with community-based and non-profit organizations governed by *The Non-profit Corporations Act* to provide services.

Detoxification services provide a safe and supportive environment in which the client is able to undergo the process of alcohol and/or other drug withdrawal and stabilization. Accommodation, meals and self-help groups are offered for up to 10 days.

In-patient services are provided to individuals requiring intensive rehabilitative programming for 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.

Long-term residential services provide maintenance and transition programs 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.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	1,024,788	1,024,827	1,007,753	1,018,057	1,021,080

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	66	65	66	65	66
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. other	0	0	0	0	0
e. total	67	66	67	66	67
3. Payments ($):					
a. acute care	720,174,393 [1]	not available	811,561,671 [2]	867,261,000 [2]	922,675,000 [2]
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	39,656,384	not available	not available [3]	not available [3]	not available [3]
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	759,830,777	not available	811,561,671	867,261,000	922,675,000 [2]
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

1. Based on provincial government funding summaries provided to the former health districts.
2. This number includes estimated government funding to Regional Health Authorities (RHAs)(based on total projected expenditures less non-government revenue), as provided to Saskatchewan Health through the RHA annual operational plans.
   — Acute care funding includes: acute care services , specialized hospital services, and in-hospital specialist services.
   — Does not include inpatient rehabilitative care, inpatient mental health, or addiction treatment services.
   — Does not include payments to Saskatchewan Cancer Agency for outpatient chemotherapy and radiation .
3. Comparable annual information is not available at this time.

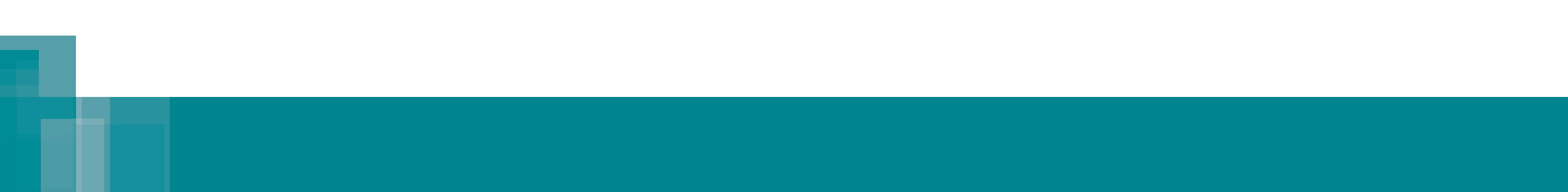
Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	937	936	946	967	990
b. specialists	696	700	716	718	729
c. other	0	0	0	0	0
d. total	1,633	1,636	1,662	1,685	1,719
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	not available	not available	not available	not available	not available
b. total payments	394,831,408	421,709,330	449,108,573	491,805,817	528,759,380
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	6,760,156	6,631,582	6,434,620	6,397,252	6,388,932
b. specialists	3,700,801	3,637,879	3,499,069	3,573,354	3,644,949
c. other	0	0	0	0	0
d. total	10,460,957	10,269,461	9,933,689	9,970,606	10,033,881
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	137,541,402	139,410,263	147,119,703	160,986,686	172,656,264
b. specialists	144,566,069	151,061,558	157,419,082	176,829,943	190,228,546
c. other	0	0	0	0	0
d. total	282,107,471	290,471,821	304,538,785	337,816,629	362,884,810
13. Number of services provided through fee for service, by category:					
a. medical	6,017,477 [4]	5,788,055 [4]	5,841,196 [4]	5,801,265 [4]	5,779,846 [4]
b. surgical	994,321 [5]	984,405 [5]	998,210 [5]	1,015,900 [5]	1,020,399 [5]
c. diagnostic	2,262,256 [6]	2,179,286 [6]	2,174,220 [6]	2,187,590 [6]	2,248,621 [6]
d. other	1,186,903 [7]	1,317,715 [7]	920,063 [7]	965,851 [7]	985,015 [7]
e. total	10,460,957	10,269,461	9,933,689	9,970,606	10,033,881
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	160,742,594 [4]	162,032,557 [4]	170,595,840 [4]	192,359,771 [4]	208,290,658 [4]
b. surgical	56,027,014 [5]	58,596,690 [5]	60,515,275 [5]	70,671,415 [5]	75,149,703 [5]
c. diagnostic	44,488,404 [6]	48,355,683 [6]	51,280,830 [6]	57,032,791 [6]	61,675,211 [6]
d. other	20,849,458 [7]	21,486,890 [7]	22,145,286 [7]	17,752,650 [7]	17,769,239 [7]
e. total	282,107,470	290,471,821	304,537,231	337,816,627	362,884,810

4. Includes visits, hospital care, psychotherapy.
5. Includes surgeries, surgical assistance, obstetrics, anaesthesia.
6. Includes x-rays, laboratory services, diagnostics.
7. Includes surcharges, premiums, on-call physician services.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	4,692	4,422	4,561	4,307	4,566
16. Total number of claims, out-patient.	45,320	50,401	45,510	51,678	55,067
17. Total payments, in-patient ($).	22,037,200	23,447,100	30,528,100	30,461,943	33,671,100
18. Total payments, out-patient ($).	5,836,500	7,144,800	6,405,900	9,345,190	11,044,200
19. Average payment, in-patient ($).	4,696.76	5,302.37	6,693.29	7,072.66	7,374.31
20. Average payment, out-patient ($).	128.78	141.76	140.76	180.83 [2]	200.56
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	444,430	458,100	509,784	513,694	542,651
22. Total payments ($).	15,520,000	16,948,900	19,477,300	19,868,600	20,541,894
23. Average payment per service ($).	34.92	37.00	38.21	38.68	37.85

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	252	287	231	254	248
25. Total number of claims, out-patient.	1,172	1,049	875	1,002	1,194
26. Total payments, in-patient ($).	1,009,400	1,891,800	728,400	730,849	2,033,300
27. Total payments, out-patient ($).	375,900	359,400	373,300	251,957	1,486,500
28. Average payment, in-patient ($).	4,005.56	6,591.64	3,153.25	2,877.36	8,198.79
29. Average payment, out-patient ($).	320.73	342.61	426.63	251.45	1,244.97
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	not available	not available	not available	not available	not available
31. Total payments ($).	588,100	1,129,300	583,200	510,600	695,900
32. Average payment per service ($).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of particpating dentists.	94	94	94	84	78
34. Number of services provided.	18,900	18,500	18,300	19,400	18,511
35. Total payments ($).	1,275,400	1,264,200	1,345,900	1,442,800	1,539,420
36. Average payment per service ($).	67.48	68.34	73.55	74.37	83.16



Alberta

Introduction: Alberta's Health Care System

Alberta provides medically necessary, insured services in a public system that follows the principles of the *Canada Health Act:* public administration, comprehensiveness, universality, portability and accessibility. Medically necessary services include hospital and physician services and specific kinds of services provided by oral surgeons and other dental professionals.

Health System Governance

Alberta's health care system is defined in legislation and is governed by the Minister of Health and Wellness. The Ministry of Alberta Health and Wellness provides strategic direction and leadership to the provincial health system. This role includes developing the overall vision for the health system, defining provincial goals, objectives, standards and policies, encouraging innovation, setting priorities and allocating resources. The ministry's role is to assure accountability and balance health service needs with fiscal responsibility. Alberta Health and Wellness also has a major role in protecting and promoting public health. This role includes: (1) monitoring the health status of the population; (2) identifying and working toward reducing or eliminating risks posed by communicable diseases and food-borne, drug and environmental hazards; (3) providing appropriate information to prevent the onset of disease and injury; and (4) promoting healthy choices. The *Regional Health Authorities Act* makes regional health authorities responsible to the Minister for ensuring the provision of health services that are responsive to the needs of individuals and communities. Regional health authorities ensure the provision of acute care hospital services, community and long-term care services, mental health services, public health protection and promotion services and other related services. The *Cancer Programs Act* makes the Alberta Cancer Board responsible to the Minister for providing cancer prevention and treatment services, education and research. The Alberta Mental Health Board advises the Minister on strategic and policy matters related to mental health programs and services. Regional health authorities and provincial health boards are also responsible for assessing needs, setting local priorities, allocating resources and monitoring performance for the continuous improvement of health service quality, effectiveness and accessibility. Alberta's health legislation can be accessed at:

www.health.gov.ab.ca/about/minister_legislation.html

Significant Events in 2005–2006

In 2005–2006 Alberta's health ministry started work on a new approach to health renewal and reform. The process began with the fundamental commitment that in Alberta a person's ability to pay would never determine their ability to access health care. Alberta's approach to health care renewal is about being open to new options and choices — choices that strengthen our health care system and allow us to get on with the things that need to be done. The approach emphasized improving choice and access, and addressed the need to curb health care costs to meet our ultimate goal of providing Albertans with a sustainable and high performing health system for the future.

In May 2005, the provincial government hosted the "Alberta Symposium on Health". The international symposium provided a unique opportunity for representatives of Alberta's health regions, communities, health organizations and professional groups to exchange information and experience and to consult with international experts. Some of the important lessons learned at the symposium were: (1) there is no single solution to the challenges in the health system, but rather improvements must evolve over time; (2) improvements must focus on the patient and emphasize evidence-based outcomes; and (3) solutions must meet the expectations and values of the society in which they take place.

Based on what was learned at the symposium, the Premier and the Minister announced, in July 2005, a series of action items in the *Getting on with Better Health Care* package. The action items identified ways for improving the health system in areas such as: disease and injury prevention, children's health, mental health, and the health needs of rural communities. The action items also referred to important strategies to improve performance in such areas as primary health care; new quality standards for long term care; the use of new technology such as Alberta Netcare (Alberta's electronic health record) to improve communications and reduce error; and increase the number of health system providers. These action items continue to be a driving force for continued improvement in the health system.

The first action item was to develop a *Health Policy Framework* that would provide clear and consistent direction to guide the decisions of health system leaders. The *Framework*, initially released in February 2006, opened the discussion about health care sustainability and was a catalyst for Albertans to provide their ideas about how the system needs to change. The *Framework* will set the stage for a sustainable, flexible and accessible health system for all Albertans.

Significant investments were made in Alberta Netcare to support province-wide technology enhancements and provide health professionals access to the patient information they need to make the best care decisions. Through the Diagnostic Imaging Strategy, $51.6 million was provided to digitize X-rays, Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) scans across the province. This helped to improve the quality of care for Albertans by providing doctors and patients with faster access to reports and images.

Additional funding was provided to address the recommendations of the MLA Task Force on Continuing Care Health Services and Accommodation Standards. Funding was provided to increase the number of nursing hours in long-term care facilities from 3.1 to 3.4 hours per resident day, support the implementation of new standards for medication management and accelerate the implementation of continuing care system projects to improve the availability of information used in decision making.

In 2005–2006, health facilities infrastructure became a joint responsibility of the Ministers of Infrastructure and Transportation, and Health and Wellness. In October 2005, $1.4 billion was announced for 20 capital projects of which $64.6 million was provided to the health authorities in 2005–2006.

The Alberta Alcohol and Drug Abuse Commission (AADAC) received funds which they allocated towards the development of youth detoxification and residential programs. AADAC opened 24 new addiction treatment beds to serve youth aged 12 to 17 years. This includes two four-bed detoxification programs and two eight-bed residential programs in Edmonton and Calgary. The residential program in Edmonton incorporates a group care model, while the program based in Calgary utilizes an adventure therapy wilderness model.

This was the first year funding was provided to help municipalities provide pre-hospital ground ambulance transportation. In addition, regional health authorities and the Alberta Mental Health Board received the first year of funding for 36 new Mental Health Innovation projects ranging from outreach programs, to day treatment and crisis intervention services. Funding was also provided to the Alberta Mental Health Board for two justice related mental health programs. The provincial Family Violence treatment program provides mandatory assessment and treatment services for perpetrators of family violence and the provincial Diversion program redirects individuals with mental illness who have committed minor offences from the criminal justice system into appropriate mental health, social and support services.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Government Organization Act* describes the departments of government that are to be administered by Ministers. Schedule 7 to this Act sets out the specific powers, duties and functions to be exercised or performed by the Minister of Health and Wellness. The Alberta Ministry of Health and Wellness administers the Alberta Health Care Insurance Plan on a non-profit basis and in accordance with the *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* has governed the

operation of the Alberta Health Care Insurance Plan. The Minister of Health and Wellness determines what services are covered by the Alberta Health Care Insurance Plan. Alberta Health and Wellness reviews scientific literature, consults with expert advisors, assesses policy, and considers funding and training that is required when deciding which medical products, services or devices will be covered under the Alberta Health Care Insurance Plan.

Alberta Health and Wellness registers eligible Alberta residents for coverage under the Plan and pays practitioners for insured services listed in the Schedule of Medical Benefits and the Schedule of Oral and Maxillofacial Surgery Benefits. Alberta Health and Wellness also provides funding to regional health authorities and provincial boards for the provision of insured hospital services.

1.2 Reporting Relationship

The Minister of Health and Wellness is fully accountable for the Alberta Health Care Insurance Plan, which is managed by the Minister's departmental staff. Under sections 13 and 14 of the *Government Accountability Act,* the Minister must prepare a business plan and an annual report for each fiscal year. The *Alberta Ministry of Health and Wellness Three-year Business Plan 2005 to 2008* was tabled in the Alberta Legislature on March 24, 2005. The Ministry's annual report documents the health care system's key activities, including the Alberta Health Care Insurance Plan, and provides consolidated financial statements for the previous fiscal year. It also provides information about key achievements and results in response to key performance measures and targets included in the previous year's business plan. The 2005–2006 Annual Report of the Alberta Ministry of Health and Wellness was publicly released September 26, 2006 and can be accessed at:

www.health.gov.ab.ca/resources/AR06.html

The Ministry also issues an annual statistical supplement on data related to the Alberta Health Care Insurance Plan. An announcement will be made when the 2005–2006 statistical supplement is available.

Under section 16 of the *Government Accountability Act,* "accountable organizations" (regional health authorities and provincial health boards) must prepare and provide to the Minister a business plan and annual report for each fiscal year. In addition, under section 9 of the *Regional Health Authorities Act,* regional health authorities and provincial health boards must provide to the Minister, a health plan indicating how the authority will carry out its responsibilities under section 5 of the Act, and how its performance will be measured. Health plans and business plans must be provided to the Minister by March 31 of each year. Health authority annual reports are due to the Minister by July 31 of each year, and are tabled in the Alberta Legislature within 15 days of the beginning of the fall session.

1.3 Audit of Accounts

The Auditor General of Alberta is the auditor of all government ministries, departments, regulated funds, and provincial agencies, and is responsible for assuring the public that the government's financial reporting is credible. The Auditor General reports on the adequacy of regulatory administration, management structures, accounting systems and management control systems, including those designed to ensure economy and efficiency. The Auditor General of Alberta audits the performance reporting, records and financial statements of the Ministry of Health and Wellness as well as regional health authorities and provincial health boards.

2.0 Comprehensiveness

2.1 Insured Hospital Services

In Alberta, regional health authorities are responsible to the Minister for ensuring the provision of insured hospital services with the exception of cancer hospitals, which are the responsibility of the Alberta Cancer Board. The *Hospitals Act*, the Hospitalization Benefits Regulation (AR 244/1990), the *Health Care Protection Act* and the Health Care Protection Regulation (AR 208/2000) define how insured services are provided by hospitals or designated surgical facilities. During 2005–2006 no amendments were made to the legislation regarding insured hospital services.

According to the legislation, the Minister must approve all hospitals and surgical facilities. A directory of approved hospitals in Alberta can be found at:

www.health.gov.ab.ca/regions/hospital_directory.pdf

Alberta's *Health Care Protection Act* governs the provision of surgical services through non-hospital surgical facilities. Ministerial approval of a contract between the facility operator and a regional health authority is required to provide insured services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta are also required. According to the College, there are currently 58 non-hospital surgical facilities with accreditation status. Of these, 26 facilities have contracts with regional health authorities to provide insured services.

According to the *Health Care Protection Act*, Ministerial approval for a contractual agreement shall not be given unless:

- the insured surgical services are consistent with the principles of the *Canada Health Act;*
- there is a current and likely future need for the services in the geographical area;
- the proposed surgical services will not have a negative impact on the province's public health system;
- there will be an expected benefit to the public;
- the regional health authority has an acceptable business plan to pay for the services;
- the proposed agreement contains performance expectations and measures; and
- the physicians providing the services will comply with the conflict of interest and ethical requirements of the *Medical Profession Act* and bylaws.

The publicly funded services provided by approved hospitals in Alberta range from the most advanced levels of diagnostic and treatment services for in- and out-patients to the routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are defined in the Hospitalization Benefits Regulation (AR244/1990). The Regulation is available at:

www.health.gov.ab.ca/about/minister_legislation.html

2.2 Insured Physician Services

The *Alberta Health Care Insurance Act* governs the payment of physicians for insured physician services under the Alberta Health Care Insurance Plan. Only physicians who meet the requirements stated in the *Alberta Health Care Insurance Act* are allowed to provide insured services under the Alberta Health Care Insurance Plan. In addition to physician services, a number of other practitioner services are covered under the Alberta Health Care Insurance Plan. They include services provided by podiatrists, optometrists and chiropractors. In 2005–2006 a change was made to the Alberta Health Care Insurance Regulation (sections 30 and 31) which removed the requirement that people exhaust the provincially funded limit for podiatrist and chiropractic visits prior to being able to have their private insurance companies cover a portion of the costs not covered by the Plan.

As of March 31, 2006, there were 7,108 practitioners (i.e. podiatrists, chiropractors, dentists and physicians) enrolled in the Alberta Health Care Insurance Plan. Before being registered with the Alberta Health Care Insurance Plan, a practitioner must complete the appropriate registration forms and include a copy of his or her license issued by the appropriate governing body or association, such as the College of Physicians and Surgeons of Alberta. Under section 8 of the *Alberta Health Care Insurance Act,* physicians may opt-out of the Alberta Health Care Insurance Plan. As of March 31, 2006, there were no opted-out physicians in the province.

The Medical Benefits Regulation and the Alberta Health Care Insurance Regulation define which medical services are insured. These services are documented in the Schedule of Medical Benefits, which can be accessed at:

www.health.gov.ab.ca/professionals/somb.html

The *Schedule of Medical Benefits* is continuously revised and updated; for example, the Obstetric and Gynecological portion of the Schedule was extensively revised in 2005–2006.

Insured physician services and any changes to the *Schedule of Medical Benefits* are negotiated among Alberta Health and Wellness, the Alberta Medical Association (AMA) and the regional health authorities. All changes to the *Schedule of Medical Benefits* require ministerial approval.

2.3 Insured Surgical-Dental Services

In Alberta a dentist may perform a small number of insured surgical-dental services, but the majority of procedures can only be billed to the Alberta Health Care Insurance Plan when performed by a dentist certified as an oral and maxillofacial surgeon who meets the requirements stated in the *Alberta Health*

Care Insurance Act. Under section 7 of the *Alberta Health Care Insurance Act,* all dentists are deemed to have opted into the plan. A dentist may opt out of the plan by notifying the Minister in writing of the effective date of their opting out and ensuring that each patient is advised of their opted out status before any service is provided to the patient. As of March 31, 2006 there were no dentists opted out of the Plan in Alberta.

Alberta insures a number of medically necessary oral surgical and dental procedures that are listed in the *Schedule of Oral and Maxillofacial Surgery Benefits* available at:

www.health.gov.ab.ca/professionals/allied.html

In 2005–2006 there were 230 dentists/oral surgeons providing insured services under the Alberta Health Care Insurance Plan. Although there is no formal agreement between dentists and Alberta Health and Wellness, the department meets with members of the Alberta Dental Association and College to discuss changes to the *Schedule of Oral and Maxillofacial Surgery Benefits*. All changes to the benefit schedule require ministerial approval.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Section 12 of the Alberta Health Care Insurance Regulation defines what services are not considered to be insured services. Section 4(2) of the Hospitalization Benefits Regulation provides a list of uninsured hospital services. Effective September 1, 2005, the Hospitalization Benefits Regulation was amended to remove preferred accommodation rates from the regulation and allow the Boards of regional health authorities to set these rates. The Health Care Protection Regulation was amended at the same time to remove the requirement that enhanced medical goods and services be listed in a schedule to this regulation and to remove the prescriptive formula used to calculate charges for enhanced goods or services. The changes allow regional health authorities to determine, in keeping with the provisions of the *Health Care Protection Act*, the range of enhanced goods or services that each is prepared to offer in response to patient preferences and the charges for these enhanced goods or services.

A new provincial policy for *Preferred Accommodation and Non-Standard Goods or Services* came into effect September 1, 2005 and is posted on the AHW website at:

www.health.gov.ab.ca/key/prefacc.pdf

The policy describes the province's expectations of regional health authorities and guides their decision-making with respect to provision of preferred accommodation and enhanced or non-standard goods and services. This policy framework requires regional health authorities to provide 30 days advance notice to other regional health authorities and the Minister's designate regarding the categories of preferred accommodation offered by the health region and the charges associated with each category. Regional health authorities are also required to provide 30 days advance notice to other regional health authorities and the Minister's designate regarding any goods or services that will be provided as non-standard goods or services. They are also required to provide information about the associated charge for these goods or services, and when applicable, the criteria or clinical indications that may qualify patients to receive it as a standard good or service. Finally, each regional health authority must publish and keep current a list of non-standard medical goods or services; these lists are periodically reviewed by Alberta Health and Wellness and the regional health authorities.

As of March 31, 2006, no regional health authority had notified the Minister's designate of any new enhanced or non-standard goods or services being provided through the region or of any changes to the preferred accommodation rates in effect on September 1, 2005.

3.0 Universality

3.1 Eligibility

Under the terms of the *Alberta Health Care Insurance Act*, all Alberta residents are eligible to receive publicly funded health care 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 the province his or her home, and is ordinarily present in Alberta. The term "resident" does not include a tourist, transient or visitor to Alberta. Persons moving permanently to Alberta from outside Canada are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. Temporary residents may also be eligible for coverage, if they intend to remain in Alberta for 12 months and their Canada entry documents are in order.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan include:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank in it; and
- persons serving a term in a federal penitentiary.

During 2005–2006 no amendments were made to the legislation regarding eligibility.

3.2 Registration Requirements

All new Alberta residents are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan. New residents in Alberta should apply for coverage within three months of arrival. Family members are registered on the same account for premium billing purposes. The Alberta Health Care Insurance Plan processes for registering Albertans and issuing replacement health cards require registrants to provide documentation that proves their identity, legal entitlement to be in Canada and Alberta residency. These requirements have improved security and confidentiality, while reducing the potential for fraud or abuse. As of March 31, 2006, there were 3,275,931 Alberta residents registered with the Alberta Health Care Insurance Plan. Under the *Health Insurance Premiums Act*, a resident may opt out of the Alberta Health Care Insurance Plan by filing a declaration with the Minister. As of March 31, 2006 there were 294 Alberta residents opted out of the Plan.

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. There were 22,033 people covered under these conditions as of March 31, 2006.

3.4 Premiums

The majority of Alberta residents are required to pay premiums. Exceptions include:

- dependants (residents, however, are required to pay premiums on behalf of their dependants);
- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank in it;
- persons serving a term in a federal penitentiary;
- seniors aged 65 and older, their spouses and dependants;
- individuals enrolled in special groups such as Alberta Widows' Pension or income support programs;
- anyone eligible for full premium assistance; and
- any resident who elects to opt-out of the plan.

Although Albertans are required to pay premiums, no resident is denied service due to an inability to pay. Two programs help lower-income, non-senior Albertans with the cost of their premiums: they are the "Premium Subsidy Program" and the "Waiver of Premiums Program".

4.0 Portability

4.1 Minimum Waiting Period

Under the *Alberta Health Care Insurance Act,* 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

The Alberta Health Care Insurance Plan provides coverage for the first 12 months of absence to eligible Alberta residents who temporarily leave Alberta for other parts of Canada. Residents who wish to maintain coverage for a longer period may apply for the following extensions of coverage:

- **Visit/Vacation:** up to 24 months coverage (requests to extend coverage for a period longer than 24 months are reviewed on a case-by-case basis);
- **Work/Business/Missionary Work:** up to 48 months; and
- **Post-secondary Education:** no limit (coverage continues until studies are completed).

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy Alberta Health and Wellness that Alberta is their permanent and principal place of residence.

Alberta participates in the inter-provincial hospital and medical reciprocal agreements. These agreements were established to minimize complex billing processes and help ensure timely payments to health practitioners and hospitals when they provide services to residents from other provinces and territories (Quebec does not participate in the medical reciprocal agreement). Under these agreements Alberta pays for insured services Albertans receive in other parts of Canada at the host province or territorial rates. More information on coverage during temporary absences outside Alberta is available at:

www.health.gov.ab.ca/ahcip/travel.pdf

4.3 Coverage During Temporary Absences Outside Canada

The Alberta Health Care Insurance Plan provides coverage for the first six consecutive months of temporary absence from Canada. Residents who wish to maintain coverage for a longer period may apply for the following extensions of coverage:

- four years (48 months) if the absence is due to work, business or missionary service.
- two years (24 months) if the absence is due to travel, personal visits or an educational leave (sabbatical).
- duration of studies if absence is due to full-time attendance at an accredited educational institute.

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy Alberta Health and Wellness that Alberta is their permanent and principal place of residence.

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 visit rate is $50 (Canadian), with a limit of one visit per day. The only exception is haemodialysis, which is paid at a maximum of $341 per visit, with a limit of one visit per day. Physician and allied health practitioner services are paid according to Alberta rates. More information on coverage during temporary absences outside Canada is accessible at:

www.health.gov.ab.ca/ahcip/travel.pdf

During 2005–2006 no amendments were made to the legislation regarding the portability of health insurance.

4.4 Prior Approval Requirement

Prior approval is not required for elective insured services received outside Alberta, except for high-cost items not included in reciprocal agreements, gender reassignment surgery, and gamma knife surgery. Prior approval is required for elective services received out-of-country and will only be given for insured services that are medically required, are not experimental, and are not available in Alberta or elsewhere in Canada. Approval by the Minister must be received before these services can be covered.

5.0 Accessibility

5.1 Access to Insured Health Services

All Alberta residents have access to provincially funded and insured health services regardless of where they live in the province. In the province, nine regional health authorities, the Alberta Cancer Board and the Alberta Mental Health Board cooperate with each other to ensure that all Albertans have access to needed health services. There are two major metropolitan regions, the Calgary Health Region and Capital Health (Edmonton), which provide provincially funded, province-wide services to Alberta residents who need tertiary-level diagnostic and treatment services.

5.2 Access to Insured Hospital Services

Alberta Health and Wellness, regional health authorities, the Alberta Cancer Board, and the Alberta Mental Health Board actively participate in a health workforce planning process to ensure an adequate supply of key personnel. The key professions utilized in providing insured hospital services include: physicians, nurses (RNs, LPNs, RPNs), pharmacists, rehabilitation therapists (OTs, PTs, RTs) and clinical support personnel. As of March 31, 2006 there were 49,640 health workforce practitioners in Alberta. These professions combined comprise approximately half of the total workforce employed in the province.

Alberta is committed to ensuring that Albertans have access to new health services and technologies, and that they are introduced based on clinical and economic evidence that respects benefits and costs. The Alberta Health Technologies Decision Process and the Alberta Advisory Committee on Health Technologies have been established to support coverage and funding decisions at the provincial level related to non-pharmaceutical services and technologies using an evidence-informed process.

Health authorities are required to develop capital equipment plans as part of their annual business plan submissions to the Minister of Health and Wellness. Funding for regional health authorities and provincial boards in 2005–2006 (which includes health services, hospitals, medical equipment and province-wide services) was $6.2 billion.

The Alberta government made a significant $2.26 billion commitment to additional capital investment in health infrastructure in 2005–2006. This will allow Alberta to continue to preserve and expand infrastructure, thus improving access to health services. The current provincial Capital Plan will provide for nearly 2,200 additional acute care beds at various hospitals throughout the province over the next ten years as well as targeted growth in capacity in areas such as surgical, diagnostic, ambulatory and emergency care.

Alberta mental health services were expanded, through funding from the three-year Mental Health Innovation Fund, with the approval of 36 new projects ranging from outreach programs to day-treatment and crisis intervention services. The projects will provide a variety of services across the province, including a seniors' mental health outreach service in the Chinook Health Region, a program to address mental health services for high needs children and their families in the Calgary Health Region, a day treatment and learning centre for youth in Red Deer, and crisis intervention services in rural and aboriginal communities.

Alberta tracks waiting time information (excluding urgent patients who are seen without delay) on the Alberta Waitlist Registry. The registry provides information on wait times for hip and knee replacement surgery, cataract surgery, cardiac surgery and MRI and CT examinations for both hospitals and community providers. The registry is accessible at:

www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp

The "Access Standards Gating Framework" was developed as a tool to assist selected health service areas to progressively reduce wait times. This is accomplished through standards development and new care path pilot testing and implementation in six service areas: cardiac; children's mental health; MRI/CT scans; breast and prostate cancer; hip and knee replacements and vision restoration. The implementation is at varying phases for each service.

The "Alberta Hip and Knee Replacement" pilot project was launched in April 2005. It tested a new care pathway for providing better access to hip and knee joint replacement surgeries, and for improving the delivery of orthopaedic care. Capital Health, the Calgary Health Region and the David Thompson Health Region participated in the pilot along with the Alberta Medical Association, the Alberta Orthopaedic Society and the Alberta Bone and Joint Health Institute. Interim findings showed: decreased wait time for first orthopaedic consult; decreased wait time between first orthopaedic consult and surgery; decreased length of stay in hospital; and improved satisfaction with the care provided among surveyed patients and physicians.

5.3 Access to Insured Physician and Dental-Surgical Services

Alberta Health and Wellness worked with health authorities to develop health workforce strategies. Data definitions have been established and health authorities now report health workforce information and statistics to help track and assess health workforce needs. Some of the actions

taken by Alberta Health and Wellness to improve access to physician services and reduce wait times include:

- Grants to the Community Medicine Residency Training Programs in Alberta were renewed to support the training of future public health physicians. Training rotations at Alberta Health and Wellness were offered to students and medical residents in order to highlight and enhance the important role of public health, enrich training within public health, and improve collaboration between public health and related fields.
- Devoting $3 million for the Alberta International Medical Graduate Program allowing for up to 14 additional residency seats for foreign-trained doctors now living in the province.
- The Telehealth Clinical Services Grant Fund helped to support 21 telehealth initiatives across Alberta. The fund supports new telehealth programs that allow Albertans, regardless of location, to have access to needed medical professionals and specialists. The programs that received grants covered a broad spectrum of medical fields including adolescent psychiatry, smoking cessation, cardiology, rural health and chronic disease management.
- Physician Locum Services provided weekend and short-term family physician and specialist replacements in response to more than 1,100 requests from rural Alberta physicians. Locum physician replacements help to maintain the continuity and convenience of medical service for rural Albertans.
- As part of its comprehensive program to educate, recruit and retain physicians for rural Alberta medical practice, a new program of the Alberta Rural Physician Action Plan offered 10 bursaries to medical students from rural areas of Alberta. The program reimburses tuition costs throughout their medical school training. Up to 10 bursaries will continue to be offered annually to rural Alberta students attending medical school in Alberta in return for a five-year commitment to practice in rural Alberta upon graduation.
- The Alberta Rural Family Medical Network was expanded by 10 entry positions (to 30 entry positions annually) to place more medical residents in rural Alberta, as preparation for rural practice upon graduation.

5.4 Physician Compensation

Most physicians are compensated through the Alberta Health Care Insurance Plan on a traditional, volume-driven, fee-for-service basis. Alternate Relationship Plans and Primary Care Networks for specialists and family physicians offer alternative compensation models to the fee-for-service payment system and contribute to better health outcomes by supporting innovative health care delivery.

Physician compensation is negotiated as part of a tri-lateral agreement involving the Alberta Medical Association, Alberta Health and Wellness and regional health authorities. The agreement also contains provisions to improve access to physician services. Under this agreement, Alternate Relationship Plans (ARPs) have been established to enhance specialist physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction and value for money. ARPs provide predictable funding that enables physician groups to recruit new physicians to their programs and retain their services. ARPs are unique in that they offer alternatives to the way government has traditionally funded health service delivery. Currently there are 26 ARPs in operation in Alberta and 5 Academic Alternate Relationship Plans (ARPs) have been established in Edmonton and Calgary. Academic ARPs include compensation for teaching and other academic services.

Also under the agreement, family physicians can partner with their health regions to create Primary Care Networks that will manage 24-hour access to front-line services. As of March 2006 there were 14 Primary Care Networks in operation, involving approximately 550 family physicians and providing services to more than 700,000 patients. Primary Care Networks use a team approach to coordinate care for their patients. Family physicians work with health regions to better integrate health services by linking to regional services such as home care. Family physicians also work with other health providers such as nurses, dieticians, pharmacists, physiotherapists and mental health workers who help to provide services within the Networks.

As with the majority of physicians, dentists performing oral surgical services insured under the Alberta Health Care Insurance Plan are compensated through the Plan on a volume driven, fee-for-service basis. Alberta Health and Wellness establishes fees through a consultation process with the Alberta Dental Association and College.

5.5 Payments to Hospitals

Most insured hospital services in Alberta are funded through a population-based funding formula for regional health authorities. Regional health authorities also receive a mental health funding grant for insured services provided in mental health hospitals and for community mental health services. Capital Health and the Calgary Health Region receive funding to provide highly specialized province-wide services to all Alberta residents. The Alberta Cancer Board receives grant funding to provide insured services in cancer hospitals and to pay for cancer services that patients receive in regional hospitals. The regional health authorities and the Alberta Cancer Board are responsible for planning the allocation of funds for insured hospital services in accordance with regional needs assessments and health plans.

6.0 Recognition Given to Federal Transfers

The consolidated financial statements in the Ministry's Annual Report recognize the federal contributions provided under the Canada Health Transfer (CHT).

The 2005–2006 Annual Report of the Alberta Ministry of Health and Wellness can be accessed at:

www.health.gov.ab.ca/resources/ar06.html

7.0 Extended Health Care Services

Alberta also provides full or partial coverage for health care services not required by the *Canada Health Act*. They include: home care and long-term care; mental health services; dental, denturist and eyeglass benefits for recipients of the Alberta Widows' pension and their eligible dependants; palliative care; immunization programs for children; allied health services such as optometry (for residents under 19 and over 64 years), chiropractic and podiatry services; and drugs and other benefits through Alberta Blue Cross.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006 [1]
1 Number as of March 31st.	3,072,384	3,124,487	3,165,157	3,210,035	3,275,931

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006 [1]
2 Number:					
a. acute care	103	100	102	101	101
b. chronic care	106	110	107	106	103
c. rehabilitative care	1	1	1	1	1
d. other	3	3	3	3	3
e. total	213	214	213	211	208
3 Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006 [1]
4 Number:					
a. surgical facilities	not available	not available	not available	not available	not available [2]
b. diagnostic imaging facilities	not available	not available	not available	not available	not available [2]
c. total	not available	not available	not available	not available	not available [2]
5 Number of insured hospital services provided:					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available
6 Payments ($):					
a. surgical facilities	not available	not available	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	not available	not available	not available	not available	not available

1. These figures are considered preliminary until the release *Alberta Health Care Insurance Plan Statistical Supplement* report.
2. These data are available from the College of Physicians and Surgens of Alberta at www.cpsa.ab.ca/home/home.asp

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006 [3]
7. Number of participating physicians:					
a. general practitioners	2,746	2,841	2,937	3,026	3,122
b. specialists	2,333	2,365	2,426	2,475	2,463
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	5,079	5,206	5,363	5,501	5,585
8. Number of opted-out physicians:					
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
9. Number of not participating pysicians:					
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
10. Services provided by physicians paid through all payment methods :					
a. number of services	not available	not available	not available	not available	not available
b. total payments	not available	not available	not available	not available	not available
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	16,132,591	16,450,512	16,924,877	17,973,020	18,725,190
b. specialists	11,710,080	12,878,411	13,119,523	13,710,640	14,702,908
c. other	0	0	0	0	0
d. total	27,842,671	29,328,923	30,044,400	31,683,660	33,428,098
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	474,076,958	543,635,736	564,936,923	596,936,029	651,131,259
b. specialists	587,092,735	681,990,901	707,843,059	751,788,155	821,502,795
c. other	0	0	0	0	0
d. total	1,061,169,693	1,225,626,637	1,272,779,982	1,348,724,184	1,472,634,054
13. Number of services provided through fee for service,					
a. medical	20,647,611	21,153,134	21,680,907	22,640,833	23,436,946
b. surgical	1,396,422	2,417,363	2,513,638	3,043,454	3,560,240
c. diagnostic	5,798,638	5,758,426	5,849,855	5,999,373	6,430,912
d. other	0	0	0	0	0
e. total	27,842,671	29,328,923	30,044,400	31,683,660	33,428,098
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	684,971,654	788,450,446	816,374,918	856,868,540	936,361,692
b. surgical	164,427,152	190,259,821	196,291,136	209,890,970	226,799,013
c. diagnostic	211,770,887	246,916,370	260,113,928	281,964,674	309,473,349
d. other	0	0	0	0	0
e. total	1,061,169,693	1,225,626,637	1,272,779,982	1,348,724,184	1,472,634,054

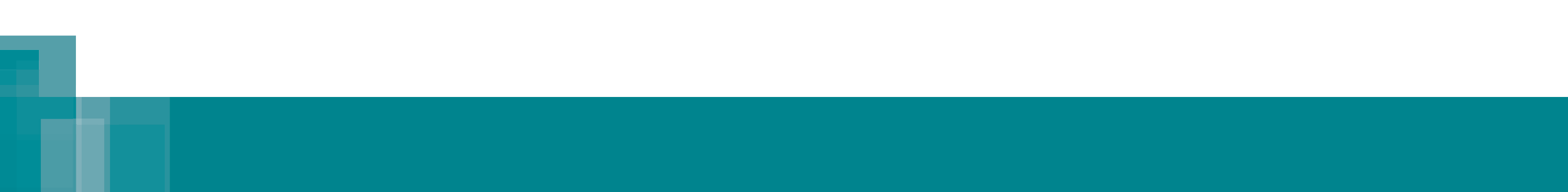
3. These figures are considered preliminary until the release *Alberta Health Care Insurance Plan Statistical Supplement* report.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006[4]
15. Total number of claims, in-patient.	4,205	4,275	4,651	4,550	4,508
16. Total number of claims, out-patient.	61,230	67,975	68,469	72,495	77,438
17. Total payments, in-patient ($).	12,328,205	15,753,884	19,411,517	20,139,919	21,080,232
18. Total payments, out-patient ($).	7,115,105	7,953,195	7,982,851	11,473,142	12,820,959
19. Average payment, in-patient ($).	2,931.80	3,685.12	4,173.62	4,426.36	4,676.18
20. Average payment, out-patient ($).	116.20	117.00	116.59	158.26[2]	165.56
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006[4]
21. Number of services.	493,798	559,503	485,841	444,884	479,029
22. Total payments ($).	11,998,825	13,880,981	15,139,409	15,871,755	17,745,928
23. Average payment per service ($).	24.30	24.81	31.16	35.68	37.05

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006[4]
24. Total number of claims, in-patient.	4,457	3,698	3,319	4,266	4,124
25. Total number of claims, out-patient.	3,942	3,739	3,405	4,089	3,918
26. Total payments, in-patient ($).	416,635	340,169	300,233	381,217	379,710
27. Total payments, out-patient ($).	309,119	206,684	212,949	227,609	222,896
28. Average payment, in-patient ($).	93.48	91.99	90.46	89.36	92.07
29. Average payment, out-patient ($).	78.42	55.28	62.54	55.66	56.89
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006[4]
30. Number of services.	22,928	21,289	20,753	26,017	24,944
31. Total payments ($).	1,043,997	976,232	963,299	1,208,422	1,049,384
32. Average payment per service ($).	45.53	45.86	46.42	46.45	42.07

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006[4]
33. Number of particpating dentists.	250	234	216	216	230
34. Number of services provided.	14,585	16,759	14,802	14,658	17,007
35. Total payments ($).	2,167,898	2,394,458	2,404,042	2,843,638	3,275,978
36. Average payment per service ($).	148.64	142.88	162.41	194.00	192.63

4. These figures are considered preliminary until the release *Alberta Health Care Insurance Plan Statistical Supplement* report.



British Columbia

Introduction

British Columbia has an integrated health system that includes insured services under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The health system in British Columbia is delivered through a regional structure utilizing numerous health workers and self-regulating professions to provide quality, accessible and affordable health services to all British Columbians.

British Columbia's five regional health authorities are responsible for managing and delivering a range of health services, including health protection and promotion services, primary care, hospital services, home and community care, mental health and addictions services, and end-of-life care. In addition to the regional health authorities, a Provincial Health Services Authority is responsible for ensuring British Columbians have access to a coordinated network of high quality specialized health services, such as cancer care, specialized cardiac services and transplant operations.

Health authorities are provided three-year funding commitments, updated annually, to enable them to plan and act with certainty, and are accountable to government through performance agreements that define expectations and performance deliverables for three fiscal years. Performance agreements also set out the major changes required in areas of service such as emergency care, surgical services, home and community care, public and preventive health and mental health and addiction services.

Overall, British Columbia has made tremendous progress in redesigning its health system and in 2005–2006 was recognized by both the Conference Board of Canada and Cancer Advocacy Coalition as national leaders in health care. The Conference Board rated B.C. as having the best overall health system performance in Canada, while the Cancer Advocacy Coalition noted British Columbia provides the timeliest access to cancer drugs and has the best cancer outcomes in the country.

Activities for 2005–2006

Since 2001, British Columbia's health system has undergone a number of significant changes designed to improve health services and make the health system sustainable into the future. These efforts continued throughout 2005–2006.

Nation-wide trends are creating unprecedented demands on health systems across the country, including British Columbia's. A lack of physical activity and rising rates of obesity, along with tobacco use and problematic substance use are affecting the health status of individuals and increasing demands for health services. In addition, British Columbia has a growing population that is aging. As a result the prevalence of chronic diseases is resulting in increased demand for more complex and expensive health services.

Significant reforms and new initiatives have continued across the health system, as the British Columbia Ministry of Health works with health authorities and health professionals to meet the health needs of British Columbians. In 2005–2006, the Ministry introduced, continued or enhanced a number of strategies across the continuum of health services, including: population health and safety; primary care; chronic disease management; prescription drug coverage; ambulance services; community programs for mental health and addictions; hospital and surgical services; home care; assisted living; residential care; and end-of-life care. The Ministry also continued to work on strategies to ensure an adequate supply of skilled health providers is available to deliver services across the continuum of care.

To support health reforms and help meet rising demands for service, health funding in British Columbia increased in 2005–2006, allowing more surgeries and services to be delivered in BC's health system than ever before. While increased funding is beneficial, the system will not be sustainable, nor will it meet the needs of individuals, unless it is redesigned to support good health and foster improved quality. Accordingly, British Columbia has continued to work to improve its health system to make it patient-centred, accessible and sustainable into the future.

Significant Achievements in 2005–2006

Working to Keep People Healthy: In 2005–2006, the Ministry of Health introduced a number of health promotion and disease prevention initiatives designed to improve the health and wellness of British Columbians:

In 2005–2006, the Ministry:

- Continued support for ActNow BC, an award-winning program that cuts across all sectors to promote healthy lifestyles, prevent disease and mobilize communities. ActNow BC provides individuals with the information, resources and support they need to make healthy lifestyle decisions.
  - Through ActNow BC, invested in health promotion through partnerships with the BC Healthy Living Alliance ($25.2 million) to pursue recommendations outlined in their report *The Winning Legacy: A Plan for Improving the Health of British Columbians by 2010*, and *2010 Legacies Now* ($4.8 million) to support physical activity and healthy lifestyles.
  - Through ActNow BC, invested in B.C. School Sports to help improve the health of B.C. students. This includes support for *Action Schools! BC*; the purchase of new physical activity equipment; the development of a provincial network of healthy schools; and funding to support volunteer committees responsible for hosting zone and provincial championships for more than 400 schools.
  - Through ActNow BC, invested in a public website that provides information and resources to help people make healthy lifestyle choices.
  - Introduced guidelines for food and beverage sales in schools to help eliminate junk food and improve student health and achievement.
- Made changes to the *Tobacco Sales Act* to better prevent youth access to tobacco products. When adopted, the legislation will make B.C. the first province to have an administrative process that can impose financial penalties for contraventions of tobacco legislation.
- Joined with the BC Centre for Disease Control to design and launch a comprehensive website to help families, communities and organizations prepare for pandemic influenza.
- Provided support for meat processors to help the industry meet new requirements for a province-wide meat inspection system that will ensure food safety and ongoing public confidence in the food supply.
- In January 2005, lowered the eligibility age for chickenpox vaccine from school entry to around the time of an infant's first birthday. Implemented in 2005–2006, this change will provide enhanced protection against the disease.
- In June 2005, all infants in BC became eligible for a Meningococcal C vaccine.
- Invested an additional $1 million in an awareness campaign designed to increase the number of women having mammography screenings.
- Provided $5 million to the Union of BC Municipalities to kick-start local government involvement in building healthier communities.
- Increased the base budget for public health programming by $8 million with planned further increases of $8 million in fiscal year 2006 and $8 million in 2007 respectively.

Increasing Access: Access has been expanded across the spectrum of care, from reducing wait times to enhancing research opportunities.

In 2005–2006, the Ministry:

- The Ministry of Health's spending for 2005–2006 stands at $11.4 billion, which includes a record $6.6 billion in regional funding for the province's six health authorities.
- Committed to significant three-year investments in "eHealth" that will improve patient care and assist health professionals in delivering faster, more effective treatments to patients.
- Launched a major initiative to reduce wait times for hip and knee surgeries and maximize the number of surgeries. The strategy includes a new Centre for Surgical Innovation at the University of British Columbia; funding to address backlogs; a Provincial Surgical Patient Registry; and a Research Centre for Hip Health at Vancouver General Hospital.
- Developed a CPR training program in BC high schools that has resulted in 5,900 Grade 10 students learning CPR skills taught by over 120 high school teachers.

- Committed to providing over $35 million over three years to improve access to dental treatment for young children and low-income families.
- Funded $3.5 million to expand diagnostic and assessment services for children with special needs, including those with Fetal Alcohol Spectrum Disorder.

Improving Quality of Health Services in 2005–2006: A number of important initiatives were undertaken across the health system to improve the quality of health services provided. Innovations, integrated services and the application of proven best practices in treating health conditions are leading to better health outcomes for British Columbians.

In 2005–2006, the Ministry:

- Provided $78 million for health research through the work of the Michael Smith Foundation to be distributed among a record 170 graduate students and post-doctoral fellows studying across the spectrum of health research, including prevention of hip fractures, new methods for cancer diagnosis and better understanding of brain physiology.
- Registered British Columbia's first group of nurse practitioners and created the College of Registered Nurses of British Columbia as the governing body for all registered nurses.
- Issued a new version of the *BC HealthGuide* handbook that includes new and medically reviewed information and more topics on seniors' health.
- Expanded the Loan Forgiveness Program to include nurse practitioners who choose to practice in rural and remote areas of the province.
- Provided an additional $8 million to continue the fight against crystal meth addictions by providing additional treatment beds and programs.

Other projects are underway, including developing an electronic health record, which will improve efficiency and safety by enabling care providers to access clinical information, such as patient medication profiles, lab and other testing results, using web-based technology.

Investing for Future Sustainability: Making the right strategic investments now will ensure the health system is sustainable into the future. Investing in infrastructure and health human resources, independently or with funding partners, is a key priority for the government.

In 2005–2006, the Ministry:

- Invested an additional $ 45 million in the provincial nursing strategy to educate, recruit and retain more nurses. Funding will support education for front-line unit managers, an expanded undergraduate nursing program to support student nurses on work terms, specialty education and support to increase the number of Aboriginal nurses in B.C. and ongoing integration of nurse practitioners into the B.C. health system.
- Completed the $6.9 million renovation and redesign of in-patient units at B.C. Children's Hospital, allowing staff to provide safer, more efficient patient care for children and teens across the province.
- Doubled funding to support innovative projects that help health-care students gain practical experience.
- Opened the province's first publicly funded PET/CT scanner at the Centre of Excellence for Functional Cancer Imaging (BC Cancer Agency). This will allow physicians to more accurately diagnose and manage disease.
- Announced the Okanagan Medical Program which will further expand the University of British Columbia's medical school by an additional 30 seats in 2009–2010.
- Invested $400,000 in a partnership that encourages collaboration among students and practitioners from different health disciplines to improve patient care. Funding to the Interprofessional Network of British Columbia is spread over four years and involves projects from a wide-range of disciplines including medicine, nursing, midwifery, pharmacy, rehabilitation services and social work.
- Transferred 25 acute tertiary neuropsychiatric beds from Riverview Hospital to a new 44-bed mental health facility in Kamloops.
- Continued to plan, build and complete additional housing and care options including:
  - $4 million for a 17-unit assisted living facility in Burns Lake;
  - $7.7 million for a 30-unit assisted living facility on Salt Spring Island;
  - a 154-unit assisted living development in Surrey;
  - $8 million for a 40-unit assisted living facility in Powell River;
  - a 104-unit assisted living development in Abbotsford;

- a 25-unit assisted living facility in Lake Country (Oyama, Winfield, Carr's Landing, and Okanagan Centre);
- 70 residential care beds at the Residence at Morgan Heights;
- a 36-unit assisted living facility in Haro Park, Vancouver;
- an 87-bed multi-level care facility in Ladysmith;
- 20 new units of seniors' housing in Ucluelet;
- a 66-unit assisted living development in Chilliwack;
- 2 new assisted living apartments in Fort St. James;
- a 70-unit supportive seniors housing project, through the $10.6 million redevelopment of Rose Manor in Victoria;
- a 10-bed end-of-life care facility in Richmond; and
- a commitment to complete 10 bed hospices in Chilliwack, Mission, Surrey, Maple Ridge and Langley.

Information on health and health services in British Columbia is available at:

www.gov.bc.ca/healthservices

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The British Columbia Medical Services Plan (MSP) is administered by the BC Ministry of Health; the plan insures medically required services provided by physicians and supplementary health care practitioners, laboratory services and diagnostic procedures. The Ministry of Health sets province-wide goals, standards and performance agreements for health service delivery, and works together with BC's six health authorities to provide quality, appropriate and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); the *Continuing Care Act* (section 3); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages MSP on behalf of the Government of BC in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose of this Act is to preserve a publicly managed and fiscally sustainable health care system for BC, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function and mandate of the MSC is to facilitate, in the manner provided for in the Act, reasonable access throughout BC to quality medical care, health care and diagnostic facility services for residents of BC under MSP.

The MSC is a nine-member statutory body made up of three representatives from Government, three representatives from the British Columbia Medical Association (BCMA) and three members from the public jointly nominated by the BCMA and Government to represent MSP beneficiaries.

1.2 Reporting Relationship

The MSC is accountable to the Government of BC through the Minister of Health. A report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees and other delegated bodies. In addition, the MSC Financial Statement is published annually: it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals and diagnostic facilities for each fiscal year, and is available in September for the prior fiscal year.

The Ministry of Health provides extensive information in its annual service plan report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting, and is consistent with requirements contained in the province's *Budget Transparency and Accountability Act* (2000).

The Ministry of Health reports through various publications, including:

- Ministry Annual Service Plan Report;
- Report on Health Authority Performance (annual);
- Nationally Comparable Indictors Report; and
- Provincial Health Officer's Annual Report (on the health of the population).

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- The Office of the Comptroller General's Internal Audit and Advisory Services, the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry.
- 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 audit recommendations.

1.4 Designated Agency

a) The Medical Service Plan (MSP) of BC requires premiums to be paid by eligible residents. The monies are collected by the Ministry of Small Business and Revenue.

Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance and collection, on behalf of the Province of British Columbia (Ministry of Small Business and Revenue). The Province remains responsible for, retains control of and performs all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:

- *Ombudsman Act* (British Columbia).
- *Business Practices and Consumer Protection Act* (British Columbia).
- *Financial Administration Act* (British Columbia).
- Freedom of Information Legislation: *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

The enabling legislation is:

- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8.
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums

b) Effective April 1, 2005, the Ministry of Health contracted with MAXIMUS BC to deliver the operations of the Medical Services Plan and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). This new organization is called Health Insurance BC. Policy and decision-making functions remain with the Ministry of Health.

- The contract with Maximus BC is enabled through the Medical Services Commission (MSC is empowered to manage MSP on behalf of the Government of BC).
- Health Insurance BC submits monthly reports to the Ministry of Health, reporting performance on service levels to the public and health care providers.
- Health Insurance BC posts quarterly reports on their website on performance on key service levels.
- Health Insurance BC applies payments against fee items approved by the Ministry of Health. The Ministry approves all payments before they are released.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister to designate facilities as hospitals, to license private hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for operation of hospitals.

The *Hospital Insurance Act* provides the authority for the Minister to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

There were no legislative or regulatory amendments made to the *Hospital Act* or *Hospital Insurance Act* or their regulations in 2005–2006.

In 2005–2006, there were a total of 137 facilities designated as hospitals. This included:

- 82 acute care hospitals (community hospitals, large tertiary care and teaching hospitals);
- 19 chronic care hospitals;
- 4 rehabilitation hospitals; and
- 32 other hospitals (including diagnostic and treatment centres, free-standing abortion clinics, cancer clinics, etc.) (Note: the overall number of hospitals is the same as last year, but the groupings have changed to reflect categories requested by Health Canada).

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital, and are deemed medically required by the attending physician, nurse practitioner or midwife. These services are provided to beneficiaries without charge, with the exception of incremental charges for preferred, but not medically required medical/surgical supplies, non-standard accommodation when not medically required, and for residential care patients in extended care or general hospitals, a daily fee based on income.

General hospital services, and the conditions under which they are provided, are described in the Hospital Insurance Act Regulations, division 5, and include the following for in-patients: 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 in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; drugs, biologicals and related preparations; routine surgical supplies; use of operating and case room and anaesthetic facilities, including necessary equipment and supplies; use of radiotherapy and physiotherapy facilities, where available; and other services approved by the Minister.

The following out-patient general hospital services are also insured: day care surgical services; out-patient renal dialysis treatments in designated hospitals or other approved facilities; diabetic day-care services in designated hospitals; out-patient dietetic counseling services at hospitals with qualified staff dieticians; psychiatric out-patient and day-care services; rehabilitation out-patient services; cancer therapy and cytology services; out-patient psoriasis treatment; abortion services; and MRI services.

Insured services in rehabilitation hospitals include: accommodation and meals at the standard or public ward level; necessary nursing services; drugs, biologicals and related preparations; use of physiotherapy and occupational therapy facilities; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; and other services approved by the Minister.

Insured hospital services do not include: transportation to and from hospital (however, ambulance transfers are insured under another Ministry of Health program, with a small user charge); services provided to non-beneficiaries (with the exception of emergency treatment); services or treatment that the Minister, or a person designated by the Minister, determines, on a review of the medical evidence, the beneficiary does not require; and services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council.

No new hospital services were added during the fiscal year.

There is no regular process to review insured hospital services, as the list of insured services included in the regulations is intended to be both comprehensive and generic and does not require routine review and updating. There is a formal process to add specific medical services (physician fee items) to the list of services insured under the *Medicare Protection Act*, but this process is described elsewhere.

2.2 Insured Physician Services

The range of insured physician services covered by MSP includes all medically necessary diagnostic and treatment services.

Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care practitioners, such as midwives) who are enrolled and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as Medical Services Plan (MSP) benefits under the MPA in accordance with the *Canada Health Act*:

- medically required services provided to "beneficiaries" (residents of British Columbia) by a medical practitioner enrolled with MSP; and
- medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

The *Medical and Health Care Services Regulation* of the MPA was passed during fiscal year 2005–2006. The Regulation further defines beneficiaries of MSP, premiums to be paid and payment of benefits.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In fiscal year 2004–2005, 8,271 physicians (includes only GPs and Medical Specialists who billed fee-for-service (FFS) in 2004–2005) were enrolled with MSP and billed fee-for-service. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) to the health authorities. Physicians paid by these alternative mechanisms may also practice on a fee-for-service basis.

Non-physician healthcare practitioners who can be enrolled to provide insured services under MSP are midwives and supplementary benefit practitioners (dental surgeons, optometrists, podiatrists). Only those MSP beneficiaries with premium assistance status qualify for MSP coverage of physiotherapy, massage therapy, chiropractic, naturopathy and non-surgical podiatry services. In 2004–2005 there were 12,363 practitioners registered with MSP.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission (MSC). Enrolled physicians may cancel their enrolment by giving 30 days' written notice to the Commission. Patients are responsible for the full cost of services provided by non-enrolled physicians.

Enrolled physicians can elect to be paid directly by patients by giving written notice to the Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered.

During fiscal year 2005–2006 physician services added as MSP insured benefits include fee items which reflect current practice standards in specialties including otolaryngology, internal medicine and interventional radiology, and evolving technologies, for example: telehealth consultations; upper gastrointestinal endoscopy; video capsule endoscopy; and sentinel lymph node biopsy.

Under the Master Agreement between the government, MSC and the British Columbia Medical Association (BCMA), modifications to the payment Schedule such as additions, deletions or fee changes are made by the Commission, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time while definitive listings are established.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by MSP when hospitalization is medically required for the safe and proper completion of surgery, and when it is listed in the Dental Payment Schedule. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the Medical Services Commission. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction.

Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in the Medical Services Plan may provide insured surgical-dental services in hospital. There were 228 dentists (includes only Oral Surgeons, Dental Surgeons, Oral Medicine and Orthodontists who billed fee-for-service in 2004–2005) enrolled with the Medical Services Plan and billing fee-for-service in 2004–2005. None have de-enrolled or 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* include: 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 include: 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 medical examinations that are not medically required; oral surgery rendered in a dentist's office; acupuncture; telephone advice unrelated to insured visits; reversal of sterilization procedures; *in vitro* fertilization; medico-legal services; and most cosmetic surgeries.

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

The *Medicare Protection Act*, (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit". The Ministry of Health responds to complaints made by patients and takes 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 BCMA's Tariff Committee. No services were de-listed in 2005–2006.

3.0 Universality

3.1 Eligibility

Section 7 of the *Medicare Protection Act* defines the eligibility and enrollment of beneficiaries for insured services. Part 2 of the Medical and Health Care Services Regulation made under the *Medicare Protection Act* details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits. The *Medicare Protection Act*, in section 1, 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;
- is physically present in British Columbia at least 6 months in a calendar year; and
- is deemed under the regulations to be a resident.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see section 3.3 below), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in BC are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces, appointed members of the Royal Canadian Mounted Police, or serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance.

The Medical Services Plan (MSP) 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

Residents must be enrolled in the Medical Services Plan (MSP) to receive insured hospital and physician services. Those who are eligible for coverage are required to enrol. Once enrolled, beneficiaries are assigned a unique Personal Health Number and issued a **CareCard**. There is no expiration date on the card. New residents are advised to make application immediately upon arrival in the province.

Beneficiaries may cover their dependents, provided the dependents are residents of the province. Dependents include a spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward supported by the beneficiary, and either under the age of 19 or under the age of 25 and in full-time attendance at a school or university.

The number of MSP registrants in 2004–2005 was 4,253,580. Enrollment in MSP is mandatory, in accordance with the *Medicare Protection Act* (section 7). Only those adults who formally opt out of all provincial health care programs are exempt. A beneficiary who wishes to opt out of MSP can do so by completion and submission of the appropriate Election to Opt Out (ETOO) form. The term of this decision is 12 months from the first of the month of receipt of the application, after which each adult must re-apply to remain opted out of MSP.

3.3 Other Categories of Individual

Holders of Minister's Permits, Temporary Resident Permits, study permits, and work permits are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section 2 of the Medical and Health Care Services Regulation.

3.4 Premiums (if applicable)

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 $54 for one person, $96 for a family of two, and $108 for a family of three or more. Residents with limited incomes 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 resided in Canada and are either a Canadian citizen or have permanent resident (landed immigrant) status under *Immigration and Refugee Protection Act* (Federal)

4.0 Portability

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in BC are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage During Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations of the *Medicare Protection Act* define portability provisions for persons temporarily absent from BC with regard to insured services. In 2005–2006, there were no amendments to the Medical and Health Care Services Regulation with respect to the portability provisions. 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 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. Section 24 of the *Hospital Insurance Act* states that hospital services rendered outside BC to beneficiaries must be reimbursed by the Ministry.

Individuals who leave the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 months. Approval is limited to once in five years for absences that exceed six months in a calendar year. Residents who spend part of every year outside BC must be physically present in Canada at least six months in a calendar year and continue to maintain their home in BC in order to retain coverage. When a beneficiary stays outside BC longer than the approved period, they will be required to fulfill a waiting period upon returning to the province before coverage can be renewed. 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 BC residents, on presentation of a valid MSP Card (**CareCard**). BC 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. In 2005–2006, the amount paid to physicians in other provinces and territories was $ 25.7 million.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to BC beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec or outside of Canada, the beneficiary will probably be required to pay for medical services and seek reimbursement later from MSP.

BC pays host provincial rates for insured services according to the Interprovincial Health Insurance Agreements Coordinating Committee.

With the amendment to the Medical and Health Care Services Regulation in 2005, beneficiaries who submit bills for optometric and podiatric services obtained in Alberta or the Yukon, when that is the nearest convenient location outside BC, will be reimbursed.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, s. 24; the Hospital Insurance Act Regulations, Division 6; the *Medicare Protection Act*, s. 51; and the Medical and Health Care Service Regulation, ss. 3, 4, 5. The Medical and Health Care Services Regulation was amended by BC Reg. 111/2005. These changes were effective March 18, 2005.

The amendments ensure that the regulation is in line with current policy and are expected to improve the administration and delivery of Medical Services Plan (MSP) services. There are also a number of minor amendments that update terminology and bring the regulation in line with the *Immigration and Refugee Protection Act* (Federal).

The relevant issues addressed by the amendments are as follows:

- All provinces, except Quebec, have eliminated caps on MSP coverage for students studying abroad, enabling them to finish their undergraduate and graduate studies. The amendment brings BC in line with other provinces and removes the 60-month cap for full-time students studying abroad at an educational institution. The students must be enrolled in and attending the institution.
- Because of increasing demand for a specialized and mobile work force employed for short-term contracts and assignments, many provinces have extended health insurance coverage to 24 months of absence. British Columbians were deemed residents for the first 12 months of absence. This amendment extends coverage to 24 months; approval is limited to once in five years for absences that exceed six months in a calendar year. This brings BC in line with practice in other provinces.
- BC residents who are temporarily absent from BC and cannot return due to extenuating health circumstances are deemed residents for an additional 12 months if they are visiting in Canada or abroad. This amendment also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

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 Medical Services Commission is required for procedures that are not covered under the reciprocal agreements.

Physician services excluded under the Inter-Provincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims: surgery for alteration of appearance (cosmetic surgery); gender-reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; *in vitro* fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies; RCMP, Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries); services requested by a "Third Party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the BC physician.

Some treatments (e.g. treatment for anorexia) may require the approval of the Performance Management and Improvement Division of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the Commission before the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

Beneficiaries in BC, as defined in section 1 of the *Medicare Protection Act* 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*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

Nurses comprise the largest group of professional staff within the health care sector. The number of Registered Nurses licensed to practice in British Columbia (BC) as of December 2005 was 30,878. BC hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2005, there were 2,137 RPNs and 5,606 LPNs licensed to practice in the province.

In 2005, the BC government provided additional funding to build on successful recruitment, retention and education nursing strategies. This funding brought the government's total commitment to nursing strategies to $120 million since 2001. British Columbia's nursing strategies are developed and implemented annually by the Ministry of Health's Nursing Directorate through consultation with stakeholders, input from the Nursing Advisory Committee of British Columbia, and a review of national trends and policies. The following priorities form the broad strategy framework:

- human resources planning for recruitment, retention and education of nurses in British Columbia;
- enhancing nursing practice environments by supporting health authorities and government to make sound nursing policy in keeping with current research and provincial, national and global trends;
- compiling nursing data to enhance the Ministry's understanding of trends and changing needs in nursing and health care; and
- promoting nursing as a career of choice to ensure the future of a quality British Columbia health care system.

Some of the programs funded in 2005–2006 included: Undergraduate Nurses Education, Operating Room Initiatives, Nurses Specialty Education, Return to Nursing Fund and Nurse Practitioner Expansion.

On August 19, 2005, the Nurses (Registered) and Nurse Practitioners Regulation came into effect. The regulation established the new College of Registered Nurses of British Columbia under the *Health Professions Act* as the regulatory body for registered nurses and also enables nurse practitioners to be regulated by the new College and to practice in British Columbia. As part of this

transition, the *Nurses (Registered) Act* was repealed and the Registered Nurses' Association of British Columbia was dissolved. The University of British Columbia and the University of Victoria graduated their first nurse practitioners in 2005. Many of these graduates are moving into primary health positions throughout the province. A third nurse practitioner program, offered at the University of Northern British Columbia in Prince George, began admitting students in September 2005.

In recent years, the Province of British Columbia has initiated changes that encourage strategic investment in capital infrastructure and innovative approaches to meeting health service delivery needs, now and in future. The Ministry of Health has introduced a longer capital planning cycle and has gathered better data on current capital assets to support improved decision-making and better forecasting of needs. The ministry is now working to extend the capital planning horizon to 10 years which is particularly beneficial in planning for major infrastructure such as hospitals that have life-cycles encompassing several decades. It also gives the health authorities more time to explore creative ways of addressing capital requirements.

The ministry provides capital funding to health authorities for maintenance, renovation, replacement and expansion of health infrastructure that is consistent with regional and provincial priorities. In 2005–2006 fiscal year, health authorities used ministry funding (in some cases, in collaboration with other funding partners such as Regional Hospital Districts, foundations, and auxiliaries) to purchase equipment, to build new or replacement facilities, and to convert facilities to uses more consistent with current and future needs.

Among the projects recently completed or underway are:

- a new 300-bed hospital and cancer centre in Abbotsford that will provide enhanced programs and services;
- a new Academic Ambulatory Care Centre in Vancouver that will consolidate out-patient services, medical education facilities, teaching physician/specialist practice offices, and related activities;
- redevelopment of Vancouver General Hospital that will consolidate hospital services to create a modern and efficient environment for quality patient care and accessibility;
- redevelopment of the existing facility in Cranbrook as a regional health care centre with expanded emergency, ambulatory care and diagnostic imaging departments;
- a new 44-bed tertiary mental health facility in Kamloops that provides patients access to a full range of services closer to home and in a more home-like environment;
- expansion of Nanaimo Regional General Hospital that will improve access to surgical services and maternal programs;
- a new 50-bed residential care facility in Vanderhoof; and
- expansion of Surrey Memorial Hospital that will increase acute care beds, and provide a new ambulatory care facility and a new emergency department.

In 2004–2005, the Province committed $27.6 million for the expansion and upgrading of academic space in teaching hospitals around BC to support increased enrollment of medical students.

The *2003 First Ministers' Accord on Health Care Renewal* established a $1.5 billion national diagnostic and medical equipment fund, of which $200.1 million was apportioned to British Columbia, over three years. Health authorities spent this fund on a wide variety of equipment for diagnostic/therapeutic and medical/surgical purposes, and to enhance comfort and safety for patients and staff.

The province invested $35 million in leading-edge medical technologies, using $25 million of the federal funding as well as provincial capital and foundation dollars. A committee of representatives from the Ministry of Health, the health authorities and various health care fields provided expertise and advice in identifying investments to improve patient access and most strategically serve the needs of British Columbians.

The funding was used by health authorities for equipment such as:

- the province's first publicly funded PET unit located at the Vancouver Cancer Agency, which will improve the management of cancer patients by providing accurate pre-treatment detection of cancerous tumors and monitoring therapy response to improve recovery;
- new CT scanners in the Lower Mainland and Victoria that will improve cardiac care in BC and increase provincial capacity for diagnosing heart and brain disease as well as handling trauma cases;
- a mobile MRI scanner for the Kootenays and South Okanagan and a CT scanner at Kelowna that will significantly improve access for patients with wide ranging needs in the province's interior regions; and

- a Picture Archiving Communication System and a Radiology Information System for the Northern Health Authority that will enhance access to care and treatment in many small communities by allowing sharing of digital images between hospitals/regions and radiologists across the north.

The *September 2004 First Ministers' Agreement* committed an additional $66 million in Medical Equipment funding for BC, and health authorities are in the process of planning for the best use of this allocation, to be spent by 2007–2008.

The BC HealthGuide Program, started in 2001, provides reliable health information and advice 24 hours every day. This comprehensive self-care program is unique in Canada and consists of print, Web and telehealth formats:

BC HealthGuide Handbook: This handbook was delivered free to every household in British Columbia in spring 2001. The updated version, published in November 2005, is available free to all British Columbians at Government Agents Offices and local pharmacies. The handbook provides information on common health concerns, illness prevention, home treatment, care options and when to see a health professional. The updated handbook contains new information on seniors' health including healthy aging and tips for caregivers. A French version of the handbook was released in June 2004 (Guide-santé — Colombie-Britannique). Translations into Chinese and Punjabi will be available in 2007.

The *BC First Nations Health Handbook* was developed in partnership with the BC First Nations Chiefs' Health Committee and distributed to Aboriginal communities in January 2003. The handbook provides specific information on health services available to Aboriginal communities. It is available on-line at www.bchealthguide.org/aboriginal.stm.

BC HealthGuide OnLine: Located at www.bchealthguide .org, this website expands on the information in the BC HealthGuide handbook with more than 35,000 medically reviewed pages covering over 3,000 health topics.

BC NurseLine: BC NurseLine is a toll-free, 24/7 nursing tele-triage and health education service. Registered nurses are specially trained to use medically approved protocols to provide confidential health information and advice on acute and chronic health symptoms and conditions and when to see a health professional. Translation services are provided in over 130 languages, as well as service for deaf and hearing impaired. In 2005–2006, the BC NurseLine received over 339,000 calls. As of December 31, 2005, the service had received over one million calls since its inception.

The pharmacist enhancement to the BC NurseLine was implemented in June 2003. Callers can speak with a pharmacist and ask medication-related questions, between 5:00 pm and 9:00 am every day.

Since implementation to the end of March 2006, over 28,000 medication-related calls were transferred from the BC NurseLine to the pharmacist service. Over this period, BC NurseLine pharmacists submitted 670 Adverse Drug Reaction (ADRs) reports to the British Columbia Regional ADR Centre, which have been approved for submission to Health Canada. These reports are used to monitor adverse effects that are unexpected, serious or for newly marketed medications. The pharmacist service is responsible for over 20 percent of all ADR reports submitted to Health Canada by the British Columbia Regional ADR Centre, making it a large and integral contributor to patient safety — not only for British Columbians, but for all Canadians.

In January 2005, the BC HealthGuide Program partnered with Fraser Health on a demonstration project to explore the feasibility of leveraging the BC NurseLine platform to provide after-hours triage and support to Hospice Palliative Care (HPC) patients. Patients could call BC NurseLine for after-hours support from 9 p.m. to 8 a.m. An evaluation of the program has been completed; future options are being considered.

BC HealthFiles: The BC HealthFiles are easy-to-understand fact sheets on a wide range of public and environmental health and safety topics. They are available at more than 120 health units, departments and other offices in B.C or on-line at www.bchealthguide.org. Files on specific topics have been translated into French and other languages.

Dial-A-Dietitian: Dial-A-Dietitian is a free nutrition information service that provides easy-to-use nutrition information for self-care, based on current scientific sources. Registered dietitians are available 9:00am to 5pm, Monday to Friday. Food allergy expertise is available. Referrals are also provided to hospital out-patient dietitians, community nutritionists and other local services. Translation services are available in over 130 languages.

The Ministry's 2004–2005 to 2006–2007 Service Plan contained a number of objectives and strategies designed to reach the Province's goals for a sustainable health system. This includes Priority Strategy 3: Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services.

While most of the strategies under this objective focus on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high-quality manner. Under this strategy, the Ministry and all five health authorities have participated in two province-wide projects to improve access to, and effectiveness of, emergency room and surgical services in hospitals across the province.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2005–2006, 4,681 enrolled general practitioners, 3,773 enrolled specialists and 238 enrolled dentists provided insured fee-for-service physician and dental-surgical services. Approximately 2,553 general practitioners and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to hire salaried physicians or contract with physicians, in order to deliver insured clinical services.

The Ministry of Health implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice to enhance the availability and stability of physician services in smaller urban, rural and remote areas of British Columbia.

These programs include:

- the Rural Retention Program, which provides eligible rural physicians (estimated at 1,300) with fee premiums and is available for visiting physicians and locums;
- the Northern and Isolation Travel Assistance Outreach Program, which funded an estimated 2,050 visits by family doctors and specialists to rural communities;
- the Rural General Practitioner Locum Program, which assisted physicians in approximately 66 small communities to attend subsidized continuing medical education and provide vacation relief;
- the Rural Specialist Locum Program, which provided locum support for core specialists in 17 rural communities while physician recruitment efforts were underway;
- the Rural Education Action Plan, which supported training physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practicing physicians;
- the Isolation Allowance Fund, which provided funding to communities with fewer than four physicians and no hospital, and where Medical On-call/Availability Program, call-back, or Doctor of the Day payments are not available; and
- the Rural Loan Forgiveness Program, which decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives and pharmacists.

Commencing in November 2002, British Columbia received $73.5 million in federal funding over four years (2002–2006) to develop sustainable improvements to primary health care (PHC) and to increase patient access to comprehensive, high-quality services in physicians' offices and community clinics — the usual first points of contact with the health care system. British Columbia continues to promote the goals estabished through the federal primary health care transition fund. The Full-Service Family Practice Incentive Program has recently been expanded through the 2006 agreement with physicians and the ministry continues to establish clinical practice guidelines and protocols to improve patient care.

The University of British Columbia's (UBC) medical school is expanding in collaboration with the University of Northern British Columbia, the University of Victoria and British Columbia's health authorities. In 2002, the government announced $134 million to build a new Life Sciences Centre at UBC in Vancouver and other distributed sites for medical programs in Prince George and Victoria. British Columbia's annual intake for medical students was 128 in 2003. The expanded program will double the number of available seats to 256 by 2007. The latest addition to the medical school expansion, the Okanagan Medical Program, will add at least another 30 first-year medical school spaces when the program begins in 2009–2010.

In addition to the medical school expansion, the government has begun a stepped expansion to post-graduate medical education. In 2004, 32 first-year residency positions were added. By 2010, the number of first-year post-graduate positions will double to 256, up from 128 in 2003.

5.4 Physician Compensation

The Province of British Columbia (BC) negotiates with the BC Medical Association (BCMA) to establish the conditions, benefits and overall compensation for physicians. The BCMA has the sole and exclusive right to represent the interests of physicians who receive funding for their services from the government.

Funding for physicians accounted for over $2.5 billion or 22 percent of the Ministry of Health budget in 2005–2006.

The BC government and the BCMA entered into a Master Agreement governing the relationship between the province and the provinces' physicians, effective December 1993 for a term which was extended to March 31, 2001. The parties entered into the Second Master Agreement February 28, 2001 with a term to expire Midnight March 31, 2006. If by that date the parties have not agreed upon a replacement or renewal, the Second Master remains in full effect until new terms are agreed upon or 12 months have expired following either Government or the BCMA receipt of the others wish to terminate the Agreement.

The Second Master Agreement established the framework for negotiation and consultation. It required the government and the BCMA to begin to negotiate Working Agreements and/or Subsidiary Agreements no later than October 1 of the year immediately preceding the expiry of the agreements. Working and Subsidiary Agreements determine physician compensation, on-call issues and benefit plans. The Working Agreement addresses matters of common interest to physicians while Subsidiary Agreements address matters of unique interest to a particular group of physicians.

Negotiations for a 2004 Working Agreement and Subsidiary Agreements proceeded through a mediation phase and had entered the conciliation phase when a negotiated agreement was finally reached. The conciliation panel was adjourned prior to their making an award. The agreements were renewed in June 2004, covering April 1, 2004 to March 31, 2007.

The 2004 Working Agreement identified a dispute resolution process that required each party to provide written advice about the details of the dispute after which the parties would meet to try to resolve the dispute. A Dispute Resolution Committee would attempt to resolve the dispute. If the dispute was not resolved, either party could refer the dispute for final resolution to arbitration under the *Commercial Arbitration Act*.

Under the agreements, there were no generalized increases in compensation rates for the fiscal years 2004–2005 and 2005–2006, with provision for negotiation, and if necessary arbitration, for a compensation increase in the third year (2006–2007).

The agreements identified funding for reallocation to direct patient care. The agreement also included reform initiatives such as enhancement of full-service family practice as well as enhanced recruitment and retention of physicians in the most rural communities and of specialists where there is a current or anticipated problem.

The government has approached negotiations with physicians in a spirit of collaboration and with the interest of quality care for patients as the foremost concern.

Negotiations for changes to the Second Master Agreement and for compensation increases for 2006–2007 began in 2005, using a principle-based approach. A tentative Agreement in Principle was reached in March 2006 and was ratified in May 2006, covering the period from 2006 to 2012.

With respect to dentists, the BC government negotiates with the British Columbia Dental Association (DABC). The previous formal negotiation process led to an updated and modernized contract. The DABC has requested renegotiation of their current contract; it is expected that this will commence in the fall of 2006.

Legislation

The *Medicare Protection Act*, RSBC 1996, c. 286, provides the authority for the Medical Services Commission to administer the Medical Services Plan (MSP) of British Columbia. There were no significant amendments of the Act or regulations in 2005–2006.

Medical practitioners are licensed under the *Medical Practitioners Act* and dentists under the *Dentists Act*.

Compensation Methods for Physicians and Dentists

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payments Program to health authorities for contracted physicians' services. In 2005–2006, over 90 percent of payments were distributed as fee-for-service payments and nearly 10 percent were distributed as alternate payments. Of the alternate payments, 72 percent are distributed through contracts, 24 percent as sessions (3.5-hour units of service) and 4 percent as salaried arrangements. The government funds health authorities for alternative payments, but does not pay physicians directly.

Payment for dental services delivered in the province is made through the Medical Services Plan totally on a fee-for-service basis.

5.5 Payments to Hospitals

Funding for hospital services is included in the annual block fund payments made to regional health authorities. This block funding is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of BC), including the provision of hospital services.

While the hospitals portion of the block fund is normally not specified, the exception to this rule is funding allocated for specific priority projects (e.g. reduction in wait times for hips and knees). For these initiatives, funding is specifically earmarked, and must be reported on separately.

Annual block funding amounts are negotiated between senior finance officials in the Ministry of Health and the CEO and Senior Financial Officer in the health authorities. The final funding amount is conveyed to health authorities by means of an annual funding letter.

The terms of agreement for government funding for hospitals is part of several larger documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual performance agreements. Taken together, these documents convey the Ministry of Health's broad expectations for health authorities, and explain how performance in relation to these expectations will be monitored.

The *Hospital Insurance Act* and its related regulations govern payments made by the health care plan to health authorities. This statute establishes the authority of the Minister to make payments to hospitals, and specifies in broad terms what services are insured when provided within a hospital.

No amendments were made during 2005–2006 to legislation or regulations concerning payments for insured hospital services.

Insured hospital services are funded by way of annual block funding to regional health authorities, as well as specific targeted funding from time to time. The basic amount of the annual grant is determined through a Population Needs Based Formula, which is modified to account for specific programs within health authorities.

A total of $6.6 billion was transferred to health authorities in 2005–2006 to provide the full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions programs, etc.).

Block funding to health authorities does not include funding for programs directly operated by the Ministry of Health, like the payments to physicians, payments for prescription drugs covered under PharmaCare, or for provincial ambulance services.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2005–2006, these documents included:

- Public Accounts 2004–2005 (tabled June 29, 2005) www.fin.gov.bc.ca/ocg/pa/04_05/pa04_05.htm
- Budget and Fiscal Plan, 2005–2006 to 2007–2008 (tabled February 15, 2005) www.bcbudget.gov.bc.ca/2005/bfp/default.htm
- Estimates, Fiscal Year Ending March 31, 2006 (tabled February 15, 2005) www.bcbudget.gov.bc.ca/2005/est/toc.htm

- Budget and Fiscal Plan, September Update, 2005–2006 to 2007–2008 (tabled September 14, 2005) www.bcbudget.gov.bc.ca/2005_Sept_Update/bfp/default.htm
- Estimates, September Update, Fiscal Year Ending March 31, 2006 (tabled September 14, 2005) www.bcbudget.gov.bc.ca/2005_Sept_Update/est.toc.htm

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care Services

Residential care facilities provide 24-hour professional nursing care and supervision in a protective, supportive environment for adults who have complex care needs and can no longer be cared for in their own homes. Residential care clients pay a daily fee based on their after-tax income. Rates are adjusted annually based on the Consumer Price Index. The legislation pertaining to residential care facilities is the *Community Care and Assisted Living Act*, the Adult Care Regulations, the *Hospital Act*, the Hospital Act Regulation, the *Hospital Insurance Ac*t, the Hospital Insurance Act Regulations, and the *Continuing Care Act,* the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Family care homes are single family residences that provide meals, housekeeping services and assistance with daily activities for up to two clients. The cost for family care homes is the same as for residential care facilities. The legislation pertaining to family care homes is the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Adults with disabilities can also live independently in the community in publicly funded group homes. Group homes are safe, affordable, four-bed to six-bed housing projects. They offer short- and long-term accommodation, skills training, peer support and counselling. Group home clients are responsible for living costs, such as food and rent, not associated with their care. Rental costs vary, depending on income. The legislation pertaining to group homes is the *Community Care and Assisted Living Act*, the Adult Care Regulations, *Continuing Care Act* and the Continuing Care Programs Regulation.

Assisted living residences provide housing, hospitality and personal assistance services for adults who can live independently, but require regular assistance with daily activities, usually because of age, illness or disabilities. Residences typically consist of one-bedroom apartments. Services include help with bathing, grooming, dressing or mobility. Meals, housekeeping, laundry, social and recreational opportunities and a 24-hour response system are also provided. Clients pay a monthly charge based on 70 percent of their after-tax income, up to a maximum of a combination of the average market rent for housing and hospitality in a particular geographic area and the actual cost of personal care. The legislation pertaining to assisted living residences is the *Community Care and Assisted Living Act*, the Assisted Living Regulation, the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

Hospice services provide a residential home-like setting where supportive and professional care services are provided to British Columbians of any age who are in the end stages of a terminal illness or preparing for death. Services may include medical and nursing care, advance care planning, pain and symptom management, and psychosocial, spiritual and bereavement support. There may be a charge for some hospice services. The legislation pertaining to hospices is the *Community Care and Assisted Living Act*, the Adult Care Regulations, the *Hospital Act* and the Hospital Act Regulation.

Services for Persons With Mental Illness and Substance Use Disorders

There are three distinct types of housing and programs for people with severe mental illness and or substance use disorders: Community Residential Care Facilities; Family Care Homes; and Supported Housing.

Community Residential Care Facilities

These facilities provide 24-hour care, intensive treatment and support services, including psychosocial rehabilitation, such as assistance with personal care, home/money management, socialization, medication administration and linking with external services such as supported education and supported employment programs. For some residents, community residential care is a "stepping stone"

towards more independent housing while for others their stay is long-term. All facilities are licensed under the *Community Care and Assisted Living Act*. Clients pay a standard daily fee for room and board.

Family Care Homes

These private homes, operated by families or individuals, provide life skills and psychosocial rehabilitation services for clients unable to live independently, who require support within a family setting to acquire the skills and confidence necessary for independent living. Homes are not licensed or registered but must meet standards set out by the health authority. Clients pay a standard daily fee for room and board.

Supported Housing

Supported housing programs include affordable, safe and secure accommodation and the availability of a range of psychosocial rehabilitation and home support services, such as assistance with meal preparation, personal care, home management, medication support, socialization, and crises management. Supported Housing programs include: **supported apartments**, including satellite apartments/mobile homes, block apartments, and congregate housing; **group homes**; and **supported hotels**.

The legislation pertaining to Supported Housing is the *Landlords and Tenants Act* and the *Community Care and Assisted Living Act*. Clients usually stay long term (over two years) in these programs and pay reduced rent based on income (maximum 35 percent of income).

Home Care Services

Home care nursing and community rehabilitation services are professional services, delivered to people of all ages by registered nurses and rehabilitation therapists. These services are available on a non-emergency basis and include assessment, teaching and consultation, care coordination and direct care or treatment for clients with chronic, acute, palliative or rehabilitative needs. There is no charge for these services.

Home support services help clients remain in their own homes. Home support workers provide personal assistance with daily activities, such as bathing, dressing, grooming and, in some cases, light household tasks that help maintain a safe and supportive home. Depending on an individual's income, there may be a cost associated with home support services. The legislation pertaining to home support services is the *Continuing Care Act*, the Continuing Care Programs Regulation and the Continuing Care Fees Regulation.

End-of-life care preserves clients' comfort, dignity and quality of life by relieving or controlling symptoms so those facing death, and their loved ones, can devote their energies to embracing the time they have together. Professional care givers and support staff provide supportive and compassionate care in the client's home, in hospital, hospice, an assisted living residence or a residential care facility. Depending on the type of care required and an individual's income, there may be a cost associated with some services.

A Palliative Care Benefits Program was implemented in 2001 to provide people living at home who are nearing the end of their life with approved medications for pain or symptom relief and some medical supplies and equipment, at no charge. Approved medications can be obtained through a local pharmacy.

Ambulatory Health Care Services

Adult day programs assist seniors and adults with disabilities to be independent. They provide supportive group programs and activities that give clients a chance to be more involved in their community and offer care providers a break. Services vary with each centre, but may include personal care, social activities, meals and transportation. Centres usually charge a small daily fee to assist with the cost of craft supplies, transportation and meals. The legislation pertaining to adult day programs is the *Continuing Care Act* and the Continuing Care Programs Regulation.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	3,994,007	4,017,912	4,099,076	4,182,682	4,216,199

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number: [1]					
a. acute care	94	92	92	92	82
b. chronic care	18	18	18	18	19
c. rehabilitative care	3	3	3	4	4
d. other	25	25	24	23	32
e. total	140	138	137	137	137
3. Payments ($): [2]					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	not available	not available	11	17	18
b. diagnostic imaging facilities	not available	not available	0	1	1
c. total	not available	not available	11	18	19
5. Number of insured hospital services provided: [3]					
a. surgical facilities	689	612	not available	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	689	612	not available	not available	not available
6. Payments ($):					
a. surgical facilities	353,100	358,600	1,470,370	not available	not available
b. diagnostic imaging facilities	not available	not available	not available	not available	not available
c. total	353,100	358,600	1,470,370	not available	not available

For items 1–2: All data is preliminary for 2004–2005. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

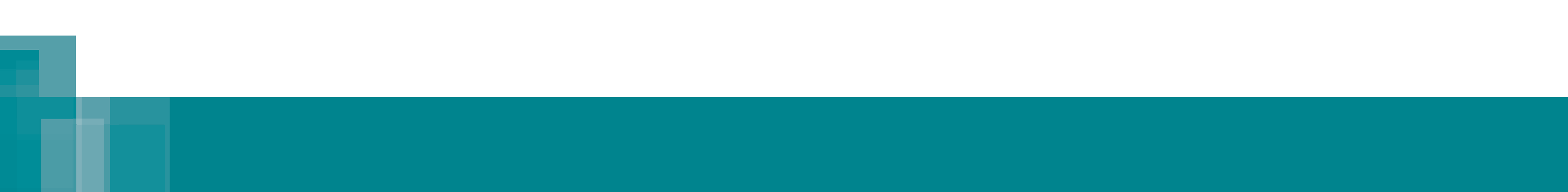
1. In British Columbia, the categories under which these facilities are reported in this report table do not match those normally used in the BC Ministry of Health, but facilities have been matched as closely as possible.
   — Acute Care includes acute care inpatient facilities, acute care ambulatory facilities and psychiatric inpatient facilities
   — Chronic Care includes extended care facilities
   — Rehabilitative care includes rehabilitation facilities
   — Other includes diagnostic and treatment centres
   The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the *Societies Act* because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.
2. Payments to Health Authorities for the provision of the full range of regionally delivered services are as follows: $4.59 billion in 1999–2000, $5.20 billion in 2000–2001, $5.62 billion in 2001–2002, $6.06 billion in 2002–2003, and $6.21 billion in 2003–2004. Payments to Health Authorities in 2004-2005, (base and one-time payments), was $6.25 billion.
3. There are approximately 66 private facilities licensed by the College of Physicians and Surgeons of British Columbia. These facilities provide mostly non-*Canada Health Act* services. Under the *Medicare Protection Act*, they are prohibited from extra-billing for any insured services. The numbers reported here reflect the number of private surgical facilities contracted with health authorities.

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	4,430	4,471	4,573	4,629	4,681
b. specialists	3,380	3,421	3,510	3,642	3,773
c. other	0	0	0	0	0
d. total	7,810	7,892	8,083	8,271	8,454
8. Number of opted-out physicians:					
a. general practitioners	3	3	3	4	4
b. specialists	3	3	2	2	2
c. other	0	0	0	0	0
d. total	6	6	5	6	6
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	not available	not available	not available	not available	not available
b. total payments	not available	not available	not available	not available	not available
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	22,781,916	23,099,248	23,930,082	23,681,176	24,219,060
b. specialists	36,207,479	38,541,400	39,828,843	42,263,797	45,864,883
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	58,989,395	61,640,648	63,758,925	65,944,973	70,083,943
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	720,487,209	749,877,257	772,944,807	760,104,435	773,230,973
b. specialists	1,076,322,482	1,154,151,676	1,194,086,689	1,196,269,921	1,259,164,813
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,796,809,691	1,904,028,933	1,967,031,496	1,956,374,356	2,032,395,786
13. Number of services provided through fee for service, by category:					
a. medical	24,989,815	25,423,936	25,921,410	26,078,714	26,809,174
b. surgical	4,317,461	4,393,613	4,520,151	4,590,296	5,348,033
c. diagnostic	29,682,119	31,823,099	33,317,364	35,275,963	37,926,736
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	58,989,395	61,640,648	63,758,925	65,944,973	70,083,943
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	1,025,581,421	1,068,484,862	1,093,649,881	1,101,606,113	1,134,825,427
b. surgical	279,710,272	296,852,722	307,628,159	313,878,348	328,946,459
c. diagnostic	491,517,998	538,691,349	565,753,456	540,889,895	568,623,900
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,796,809,691	1,904,028,933	1,967,031,496	1,956,374,356	2,032,395,786

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	**2001–2002**	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**
15. Total number of claims, in-patient.	8,113	7,618	7,294	7,467	6,517
16. Total number of claims, out-patient.	80,732	83,152	81,911	80,386	77,537
17. Total payments, in-patient ($).	40,898,996	40,195,515	45,318,174	51,869,175	49,899,859
18. Total payments, out-patient ($).	10,604,141	11,223,254	11,105,322	13,574,737	14,089,042
19. Average payment, in-patient ($).	5,041.17	5,276.39	6,213.08	6,946.45	7,656.88
20. Average payment, out-patient ($).	131.35	134.97	135.58	168.87	181.71
Physicians	**2001–2002**	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**
21. Number of services.	542,301	617,819	604,745	627,654	668,433
22. Total payments ($).	18,880,794	22,403,037	22,516,481	23,622,360	25,664,796
23. Average payment per service ($).	34.82	36.26	37.23	37.64	38.40

Insured Services Provided Outside Canada					
Hospitals	**2001–2002**	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**
24. Total number of claims, in-patient.	1,964	1,795	1,970	2,294	2,345
25. Total number of claims, out-patient.	637	949	611	761	1,247
26. Total payments, in-patient ($).	9,246,228	2,294,341	2,365,051	3,811,717	4,248,649
27. Total payments, out-patient ($).	119,928	543,969	294,712	741,617	770,215
28. Average payment, in-patient ($).	4,707.86	1,278.18	1,200.53	1,661.60	1,811.79
29. Average payment, out-patient ($).	188.27	573.20	482.34	974.53	617.65
Physicians	**2001–2002**	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**
30. Number of services.	51,594	48,457	52,673	65,134	69,741
31. Total payments ($).	2,157,483	2,145,121	2,281,820	2,767,854	3,121,999
32. Average payment per service ($).	41.82	44.27	43.32	42.49	44.77

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	**2002–2003**	**2003–2004**	**2004–2005**	**2005–2006**
33. Number of participating dentists.	275	249	243	228	238
34. Number of services provided.	43,505	36,680	36,809	38,310	41,965
35. Total payments ($).	5,401,691	5,379,450	5,170,348	5,268,900	5,833,105
36. Average payment per service ($).	124.16	146.66	140.46	137.53	139.00



Yukon

Introduction

The health care insurance plans operated by the Government of 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, Insured Health and Hearing Services. References in this text to the “Plan” refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. There are no regional health boards in the Territory.

The objective of the Yukon health care system is to ensure access to, and portability of, insured physician and hospital services according to 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 on uniform terms and conditions. The Minister, Department of Health and Social Services, is responsible for delivering all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 32,226 eligible persons registered with the Yukon health care plan on March 31, 2006.

Other 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. Non-insured health service programs include Continuing Care; Community Nursing; Community Health; and Mental Health Services.

Health care initiatives in the Territory target areas such as access and availability of services, recruitment and retention of health care professionals, primary health care, systems development and alternative payment and service delivery systems. Specifically:

- primary care initiatives are proceeding that will broaden and strengthen service delivery, modernize and improve system capabilities. These initiatives include:
  - Insured Health Information System — a new system has been installed for the processing of Health Care Registration, Medical Claims, Hospital Claims as well as for Drug Claims. Design stage is underway for Medical Travel Claims component.
  - Work with the Yukon Medical Association to find solutions for a number of Yukon residents without a family physician continues.
  - Diabetes Collaborative, which helps physicians provide improved care for patients with diabetes is operational and entering phase two. This second phase sees physicians in rural areas utilizing the Chronic Disease Management Toolkit from BC to help manage their diabetic cases.

The 2005–2006 health care expenditures increased over the 2004–2005 expenditures as follows:

- Insured Health Services increased by $3,710,900;
- Yukon Hospital Services increased by $1,722,477;
- Continuing Care increased by $1,714,054;
- Community Nursing and Emergency Medical Services increased by $874,755; and
- Community Health Programs increased by $865,898.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

- effective linkages and coordination of existing services and service providers;
- recruitment and retention of qualified health care professionals;
- increasing costs related to service delivery;
- increasing costs related to changing demographics; and
- acquiring and maintaining new and advanced high-technology diagnostic and treatment equipment.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, sections 3(2) and 4, establish the public authority to operate the health medical care plan. There were no amendments made to these sections of the legislation in 2005–2006.

The *Hospital Insurance Services Act*, sections 3(1) and 5, establish the public authority to operate the health hospital care plan. There were no amendments made to these sections of the legislation in 2005–2006.

Subject to the *Health Care Insurance Plan Act* (section 5) and Regulations, the mandate and function of the Director, Insured Health and Hearing 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 operating the Plan;
- conduct actions and negotiate settlements in the exercise of the Government of 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 and Hearing 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 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 programs 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.

1.2 Reporting Relationship

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services, make an annual report to the 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.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the auditor of the Government of Yukon in accordance with section 30 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

The most recent audit was for the year ended March 31, 2006.

Regarding the Yukon Hospital Corporation, section 11(2) of the *Hospital Act* requires every hospital to submit a report of the operations of the Corporation for that fiscal year, the report to include the financial statements of the Corporation and the auditor's report. The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

1.4 Designated Agency

The Yukon Health Care Insurance Plan has no other designated agencies authorized to receive monies or to issue payments pursuant to the *Health Care Insurance Plan Act* or the *Hospital Insurance Services Act.*

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Services Act,* sections 3, 4, 5 and 9, establish authority to provide insured hospital services to insured residents. The *Yukon Hospital Insurance Services Ordinance* was first passed in 1960 and came into effect April 9, 1960. There were no amendments made to these sections of the legislation in 2005–2006.

In 2005–2006, insured in-patient and out-patient hospital services were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital and 12 Health Centres. Additional visiting nursing services are provided from one satellite health station.

Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the Legislature and the Government to ensure "compliance with appropriate methods of operation and standards of facilities and care". Adopted on November 11, 1994, the Hospital Standards Regulation sets out the conditions under which all hospitals in the Territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establishes and maintains a quality assurance program. Currently, the Yukon Hospital Corporation is operated under a three-year accreditation through the Canadian Council on Health Services Accreditation.

The Yukon government assumed responsibility for operating Health Centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/Nursing Station Facility/Health Centre Treatment Facility, and the Community Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the Hospital Insurance Services Regulations, sections 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to in-patients, namely: accommodation and meals at the standard or public ward level; necessary nursing service; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability; drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; use of radiotherapy facilities where available; use of physiotherapy facilities where available; and services rendered by persons who receive remuneration therefore 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 service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury; drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; services rendered by

persons who receive remuneration therefore from the hospital; use of radiotherapy facilities where available; and use of physiotherapy facilities where available.

Pursuant to the Hospital Insurance Services Regulations, all in- and out-patient services provided in an approved hospital by hospital employees are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Department of Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

A total of $475,000 was dedicated for the purchase of new hospital equipment, this included a Digital Fluoro Machine and additional funding to increase the number of knee replacements performed in Yukon.

These measures will help reduce the Territory's reliance on out-of-territory services.

2.2 Insured Physician Services

Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7, 10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to these sections of the legislation in 2005–2006.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. The conditions a physician must meet to participate in the Yukon Health Care Insurance Plan are to:

- register for licensure pursuant to the *Medical Professions Act*; and
- maintain licensure pursuant to the *Medical Professions Act*.

The estimated number of resident physicians participating in the Yukon Health Care Insurance Plan in 2005–2006 was 64.

Section 7(5) of the Yukon Health Care Insurance Plan Regulations allows physicians in the Territory to bill patients directly for insured services by giving notice in writing of this election. In 2005–2006, 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. 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.

Insured services added in 2005–2006 include:

- Some examinations performed by optometrists are now insured. These must be medically necessary and problem-based and are insured only in the absence of a resident Ophthalmologist in Yukon.

The process used to add a new fee to the "Relative Value Guide to Fees" is administered through a committee structure. This process requires physicians to submit requests in writing to the joint Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee.

Following review by this committee, a decision is made to include or exclude the service. The relevant costs or fees are normally set in accordance with similar costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Public consultation is not required.

Alternatively, new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services. The Director, Insured Health and Hearing Services, manages this process and no public consultation is required.

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 given billing numbers to bill the Yukon Health Care Insurance Plan for providing insured dental services. In 2005–2006, six dentists billed the Plan for insured dental services that were provided to Yukon residents. The Plan is also billed directly for services provided outside the territory.

Dentists are able to opt out of the health care plan in the same manner as physicians. In 2005–2006, no dentists provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Regulations and require the unique capabilities of a hospital for their performance (e.g. surgical correction of prognathism or micrognathia).

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the Regulations Respecting Health Care Insurance Services. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services, administers this process.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and Regulations and the *Hospital Insurance Services Act* and Regulations are insured. All other services are uninsured.

Uninsured physician services include: services that are not medically necessary; charges for long-distance telephone calls; preparing or providing a drug; advice by telephone at the request of the insured person; medicolegal services including examinations and reports; cosmetic services; acupuncture; and 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; special/private nurses requested by the patient or family; additional charges for preferred accommodation unless prescribed by a physician; crutches and other such appliances; nursing home charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital.)

Uninsured dental services include: procedures considered restorative; and procedures that are not performed in a hospital under general anaesthesia.

Further, the Act states that any service that a person is eligible for, and entitled to, under any other Act is not insured.

All Yukon residents have equal access to services. Third parties, such as private insurers or the Worker's Compensation Health and Safety Board, do not receive priority access to services through additional payment.

The purchase of non-insured services, such as fibreglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

The Territory has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services, to monitor usage and service concerns.

Physicians in the Territory may bill patients directly for non insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include, but are not limited to, completion of employment forms; medical legal reports; transferring records; third party examinations; some elective services; and telephone prescriptions, advice or counselling. Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

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 not medically necessary, ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing. The Director, Insured Health and Hearing Services, manages this process. No services were removed from the "Relative Value Guide to Fees" in fiscal year 2005–2006.
- Hospital services — an amendment by Order-In-Council to section 2 (e) (f) of the Yukon Hospital Insurance Services Regulations is required. As of March 31, 2006, no insured in- or out-patient hospital services, as provided for in the Regulations, were deinsured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.

- Surgical-dental services — an amendment by Order In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required. A service could be de-insured if determined not medically necessary or is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services, manages this process.

3.0 Universality

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act* and Regulations, sections 2 and 4 respectively, and the *Hospital Insurance Services Act* and Regulations, sections 2 and 4 respectively. Subject to the provisions of these Acts and Regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the Yukon, but does not include a tourist, transient or visitor to the Yukon. Where applicable, the eligibility of all persons is administered in accordance with the Inter-Provincial Agreement on Eligibility and Portability.

Under section 4(1) of both Regulations "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory".

Changes affecting eligibility made to the legislation in 2004–2005 now require that all persons returning to or establishing residency in Yukon complete the waiting period. The only exception is for children adopted by insured persons.

The following persons are not eligible for coverage in the Yukon:

- persons entitled to coverage from their home province or territory (e.g. students and workers covered under temporary absence provisions);
- visitors to the Territory;
- refugee claimants;
- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP);
- inmates in federal penitentiaries;
- study permit holders; and
- employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

- establish residency in the Territory;
- become a permanent resident; and
- the day following discharge or release if stationed in or resident in the Territory.

3.2 Registration Requirements

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 and Hearing Services, at the place and in the manner and form and at the times prescribed by the Regulations". Registration is administered in accordance with the Inter-Provincial Agreement on Eligibility and Portability.

Persons and dependants under the age of 19 who move permanently to the Yukon are advised to apply for health care insurance upon arrival. Application is made by completing a registration form available from the Insured Health and Hearing Services office or community Territorial Agents. Once coverage becomes effective, a health care card is issued.

Family members receive separate health care cards and numbers. Health care cards expire every year on the resident's birthday and an updated label with the new expiry date is mailed out accordingly.

As of March 31, 2006, there were 32,226 residents registered with the Yukon Health Care Insurance Plan. There were no residents who notified Insured Health Services of their decision to opt out of the Yukon Health Care Insurance Plan in 2005–2006.

3.3 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals as follows (subject to a waiting period not to exceed three months — see section 3.1):

- Returning Canadians — waiting period is applied
- Permanent Residents — waiting period is applied
- Minister's Permit — waiting period is applied, if authorized
- Convention Refugees — waiting period is applied if holding Employment Authorization
- Foreign Workers — waiting period is applied, if holding Employment Authorization
- Clergy — waiting period is applied, if holding Employment Authorization

Employment Authorizations must be in excess of 12 months.

The estimated number of new individuals receiving coverage in 2005-2006 under the following conditions is:

- Returning Canadians — 21
- Permanent Residents — 259
- Minister's Permit — 20
- Convention Refugees — 20
- Armed Forces (retiring member) — 1
- RCMP (retiring member) — 1

The estimated number of individuals receiving coverage in 2005–2006 under the following conditions is:

- Foreign Workers — 69
- Clergy — 0

3.4 Premiums

The payment of premiums by Yukon residents was eliminated on April 1, 1987.

4.0 Portability

4.1 Minimum Waiting Period

Pursuant to section 4(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory". All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted from outside Canada by insured persons. (See section 3.1.)

4.2 Coverage During Temporary Absences in Canada

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2), and 9 of the Yukon Hospital Insurance Services Regulations.

The Regulations state that "where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence". However, persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in cancellation of the coverage.

Students attending educational institutions outside the Territory remain eligible for the duration of their academic studies. The Director, Insured Health and Hearing Services, may approve other absences in excess of 12 continuous months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director, Insured Health and Hearing Services, may approve absences in excess of 12 continuous months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-Provincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures.

No amendments were made to these sections of the legislation in 2005–2006.

The Yukon participates fully with the Inter-Provincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories with the exception of Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and

submit claims to the Yukon Health Care Insurance Plan for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside the Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside the Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the Territory are paid at the rates established by the host province. The following amounts were paid to out-of-territory hospitals (in Canada) for the fiscal year 2005–2006 :

- In-patient services — $8,698,387
- Out-patient services — $1,735,520

These figures are by date of service and may be subject to adjustment.

In 2005–2006, payments to out-of-territory physicians (including out-of-country) totalled $1,873,508.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations. No amendments were made to these sections of the legislation in 2005–2006.

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". However, persons leaving the Territory for a period exceeding two months are advised to contact the Yukon Health Care Insurance Plan and complete a form of "Temporary Absence". Failure to do so may result in cancellation of the coverage.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada. (See section 4.2.)

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. The standard ward rate for the Whitehorse General Hospital as of April 1, 2005, was $1,297. This rate is established through Order-in-Council and is based upon a corresponding Yukon value for the service.

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 $158 and is established through Order-in-Council and derived by the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC).

The following amounts were paid in 2005–2006 for elective and emergency services provided to eligible Yukon residents outside Canada:

- In-patient services — $43,454
- Out-patient services — $8,372

These figures are by date of service and may be subject to adjustment.

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Canada.

5.0 Accessibility

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program or with the support of the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

There is no extra-billing in the Yukon for any services covered by the Plan.

5.2 Access to Insured Hospital Services

Pursuant to the *Hospital Act*, the "Legislature and Government have responsibility to ensure the availability of necessary hospital facilities and programs". The Minister must approve any significant changes to the level of service delivery. Acute care beds are readily available and no waitlist for admission exists at either of Yukon's two acute care facilities.

The estimated number of fulltime equivalent (FTEs) nurses and other health care professionals working in facilities providing insured hospital services in the Yukon as of March 31, 2006, is:

Profession	Whitehorse General Hospital	Watson Lake Cottage Hospital
	# of FTEs	# of FTEs
Registered Nurses	74.50	7.50
Licensed Practical	8.00	2.00
Nurse Pract.	0	0
Social Worker	1.00	0
Pharmacist	2.00	0
Physiotherapist	4.40	9.00
Occup. Therapist	1.40	0
Psychologist	0	0
Medical Lab/X-Ray	26.25	0
Dietician	3.75	0
Public Health	0	2.00
Home Care	0	1.00

The Whitehorse General Hospital and Community Nursing manage the supply of nurses and health care professionals in the Territory's two hospitals with the Department of Health and Social Services. Shortfalls in staffing are covered by temporary, casual or auxiliary workers to ensure residents have continued access to insured services.

Recruitment and Retention

Recruitment and retention initiatives include:

1) Community Nursing:

A Yukon Advisory Committee on Nursing was struck to advise the Department of Health and Social Services on nursing issues. Recommendations will help Yukon recruit and retain nurses in both the long and short term. Yukon is providing:

- competitive salaries;
- recruitment and retention bonuses;
- participation at job fairs;
  - training and educational opportunities;
  - travel bonus / $2,000 after one year; and
  - relief positions.

2) Whitehorse General Hospital

- competitive salaries;
- wage scale recognizes experience;
- cooperative work schedules;
- on-site fitness centre/24-hour;
- monthly clinical skill development;
- continuing education/development; and
- travel bonus / $2,000 after one year.

Facilities

1) Whitehorse General Hospital:

As the only major acute care hospital facility in the Territory, this facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide Emergency Department services on rotation.

Emergency surgery patients at the Whitehorse General Hospital are normally seen within 24 hours. Elective surgery patients are normally seen within one to two weeks. The number of Visiting Specialist clinics is routinely adjusted to address wait times, particularly for orthopaedics, ear/nose/throat and ophthalmology (see section 5.3).

Surgical services provided include:

- minor orthopaedics;
- selected major orthopaedics;
- gynecology;
- paediatrics;
- general abdominal;
- mastectomy;
- emergency trauma;
- ear/nose/throat and otolaryngology; and
- ophthalmology including cataracts.

Diagnostic services include:

- radiology (including ultrasound, computed tomography, x-ray and mammography);
- laboratory; and
- electrocardiogram.

Selected rehabilitative services are available through out-patient therapies.

2) Watson Lake Cottage Hospital:

This primary acute care facility is located in Watson Lake. Medical services include emergency trauma, low-risk maternity, medicine, paediatrics, palliative and respite care. Diagnostic services include x-ray, laboratory and electrocardiogram. This is a 12-bed facility and there is no waitlist for admission.

3) Health Centres:

Out-patient and 24-hour emergency services are provided at the remaining 12 community Health Centres by Community Nurse Practitioners and auxiliary nursing staff.

Patients requiring insured hospital services not available locally are transferred to acute care facilities in territory or out-of-territory through the Travel for Medical Treatment Program.

Measures to Improve Access:

A number of measures have been taken to better manage access to insured hospital services. The Department of Health and Social Services continues to work with the Yukon Hospital Corporation and Community Nursing to ensure the current waiting time for insured hospital services in the Territory is reduced or maintained at existing levels. For example:

- Heart defibrillators were made available in all rural Yukon Health Centres. This provides an important tool for Community Nurse Practitioners and improves local access to cardiac care.
- Officials from the Department attend nursing recruitment fairs across Canada and provide information on working in the Territory to nurses in attendance.
- The Technical Review Committee continues to make recommendations to the Department on health programs and services in the Yukon as required. Its mandate is to develop criteria for initiating, eliminating, expanding or reducing programs or services.
- Telehealth provides real-time video in most Yukon communities and outlying rural communities with access to Whitehorse, and services to Whitehorse with outside centres in British Columbia or Alberta.
- Telehealth educational sessions continue to occur regularly between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia. These sessions are attended by patients, physicians, nurses, social workers, psychiatrists, mental health counsellors and allied professionals such as Community Health Representatives and First Nation Wellness workers.

5.3 Access to Insured Physician and Surgical-Dental Services

Existing legislation and administration of services provides all eligible Yukon residents with equal access to insured physician and dental services on uniform terms and conditions.

The following resident physicians, specialists and dentists provided services in the Yukon as of March 31, 2006, (see Statistical table item #7):

- General/Family Practitioners — 55
- Specialists — 9
- Dentists — 6

Beyond the usual distribution of physicians and specialists in the Territory, uniform access to insured physician and dental services is ensured through the Travel for Medical Treatment Program. This program covers the cost of medically necessary transportation, allowing eligible persons to access services that are not available in their home communities. Eligible persons are routinely sent

to Whitehorse, Vancouver, Edmonton or Calgary to receive services.

Most physicians in the Yukon are located in Whitehorse. Beyond Whitehorse, only two rural communities have resident fee-for-service physicians: Dawson City and Watson Lake. Two contracted physicians provide resident services in Faro and Mayo.

The Visiting Physician Program provides local access to insured physician services to 10 rural and remote locations. The frequency of visiting clinics is based on demand and utilization. Physicians providing visiting services through this program are compensated under contract for lost practice time, mileage, meals and accommodation, in addition to a sessional rate or fee-for-service billings.

In addition, the Department of Health and Social Services and the Visiting Specialist Program provide local access at the Whitehorse General Hospital, Mental Health Services or the Yukon Communicable Disease Unit to non-resident visiting specialist services not regularly available in the Territory. Visiting specialists are reimbursed for expenses in addition to a sessional rate or fee-for-service billings.

The number of specialists providing services under the Visiting Specialist Program and the Department of Health and Social Services is:

- Ophthalmology — 1
- Oncology — 3
- Internal Medicine — 2
- Otolaryngology — 2
- Neurology — 2
- Rheumatology — 1
- Dermatology — 1
- Dental Surgery — 3
- Infectious Disease — 1
- Psychiatry — 3
- Orthopaedics — 3

Visiting Specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2006, the waitlist for non emergency specialist services was estimated at:

- Ophthalmology — 12 to 18 months
- Orthopaedics — 2 to 24 months
- Otolaryngology — 1 to 3 months
- Neurology — 3 to 5 months
- Rheumatology — 3 to 5 months
- Dental Surgery — 2 to 3 months

Dental surgery services are not provided through the Visiting Specialist as administered by the Whitehorse General Hospital. Please note that there are no waitlists for visiting services not included in the above listing. Patients are seen on the next scheduled visit.

The Department of Health and Social Services has taken several measures to reduce waiting times for insured physician services. A variety of recruitment and retention initiatives were begun in 2001–2002 and 2002–2003 such as a Resident Support Program; Locum Support Program; Physician Relocation Program; Education Support; and a Rural Training Fund. The Department of Health and Social Services continues to work with the Yukon Medical Association to find additional cooperative initiatives to be implemented within the terms of the renewed Memorandum of Understanding of April 1, 2004.

Other measures taken in 2005–2006 to ensure access and reduce wait times:

- Yukon has declared a need that will permit internationally trained medical graduates to be granted a special license to practice in Yukon. These physicians will work under the supervision of a resident Yukon physician and provide medical services to the residents of Whitehorse.

The Yukon Medical Council and the Department of Health and Social Services promoted a program that provided clinical assessments for international medical graduates to ensure they have the necessary skills and experience to provide a high standard of care to Yukon patients. One local international medical graduate was accepted into this program and has successfully completed the program.

Physicians have indicated that they are interested in exploring new models for health care provision. The Government is working with Yukon physicians to facilitate this.

5.4 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, before entering negotiations with the Yukon Medical Association (YMA). The YMA and the Government each appoint members to the negotiating team. Meetings are held as required until an agreement is reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The most recent four-year Memorandum of Understanding came into effect April 1, 2004, and shall remain in effect to March 31, 2008. This MOU established the terms and conditions for payment of physicians and established two new programs: the New Patient Program, and the Physician Retention Program.

The legislation governing payments to physicians and dentists for insured services is the *Health Care Insurance Plan Act* and the Regulations. No amendments were made to these sections of the legislation in 2005–2006.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2005–2006, two full-time resident rural physicians and four resident specialists were compensated on a contractual basis. Two physicians providing visiting clinics in outlying communities were paid a 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 and adjusted based on operational requirements and utilization projections from prior years. In addition to the established O&M and capital funding set out in the agreement, provision is made for the hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The Watson Lake 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 Regulations. The legislation and Regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons. No amendments were made to these sections of the legislation in 2005–2006.

6.0 Recognition Given to Federal Transfers

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in its 2005–2006 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1) (d) (e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act* acknowledge the contribution of the Government of Canada

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care

Continuing Care Health Services are available to eligible Yukon residents. In 2005–2006, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services: personal care; extended care services; intermediate care; special care; respite care; day program; and meals on wheels.

In total, there were 138 continuing care beds in the Territory in 2005–2006.

There is no legislated requirement for long-term residential care services for adults in Yukon. No other major changes were made in the administration of these services in 2005–2006.

Home Care Services

The Yukon Home Care Program provides assessment and treatment, care management, personal support, homemaking services, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. Some rural communities have a dedicated home care nurse, though many rural communities provide nursing services through the community nursing program. Home support workers assist clients with personal care, homemaking and respite services. Therapy services are provided by a travelling regional team of physiotherapists and occupational therapists. Services are available Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided. Twenty-four hour care is not available.

There is no legislated requirement for home care services in Yukon. No other major changes were made in the administration of these services in 2005–2006.

Ambulatory Health Care Services

The Yukon Home Care Program provides the majority of ambulatory health care services outside institutional settings. Most other services are provided through Community Nursing or public health. All residents have equal access to services. These services are not provided for in legislation.

There were some changes made in the administration of these services in 2005–2006. The Travel for Medical Treatment Program approved increases to both the subsidy amount and the mileage reimbursement amounts. Beginning in 2006–2007, eligible individuals will be able to collect $75/day starting on the second day they are on Medical Travel Status. Mileage reimbursement for those who travel by automobile will increase to $.30/km. In addition to the services described above, the following are also available to eligible Yukon residents and are outside the requirements of the *Canada Health Act:*

- The Chronic Disease and Disability Benefits Program provides benefits for eligible 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 to receive services not available locally. (*Travel for Medical Treatment Act* and Regulation)
- The Children's Drug and Optical Program is designed to assist eligible low-income families with the cost of prescription drugs, eye exams and eye glasses for children 18 and younger. (Children's Drug and Optical Program Regulation)
- Mental Health Services provide assessment, diagnostic, individual and group treatment, consultation and referral services to individuals experiencing a range of mental health problems. (*Mental Health Act* and Regulations)
- 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.
- Emergency Medical Services 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, by providing routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.
- Dental Services provides a comprehensive diagnostic, preventive and restorative dental service to children from preschool to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for preschool to grade 12. This is a non-legislated program.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	31,036	30,534	30,917	31,505	32,226

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
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. other	13 [1]	13 [1]	13 [1]	13 [1]	13 [1]
e. total	15	15	15	15	15
3. Payments ($): [2]					
a. acute care	21,920,937	22,515,448	24,877,479	26,255,596	26,867,501
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	5,997,920 [1]	6,133,453 [1]	6,318,565 [1]	6,509,897 [1]	6,862,368 [1]
e. total	27,918,907	28,648,901	31,196,044	32,765,493	33,729,869
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

1. Includes 12 health centres and one satellite health station.
2. Amounts include payments for operating and maintenance only. For 2004–2005, payment to facilities offering ‘other’ services has been revised.

Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004 [3]	2004–2005 [3]	2005–2006 [3]
7. Number of participating physicians: [4]					
a. general practitioners	49	53	55	54	55
b. specialists	5	6	8	8	9
c. other	0	0	0	0	0
d. total	54	59	63	62	64
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	201,437	232,624	235,642	238,797	248,646
b. total payments	9,017,141	10,625,211	11,769,018	12,892,522	13,752,251
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	160,932	186,479	191,002	207,053	214,305
b. specialists	11,881	11,040	10,460	11,978	11,510
c. other	0	0	0	0	0
d. total	172,813	197,519	200,462	219,031	225,815
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	5,692,583	6,740,552	7,336,403	8,168,042	8,679,497
b. specialists	1,143,968	971,283	984,711	1,033,537	1,168,494
c. other	0	0	0	0	0
d. total	6,836,551	7,711,835	8,321,114	9,201,579	9,847,991
13. Number of services provided through fee for service, by category:					
a. medical	131,004	154,591	151,825	171,657	173,754
b. surgical	26,653	26,388	31,894	31,036	33,082
c. diagnostic	15,156	16,540	16,472	16,338	18,979
d. other	0	0	0	0	0
e. total	172,813	197,519	200,461	219,031	225,815
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	5,550,975	6,386,109	6,802,367	7,722,884	8,065,738
b. surgical	1,057,467	1,029,697	1,257,750	1,289,558	1,466,488
c. diagnostic	228,109	296,029	260,997	189,137	315,764
d. other	0	0	0	0	0
e. total	6,836,551	7,711,835	8,321,114	9,201,579	9,847,990

3. Includes on-call payments to physicians.
4. Includes only resident family physicians and specialists.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	663	666	783	674	714
16. Total number of claims, out-patient.	6,547	7,241	6,938	7,412	8,450
17. Total payments, in-patient ($).	4,299,055	5,861,530	7,587,906	5,857,725	8,698,387
18. Total payments, out-patient ($).	945,804	1,037,692	936,376	1,306,531	1,735,520
19. Average payment, in-patient ($).	6,484.25	8,801.10	9,690.81	8,690.99	12,182.61
20. Average payment, out-patient ($).	144.47	143.31	134.96	176.27	205.39
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	32,461	34,853	34,037	35,401	35,781
22. Total payments ($).	1,601,642	1,799,019	1,833,654	1,921,260	1,873,508
23. Average payment per service ($).	49.34	51.62	53.87	54.27	52.36

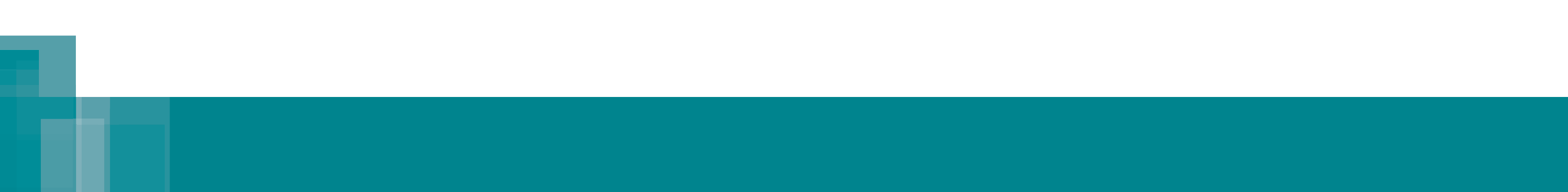
Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	15	9	8	14	15
25. Total number of claims, out-patient.	40	26	46	64	55
26. Total payments, in-patient ($).	50,599	9,339	13,536	30,566	43,454
27. Total payments, out-patient ($).	4,431	2,451	5,994	9,965	8,372
28. Average payment, in-patient ($).	3,373.27	1,037.67	1,692.00	2,183.29	2,896.93
29. Average payment, out-patient ($).	110.78	94.27	130.30	155.70	152.22
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	not available	not available	not available	not available	not available
31. Total payments ($).	not available	not available	not available	not available	not available
32. Average payment per service ($).	not available	not available	not available	not available	not available

Insured Surgical-Dental Services Within Own Province or Territory [5]					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of particpating dentists.	11	8	6	6	6
34. Number of services provided.	214	150	104	30	24
35. Total payments ($).	51,078	37,342	25,093	29,712	25,072
36. Average payment per service ($).	238.69	248.95	241.28	990.40	1,044.67

5. Includes direct billings for insured surgical-dental services received outside the territory.

Insured Physician Services Within Own Province or Territory Visiting Specialists, Locum Doctors and Member Reimbursements [6]					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
37. Number of physician services paid through fee for service, by type:					
a. general practitioners	18,663	21,896	21,109	5,264	8,229
b. specialists	11,323	12,830	6,165	7,771	8,898
c. total	29,986	34,726	27,274	13,035	17,127
38 Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	699,718	788,293	819,490	243,203 [7]	415,959
b. specialists	885,944	1,192,364	1,020,988	1,252,498	1,470,330
c. total	1,585,662	1,980,657	1,840,478	1,495,701	1,886,289
39. Number of services provided through fee for service, by category:					
a. medical	23,431	25,402	23,466	8,999	14,341
b. surgical	4,888	7,510	2,097	2,656	1,482
c. diagnostic	1,667	1,814	1,711	1,380	1,303
d. total	29,986	34,726	27,274	13,035	17,126
40. Total payments to physicians paid through fee for service, by category ($):					
a. medical	1,224,899	1,392,766	1,371,373	1,021,817	1,492,628
b. surgical	285,503	481,940	374,435	368,891	294,662
c. diagnostic	75,261	105,951	94,671	104,993	98,999
d. total	1,585,663	1,980,657	1,840,479	1,495,701	1,886,289

6. Includes Visting Specialists, Member Reimbursements, Locum Doctors, and Optometrist testing paid through fee-for-service. Excludes services and costs provided by alternative payment agreements.
7. Reduction for 2004–2005 from prior years is due to a decline in the number of general practitioner locums provided and the transfer of physician data to the resident physician category.



Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, (henceforth the Department) together with seven Health and Social Services Authorities (HSSAs) and the Tlicho Community Services Agency (TCSA), plan, manage and deliver a full spectrum of community and facility-based services for health care and social services. Community health programs include drop-in clinics, public health clinics, home care, school health programs, and educational programs. Physicians and specialists routinely visit communities without resident physicians. Services also include early intervention and support to families and children, mental health, and addictions.

As of April 1, 2006, there were more than 40,000 people living in the Northwest Territories, of which half were Aboriginal[1]. The NWT continues to have a relatively young population and a high birth rate. According to 2005 population estimates, approximately 25 percent of the NWT population is under 15 years of age, compared with 18 percent in the overall Canadian population[2].

During the reporting period, the Department undertook several important initiatives, including:

- The implementation of the *Midwifery Profession Act*, introducing midwifery as a regulated profession and insured service. Under this act, midwives are autonomous primary health care providers whom clients may choose as their first point of entry to the maternity care system, allowing some women the option of delivering closer to their home communities.
- *Access to Health Care and Addressing Wait Times in the NWT*, a report that documents work underway to address access to primary health care and wait times for surgical and diagnostic imaging procedures in the Territories. The report includes a workplan to continue efforts in improving access to health care services for all residents.
- The implementation of the *Tlicho Community Services Agency Act*. This Act deems the Tlicho Community Services Agency as a Board of Management and enables the Agency to oversee and deliver Health and Social Services programs and services in the Tlicho region.
- The passing of the *Tobacco Control Act* by the Legislative Assembly in March of 2006. This act prohibits smoking in all public places and controls the sale and display of tobacco in the NWT. Pharmacies, recreation facilities, and vending machines will no longer sell tobacco products. Retailers will not be allowed to display tobacco products and will be required to display signs disclosing information about the health risks of tobacco.

The Department maintains a bilingual (english and french) public website (www.hlthss.gov.nt.ca) that provides an exhaustive source of information, including electronic copies of reports published by the Department.

1.0 Public Administration

1.1 Health Care Insurance Plans and Public Authority

The NWT Health Care Plan includes the Medical Care Plan and the Hospital Insurance Plan. The public authority responsible for administering 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 established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA).

1 Statistics Canada, Canada's Population Estimates, First Quarter 2006.

2. Statistics Canada, CANSIM, table 051-0001.

Legislation that enables the Health Care Insurance Plan in the NWT includes the *Medical Care Act* and *Hospital Insurance and Health and Social Services Administration Act* (revised 2005). Changes to the HIHSSA are consequential amendments due to the establishment of the Tlicho Community Services Agency by the *Tlicho Community Services Agency Act*.

1.2 Reporting Relationship

In the Northwest Territories (NWT), the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for administering the *Medical Care Act* and regulations. The Director reports to the Minister each fiscal year concerning the operation of the Medical Care Plan.

The Minister also appoints members to a Board of Management for each Heath and Social Services Authority in the NWT. The Boards are established with the authority to manage, control and operate health and service facilities. The Boards' chairpersons hold office indefinitely, while other members hold office for a term of three years. Tlicho community governments appoint members to the Tlicho Board of Management for a maximum of four years.

An annual audit of accounts is performed on each Board of Management. The Minister has regular meetings with Board of Management chairpersons. This forum allows the chairperson 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 Office of the Auditor General of Canada (OAG) audits the payments made under the Medical Care Plan and the Hospital Insurance Plan.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the authority of the HIHSSA and the regulations. HIHSSA was amended in 2005 in order to recognize the newly established Tlicho Community Services Agency as a Board of Management. In the same year, the Hospital Standards Regulations were repealed for the Hospital and Health Care Facility Standards Regulations.

During 2005–2006, four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The NWT provides coverage for a full range of insured hospital services. 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, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case room and anaesthetic facilities; use of radiotherapy and physiotherapy services, where available; psychiatric 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.

The NWT also provides a number of out-patient services. These 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- and out-patient services is contained in the Hospital Insurance Regulations. Section 1 of the Regulations states that "out-patient insured services" means the following services and supplies provided to out-patients: laboratory, radiological and other diagnostic procedures together with the necessary interpretations for helping diagnose and treat any injury, illness or disability,

but not including simple procedures such as examinations of blood and urine, which ordinarily form part of a physician's routine office examination of a patient; necessary nursing service; 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 or those services from a hospital; radiotherapy services within insured facilities; and physiotherapy services within insured facilities.

The Minister may add, change or delete insured hospital services. The Minister also determines if any public consultation will occur before making changes to the list of insured services.

Where insured services are not available in the NWT, residents receive them from hospitals in other jurisdictions, provided they are medically necessary. The NWT provides medical travel assistance and a supplementary health benefit program (as outlined in the Medical Travel Policy), which ensures that NWT residents have no barriers to accessing medically necessary services.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide for insured physician services.

Physicians, nurses, nurse practitioners, and midwives are allowed to provide insured services under the health care insurance plan. Physicians and nurse practitioners must be licensed to practice in the NWT. Midwifes and Nurses must meet registration requirement set out respectively in the *Midwifery Profession Act* and the *Nursing Profession Act*. As of March 31, 2006, there were 232 licensed physicians providing insured services in the NWT.

A physician may opt-out and collect his or her fees otherwise than under the Medical Care Plan, by delivering to the Director of Medical Insurance a written notice to that effect. There are no physicians who opted-out of the Medical Care plan as of March 2006.

A wide range of medically necessary services is provided in the NWT. No limitation is applied if a service has been deemed an insured service. 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.

It is the responsibility of the Director of Medical Insurance to prepare and recommend to the Minister a tariff itemizing the benefits payable in respect of insured services. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations, as follows:

- establishing a medical care plan that provides insured services to insured persons by medical practitioners that will in all respects meet the requirements of the *Canada Health Act*, and qualify and enable the NWT to receive payments of cash contributions from the Government of Canada under the Canada Health Transfer; and
- prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the NWT, and the conditions under which the fees and charges are payable.

2.3 Insured Surgical-Dental Services

Insured services and those related to oral surgery, injury to the jaw or disease of the mouth/jaw are eligible. Only licensed oral surgeons may submit claims for billing. The NWT uses the Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided by hospitals, physicians and dentists, but not covered by the NWT Health Care Insurance Plan, 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; advice or prescriptions given over the telephone; surgery for cosmetic purposes except where medically required; dental services other than those specifically defined for oral surgery; dressings, drugs, vaccines, biologicals and related materials administered in a physician's office; 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.

In the NWT, prior approval applications must be made to the Director of Insured Services for uninsured medical goods or services provided in conjunction with an insured health service. A Medical Advisor provides the Director with recommendations regarding the appropriateness of the request.

The NWT *Medical Care Act* includes Medical Care Regulations and provides for the authority to negotiate changes or deletions to tariffs. The process is described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* defines the eligibility of NWT residents for the NWT Health Care Insurance Plan.

The NWT uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the NWT Health Care Plan Registration Guidelines to define eligibility. There were no changes to eligibility for the reporting period.

Ineligible individuals for NWT health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP), federal inmates and residents who have not completed the minimum waiting period. For persons discharged from the Canadian Armed Forces, RCMP, federal penitentiary, or Canadian citizens returning to the NWT from living outside Canada, coverage is effective the day permanent residency is established.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable; e.g. visas and immigration papers. The applicant must be prepared to provide proof of residency, if requested. Registration should occur before the actual eligibility date of the client. NWT health care cards are valid for a five-year period. Registration and eligibility for coverage are directly linked. Only claims from registered clients are paid.

As of March 2006, there were 44,082 individuals registered with the NWT 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 Individuals

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and guidelines for health care plan coverage.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the NWT. The waiting periods are consistent with the Interprovincial Agreement on Eligibility and Portability. Generally the waiting periods are the first day of the third month of residency, for those who move permanently to the NWT, or the first day of the thirteenth month for those with temporary employment of less than 12 months, but who can confirm that the employment period has been extended beyond the 12 months.

4.2 Coverage During Temporary Absences in Canada

The Interprovincial Agreement on Eligibility and Portability and the NWT 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 NWT for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the NWT for work, vacation, etc. Once an individual has completed a Temporary Absence form and been approved by the Department

as being temporarily absent from the NWT, the full cost of insured services is paid for all services received in other jurisdictions. During the 2005–2006 fiscal year, over $12 Million was paid for in- and out-patient hospital services received in other provinces and territories.

The NWT participates in both the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The NWT Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada.

As per subsection 11 (1) (b) (ii) of the *Canada Health Act*, insured residents may submit receipts for costs incurred for services received outside Canada. The NWT does provide personal reimbursement when an NWT resident leaves Canada for a temporary period for personal reasons such as vacations and requires medical attention during that time. Individuals are required to cover their own costs and seek reimbursement upon their return to the NWT. Benefits payable are provided in the approved tariff. If services are rendered outside Canada, the benefits payable must not exceed the benefits for insured services rendered in the Territories.

Individuals may be granted coverage for up to a year with prior approval, if they are outside the country. In the eligibility rules, NWT residents may continue their coverage for up to one year if they are leaving Canada, but they must provide extensive information confirming that they are maintaining their permanent residence in the NWT.

4.4 Prior Approval Requirement

The NWT requires prior approval if coverage is to be considered for elective services in other provinces, territories and outside the country. 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 Program ensures that economic barriers are reduced for all NWT residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed unless the medical practitioner has made an election to collect her or his fees for medical services to insured persons otherwise than under the Medical Care Plan.

5.2 Access to Insured Hospital Services

If a bed shortage were to arise, the resident would be transported to another facility where appropriate beds exist. NWT hospitals and health centres continued to face some short-term staffing difficulties that had negative effects on their operations. However, through the use of medical travel arrangements, access to services was maintained throughout 2005–2006.

Facilities in the NWT do offer a range of medical, surgical, rehabilitative and diagnostic services. The NWT Medical Travel Program ensures that residents will have access to necessary services not available in NWT facilities.

The number of Telehealth sites remained unchanged during 2005–2006. The Telehealth program has entered into a three-year strategic planning process, which is to provide direction on integration and sustainability for the Telehealth program in relation to the Integrated Service Delivery Model.

With regards to recruiting and retaining professional staff, the NWT faces the same challenges as the rest of Canada. In addition, the NWT faces unique demands due to its remoteness and socio-economic realities.

The Department developed a comprehensive five-year human resource strategy in 2004 to address these issues. This strategy outlined alternatives available to the Department of Health and Social Services and its HSSAs to increase the supply of health professionals required to meet health care needs of NWT residents. Initiatives directly related to increasing the supply of health professionals include: the promotion of health careers; succession planning; and maximizing northern employment. The Government of the Northwest

Territories is working with employees, unions and professional organizations to identify, develop and implement initiatives supporting the retention and recruitment of health and social services professionals.

5.3 Access to Insured Physician and Surgical-Dental Services

All NWT residents have access to all facilities operated by the Government of the Northwest Territories.

The Medical Travel Program provides access to physicians for residents. The Telehealth program expands the specialist services available to residents in isolated communities.

5.4 Physician Compensation

To compensate physicians, the NWT uses two models: employee contracts, and fee-for-service. The majority of family physicians are employed through a contractual arrangement with the GNWT. The remainder provides services through a fee-for-service arrangement. The *Medical Care Act* and part of the Medical Care Regulations are used in the NWT to govern amounts to be paid to physicians where insured services are provided on a fee-for-service basis.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department. Amounts allocated in the agreements are based on 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 HIHSSA and the *Financial Administration Act*. No amendments were implemented in 2005–2006 to provisions involving payments to facilities. A comprehensive budget is used to fund hospitals in the NWT.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health Transfer (CHT) has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents.

For fiscal year 2005–2006, these documents included:

- 2005–2006 Budget Address;
- 2005–2006 Main Estimates;
- 2004–2005 Public Accounts; and
- 2003–2006 Business Plan for the Department of Finance.

The Estimates (noted above) represent the government's financial plan, and are presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

Continuing Care programs and services offered in NWT communities may include: supported living; adult group homes; long-term care facilities; and extended care facilities. These programs and services operate where applicable according to the Department of Health and Social Services Establishment Policy, the HIHSSA and the Hospital and Health Care Facility Standards Regulations.

Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home care services. Current services in this area include supported living arrangements in family homes, apartments and group-living homes, where clients live as independently as possible. Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.

The NWT Home Care Program is a territory-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 is based on need and is available to NWT residents without charge. The range of Home Care services include: acute care; post-hospital care; chronic illness care; nutrition services; palliative care; personal care; and respite care. Home care services are delivered through the Regional HSSA and Tlicho Community Services Agency and are based on multi-disciplinary assessments of individual needs. The Home Care Program provides services to the seven regions of Yellowknife, Hay River, Fort Smith, Beaufort-Delta, Sahtu, Deh Cho and Tlicho.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	42,886 [3]	40,399 [3]	43,202 [3]	44,504 [3]	44,082 [3]

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	4	4	4	4	4
b. chronic care	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]
c. rehabilitative care	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]
d. other	28 [5]	28 [5]	28 [5]	28 [5]	28 [5]
e. total	32	32	32	32	32
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]
c. rehabilitative care	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]	not applicable [4]
d. other	not available	not available	not available	not available	not available
e. total	43,309,039	48,384,358	51,553,729	56,475,975	55,947,009
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided:					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable
6. Payments ($):					
a. surgical facilities	not applicable	not applicable	not applicable	not applicable	not applicable
b. diagnostic imaging facilities	not applicable	not applicable	not applicable	not applicable	not applicable
c. total	not applicable	not applicable	not applicable	not applicable	not applicable

All data are subject to future revisions.

3. 2001–2002 figure is as of September 18, 2002; 2002–2003 figure is as of September 2, 2003; the 2003–2004 figure is as of August 25, 2004; 2004–2005 figure as of September 1, 2005; and the 2005–2006 figure as of September 6, 2006.
4. 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.
5. Includes Health Centres and Public Health Units.

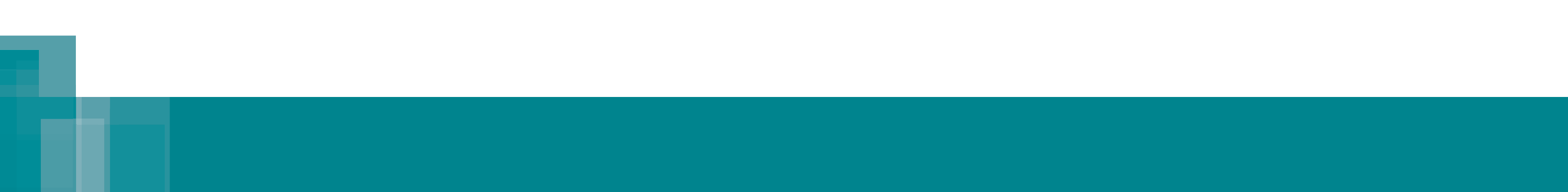
Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	24 [6]	37 [6]	44 [6]	56 [6]	56 [6]
b. specialists	13 [6]	16 [6]	15 [6]	21 [6]	21 [6]
c. other	175 [7]	155 [7]	169 [7]	139 [7]	155 [7]
d. total	212 [8]	208 [8]	228 [8]	216 [8]	232 [8]
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	199,778	195,511	199,062	203,491	166,754
b. total payments	20,125,000	20,504,000	28,791,514	28,761,951	28,559,951
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	32,343	18,494	20,689	23,828	24,204
b. specialists	5,618	5,524	5,636	4,679	4,226
c. other	0	0	0	0	0
d. total	37,961	24,018	26,325	28,507	28,430
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	1,226,824	824,506	814,895	922,239	939,212
b. specialists	616,393	617,448	698,510	648,349	607,621
c. other	not available	not available	not available	not available	not available
d. total	1,843,217	1,441,954	1,513,405	1,570,587	1,546,833
13. Number of services provided through fee for service, by category:					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	37,961	24,018	26,325	28,507	28,430
14. Total payments to physicians paid through fee for service, by category ($):					
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	1,843,217	1,441,954	1,513,405	1,570,587	1,546,833

6. 2001–2002 numbers from Canadian Institute for Health Information, Southam Medical Database; and 2002–2003 and 2003–2004 numbers are estimates from NWT Department of Health and Social Services. 2004–2005 and 2005–2006 figures are for funded positions.
7. This is an estimate of the number of locum physicians. For measures 10 and 15, locum physicians are captured within the general practitioners and specialists categories.
8. Estimate based on total active physicians for each fiscal year.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	991	1,237	1,338	1,109	1,007
16. Total number of claims, out-patient.	8,366	9,170	9,538	10,132	10,158
17. Total payments, in-patient ($).	5,881,124	8,580,504	8,741,298	7,854,074	8,916,590
18. Total payments, out-patient ($).	1,407,313	1,833,630	2,082,470	2,539,752	3,285,093
19. Average payment, in-patient ($).	5,934.53	6,936.54	6,533.11	7,082.12	8,854.61
20. Average payment, out-patient ($).	168.22	199.96	218.33	250.67	323.40
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	41,663	42,987	41,126	41,166	42,115
22. Total payments ($).	2,245,914	2,753,125	2,928,999	3,119,120	3,258,336
23. Average payment per service ($).	53.91	64.05	71.22	75.77	77.37

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	3	2	1	4	5
25. Total number of claims, out-patient.	18	56	23	23	28
26. Total payments, in-patient ($).	38,983	1,258	216	2,176	16,298
27. Total payments, out-patient ($).	16,208	124,218	21,141	7,738	5,777
28. Average payment, in-patient ($).	12,994.27	629.14	215.66	543.88	3,259.56
29. Average payment, out-patient ($).	900.43	2218.19	919.18	336.42	206.34
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	102	135	67	13	4
31. Total payments ($).	18,806	21,450	8,056	519	130
32. Average payment per service ($).	184.37	158.89	120.24	39.93	32.39

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of participating dentists.	not available	not available	not available	not available	not available
34. Number of services provided.	not available	not available	not available	not available	not available
35. Total payments ($).	not available	not available	not available	not available	not available
36. Average payment per service ($).	not available	not available	not available	not available	not available



Nunavut

Introduction

On April 1, 1999, Nunavut became Canada's third and newest territory. The Territory spans two million square kilometres and covers one-fifth of Canada's total landmass. There are 25 communities located across three time zones in Nunavut. The Territory is divided into three regions: the Baffin, which consists of 12 communities; the Kivalliq, which consists of eight communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population in Nunavut is 30,446.

Approximately 47 percent of the population is under the age of 25 years. Inuit make up about 85 percent of Nunavut's population. There is a small French-speaking population of about 4 to 6 percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, which largely includes 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 existing legislation to ensure its relevancy and appropriateness with the Government of Nunavut's objectives as outlined in "Pinasuaqtavut 2004–2009". "Pinasuaqtavut 2004–2009" describes the Government's commitment to building Nunavut's future by achieving healthy communities, simplicity and unity, self-reliance and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimajatuqangit, in program and policy development, service design and delivery, is an expectation placed on all government departments.

The delivery of health services in Nunavut is based on a primary health care model. There are local health centres in 22 communities across Nunavut, new regional facilities in Rankin Inlet and Cambridge Bay (with in/out patient capacity) and one regional hospital in Iqaluit. The primary health care providers are family physicians, nurse practitioners, community health nurses, and pharmacists. Full-time family physicians number 17 across Nunavut: 11 in the Baffin region; four in the Kivalliq region; and two in the Kitikmeot region. Nunavut recruits and hires its own family physicians and when necessary, accesses specialist services from health centres in Ottawa, Toronto, Winnipeg, Yellowknife and Edmonton. From time to time, specialists travel to Nunavut to offer clinics in the regional centres, e.g. eye surgery in Baffin Regional Hospital.

The management and delivery of health services in Nunavut was integrated into the overall operations of the Department on March 31, 2000, when the former regional boards (Baffin, Kitikmeot and Keewatin/Kivalliq) were dissolved. Former board staff became employees of the Department at that time. The Department has a regional office in each of the three regions that manages the delivery of health services at a regional level. 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 2005–2006 was $240,611,000, which includes approximately $25,392,000 allocated for capital projects. This represents a decrease of $16,774,000 and $33,878,000 respectively from 2004–2005 funding levels.

In 2005–2006, Telehealth was further expanded and is now available in all 25 communities in Nunavut. Nunavut's Telehealth network supports the delivery of a broad range of health-related services to communities, including the following: clinical program delivery such as specialist consultation services; health education; continuing medical education; family visitation; and administrative functions. Over the last year, the use of Nunavut's Telehealth network increased by 40 percent.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Despite aggressive national and international recruitment and retention activities, Nunavut finds it a challenge to staff community-based nursing positions on an indeterminate basis. A focused recruitment initiative in 2005–06 saw 34 nurses recruited from overseas, through an agency, to work in Nunavut. Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists is also a challenge.

Over one quarter of the Department's O&M budget is spent on costs associated with medical travel and treatment provided in out-of-territory facilities. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), residents must leave Nunavut to access a range of hospital and specialist services. In fall 2005, two new regional health centres, one in Rankin Inlet and one in Cambridge Bay were opened. In addition, an enhanced regional hospital facility in Iqaluit is scheduled to open in 2007. These will enhance the range of services that can be provided within the Territory. These enhancements support the Department's strategic vision of "Closer to Home", which was approved by Cabinet in January 2005. This strategy is building capacity so that more care, learning and jobs are available within the Territory.

With funds from the Primary Health Care Transition Fund (federal), the Government of Nunavut established a new family practice clinic in Iqaluit. It is expected that the clinic, staffed by one family physician and two nurse practitioners on a community-based health services delivery model, will reduce pressure on the emergency and out-patient departments of Baffin Regional Hospital.

Health promotion and prevention activities are high on the Department's list of service priorities. This includes strategies to reduce tobacco use, public education for healthy lifestyle choices, fetal alcohol spectrum disorder (FASD) awareness, diabetes awareness and prevention, the importance of traditional foods, and pre-natal nutrition. Strategies implemented in Nunavut to reduce tobacco use have produced significant results, including a 12 percent drop in smoking among youth in Nunavut since 2004.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department of Health 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/Kivalliq were dissolved and their operations were integrated into the Department of Health and Social Services effective 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.

There have been no legislative amendments in fiscal year 2005–2006.

1.2 Reporting Relationship

A Director of Medical Care is appointed under the *Medical Care Act* and is responsible for the administration of 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. 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 *2005 Report of the Auditor General of Canada to the Legislative Assembly of Nunavut* was tabled in February, 2005, and can be accessed at:

www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_e.html

There were no references to the operation of the health care insurance plan or to the principles of the *Canada Health Act* in the report.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and Regulations, sections 2 to 4. No amendments were made to the Act or regulations in 2005–2006.

In 2005–2006, insured hospital services were delivered in 25 facilities across Nunavut, including a general hospital located in Iqaluit, two regional health centres (located in Rankin Inlet and Cambridge Bay), as well as 22 community health centres . The Baffin Regional Hospital in Iqaluit is currently the only acute care facility in Nunavut providing a range of in- and out-patient hospital services as defined by the *Canada Health Act*. However, the two regional facilities will be able to offer in-patient services once staff are in place. They are now able to offer specialist clinics. Community health centres provide public health, out-patient services and urgent treatment centre services. There are also a limited number of birthing beds at the Rankin Inlet Birthing Centre. Public health services are also provided at freestanding Public Health Clinics in Rankin Inlet and Iqaluit.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services facilities in the Territory.

Insured in-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case-room and anaesthetic facilities; use of radiotherapy and physiotherapy services where available; psychiatric 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 and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy, limited audiology and speech therapy services in an out-patient facility or in an approved hospital; and psychiatric 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 services were added in 2005–2006 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1), and Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to the Act or regulations in 2005–2006.

Although the *Nursing Act* (2004) allows for licensure of nurse practitioners in Nunavut, only medical doctors are permitted to deliver insured physician services in Nunavut at this time. The department is examining legislative amendments that will give nurse practitioners an expanded role in the delivery of primary health care in the communities. It is expected that this legislative change will take place sometime in 2006–2007.

Physicians must be in good standing with a College of Physicians and Surgeons (Canada) and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 17 full-time family physician positions in Nunavut (11 in the Baffin region; four in the Kivalliq region; and two in the Kitikmeot region), as well as one surgeon at the Baffin Regional Hospital, providing services to Nunavummiut. Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. As of March 31, 2006, Nunavut had 135 physicians participating in the health insurance plan.

Physicians can make an election to collect fees other than those under the Medical Care Plan in accordance with section 12 (2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2005–2006, no physicians provided written notice of this election.

All physicians practicing in Nunavut are under contract with the department.

Insured physician services refers to all services rendered by medical practitioners that are medically required. Where the insured service is unavailable in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has health service agreements in place with medical treatment centres in Ottawa, Winnipeg, Yellowknife and Edmonton. These are the normal out-of-territory sites that Nunavut refers its patients to access medical services not available within the territory

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service. Then the decision of the group would be presented to Cabinet for approval. No insured physician services were added or deleted in 2005–2006.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the Territory must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act,* 1999). Billing numbers are provided for billing the Plan regarding the provision of insured dental services. In 2005–2006, four oral surgeons were permitted to bill the Nunavut Medical Care Insurance Plan for insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the Regulations, requiring the unique capabilities of a hospital for their performance, for example, of orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis. On rare occasions, for medically complicated situations, patients are flown out of the Territory.

The addition of new surgical-dental services to the list of insured services requires government approval. No new services were added to the list in 2005–2006.

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 physio-therapy, speech therapy and psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include: hospital charges above the standard ward rate for private or semi-private accommodation; services that are not medically required, such as cosmetic surgery; services that are considered experimental; ambulance charges (except inter-hospital transfers); dental services, other than specific procedures related to jaw injury or disease; and alcohol and drug rehabilitation, without prior approval.

The Baffin Regional Hospital charges $1,396 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 section 4.2 under Portability). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton 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 sections 3(1), (2), and (3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the Act or regulations in 2005–2006.

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 to the Territory. 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 the first day of the third month after arrival in the Territory, but first-day coverage is provided under a number of circumstances (e.g. newborns whose mothers or fathers are eligible for coverage). As well, permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents and a non-Canadian who has been issued an employment visa for a period of 12 months or more are also granted first-day coverage.

Members of the Canadian Armed Forces, the Royal Canadian Mounted Police (RCMP) and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Inter-Provincial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province/territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. To streamline document processing, a staggered renewal process was initiated in Nunavut in 2006. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province/territory is required.

As of March 31, 2006, 31,172 residents were registered with the Nunavut Health Care Plan. Nunavut's population statistics are published by Statistics Canada and 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. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which was adopted by Nunavut in 1999.

4.0 Portability

4.1 Minimum Waiting Period

Consistent with section 3 of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months; or the first day of the third month following the establishment of residency in a new province or territory; or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences in Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment. No legislative or regulatory changes were made in 2005–2006 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continuing coverage. Requests for extensions must be renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months, upon receiving a written request from the insured person.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Inter-Provincial/Territorial Agreement on Eligibility and Portability, as of January 1, 2001.

Nunavut participates in Physician and Hospital Reciprocal Billing. As well, special bi-lateral agreements are in place with Ontario, Manitoba, Alberta and the Northwest Territories.

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Interprovincial Health Insurance Agreements Coordinating Committee. 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 receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

Out-of-territory hospitals were paid $21,506,142 in the fiscal year 2005–2006.

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 $158 for out-patient care. No changes were made to these rates in 2005–2006.

In 2005–2006, Nunavut paid a total of $3,591 for insured emergency in-patient and out-patient health services to eligible residents temporarily outside Canada.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the Territory. Reimbursement is made to the insured person or directly to 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 barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services are also provided to patients in any health care setting.

5.2 Access to Insured Hospital Services

The Baffin Regional Hospital, located in Iqaluit, is currently the only operating acute care hospital facility in Nunavut. (Recently opened regional facilities located in Rankin Inlet and Cambridge Bay, were both designed with acute care capacity.) The hospital has 25 beds available for acute, rehabilitative, palliative and chronic care services and three stretchers in the emergency room. The hospital has a staff of 87, including 34 nurses and 10 physician positions. The facility provides in-patient, out-patient and 24-hour emergency services. Local physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, limited intensive care services, general medical care, maternity and palliative care. Surgical services provided 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 nursing services are provided by all 24 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, basic services were provided in 2005–2006. Nunavut is seeking to increase resources in all areas.

Telehealth services are available in all 25 communities throughout Nunavut. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options and allowing service providers and communities to use existing resources more effectively.

5.3 Access to Insured Physician and Surgical-Dental Services

In addition to the medical travel assistance and Telehealth initiatives, Nunavut has in place, agreements with a number of health regions or facilities to provide medical and visiting specialists and other visiting health practitioner services. For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions. The Telehealth network, available in all 25 communities, allows for the delivery of a broad range of services, including: specialist consultation services such as ermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education. In 2005–2006, Nunavut had 135 physicians registered.

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

All full-time physicians in Nunavut work under contract with the Department of Health and Social Services. The terms of the contracts are set by the Department. Visiting consultants are either paid on a per-diem basis or fee-for-service.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital, the two new regional centres in Rankin Inlet and Cambridge Bay, and the 22 community health centres, are part of the Department's budget as represented in the budgets for regional operations. No payments are made directly to hospitals or community health centres.

6.0 Recognition Given to Federal Transfers

Recognition of the Canada Health Transfer by the Government of Nunavut for 2005–2006 will be given when the "Medical Care Act Annual Report" is tabled in the Nunavut Legislative Assembly in 2006–2007.

7.0 Extended Health Care Services

Nursing Home Intermediate Care and Adult Residential Care

Adult Residential Care Facilities, located in a total of seven communities with a total of 64 beds, serve the needs of Nunavummiut through a mix of predominately privately owned service providers and one publicly-owned and operated facility. Licensing agreements are in place to provide for the leasing of the publicly-owned facilities. Each facility welcomes both male and female clients and offers Level III or Level IV type care on an indeterminate basis. Most facilities offer respite services and nursing services on an "as needed" or on a regular (8 hour/day and thereafter on-site) basis. Personal care is provided to all residents on a round-the-clock basis, with home care services generally offered on an as-needed basis. Rehabilitation services (Physiotherapy, Occupational Therapy and Speech-Language Pathology) are offered to residents ranging from six to 36 visits per year, depending on the facility.

No current legislation currently exists in Nunavut to formally enable the activities provided in the above-mentioned extended health care facilities.

Intermediate care is available at Naja Isabelle Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are available 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 Elders Homes in Iqaluit and Arviat. 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 services. Acute care cases are transferred to the closest hospital.

Home Care Services

The 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.

During 2005–2006, home care in Nunavut included a full array of services; from nursing and personal care, respite care, palliative care, elders programs and home-making services (which generally represent the majority of service hours provided). In addition, rehabilitation services in the form of physiotherapy and occupational therapy, are offered to clients on an "as needed" basis.

Home and Community Care (HCC) program standards are developed by a territorial HCC Coordinator through Regional Home and Community Care Managers; one located in each of the three Regions of Nunavut and who report operationally to the Executive Director in each Region. Home Care Nurses in each community in turn, report to the Managers. Home Care support staff (which include Home & Community Care Representatives and Home & Community Care Workers) report to their respective Home Care Nurse. In communities in which Home Care Nurses are not present, support staff report to the Supervisor of the local Health Centre. (Health Centre Supervisors in turn report to their respective Director, who is in turn, directly accountable to their respective Home and Community Care Manager).

Due to human and fiscal constraints, limitations have been noted in some communities. Best efforts are made to be consistent in the services offered in communities across the Territory.

Ambulatory Health Care Services

In 2005–2006, ambulatory health care services were not offered across Nunavut.

However, to address this, the Government of Nunavut committed in early 2005–2006 to the design and construction of two continuing care facilities. To be located in Igloolik and Gjoa Haven, the facilities will provide long term care, palliative care, sub-acute care, respite care, wellness and community care programs. They should be operational by late 2008.

Registered Persons					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
1. Number as of March 31st.	28,630	29,478	31,660	31,525	31,172

Insured Hospital Services Within Own Province or Territory					
Public Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
2. Number:					
a. acute care	1	1	1	1	1
b. chronic care	not available	not available	not available	not available	0
c. rehabilitative care	not available	not available	not available	not available	1
d. other	25	25	25	25	26 [1]
e. total	not available	not available	not available	not available	28
3. Payments ($):					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
Private For-Profit Facilities	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
4. Number:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
5. Number of insured hospital services provided:					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0
6. Payments ($):					
a. surgical facilities	0	0	0	0	0
b. diagnostic imaging facilities	0	0	0	0	0
c. total	0	0	0	0	0

1. This includes 22 community health centres and two regional health centres located in communities throughout the territory; and a public health unit and a family practice clinic, located in Iqaluit. The family practice clinic has nurse practitioners (NPs) and a physician offering primary health care, as it would if located in one of the communities and operating as a community health centre.

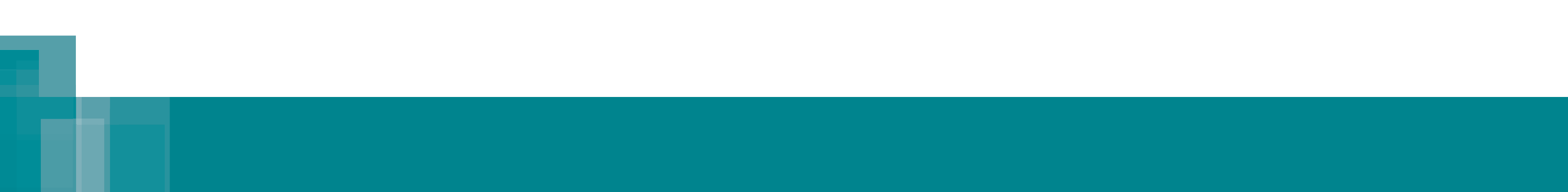
Insured Physician Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
7. Number of participating physicians:					
a. general practitioners	81	106	75	86	74
b. specialists	67	80	64	82	61
c. other	0	0	0	0	0
d. total	148	186	139	168	135
8. Number of opted-out physicians:					
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
9. Number of not participating physicians:					
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
10. Services provided by physicians paid through all payment methods:					
a. number of services	not available	not available	not available	not available	not available
b. total payments	not available	not available	not available	not available	not available
11. Number of physician services paid through fee for service, by type:					
a. general practitioners	39,035	44,876	43,142	42,909 [2]	40,609 [2]
b. specialists	19,733	20,656	17,419	16,633 [2]	16,754 [2]
c. other	0	0	0	0	0
d. total	58,768	65,532	60,561	59,542 [2]	57,363 [2]
12. Total payments to physicians paid through fee for service, by type ($):					
a. general practitioners	1,943,399	2,137,218	2,023,584	2,037,408 [2]	1,952,282 [2]
b. specialists	1,042,366	1,199,648	1,524,873	1,075,253 [2]	910,793 [2]
c. other	0	0	0	0	0
d. total	2,985,765	3,336,866	3,548,457	3,112,661 [2]	2,863,075 [2]
13. Number of services provided through fee for service, by category:					
a. medical	not applicable	not applicable	not applicable	not applicable	not applicable
b. surgical	not applicable	not applicable	not applicable	not applicable	not applicable
c. diagnostic	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	not applicable	not applicable	not applicable	not applicable	not applicable
14. Total payments to physicians paid through fee for service, by category ($):					
a. medical	not applicable	not applicable	not applicable	not applicable	not applicable
b. surgical	not applicable	not applicable	not applicable	not applicable	not applicable
c. diagnostic	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	not applicable	not applicable	not applicable	not applicable	not applicable

2. Nunavut does not pay physicians through fee-for-service. Instead, the majority of physicians are compensated through salaries and alternative methods. Information on salaried physicians is reported via the shadow billing process. Figures include shadow billed claims.

Insured Services Provided to Residents in Another Province or Territory					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
15. Total number of claims, in-patient.	1,782	2,524	2,526	2,544	2,721
16. Total number of claims, out-patient.	9,155	10,677	12,112	14,492	16,939
17. Total payments, in-patient ($).	7,681,154	18,640,982	17,202,646	15,851,159	17,909,264
18. Total payments, out-patient ($).	1,525,710	1,740,038	1,552,418	2,521,841	3,596,878
19. Average payment, in-patient ($).	4,310.41	7,385.49	6,981.59	6,438.33	6,581.87
20. Average payment, out-patient ($).	166.65	162.00	138.47	181.95	212.34
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
21. Number of services.	39,438	43,064	51,050	45,334	57,332
22. Total payments ($).	2,335,998	2,674,445	2,955,996	2,816,282	3,471,307
23. Average payment per service ($).	59.23	62.10	58.61	62.40	60.55

Insured Services Provided Outside Canada					
Hospitals	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
24. Total number of claims, in-patient.	0	0	2	1	1
25. Total number of claims, out-patient.	53	3	2	1	16
26. Total payments, in-patient ($).	0	0	6,300	6,345	954
27. Total payments, out-patient ($).	128,398	982	400	433	2,637
28. Average payment, in-patient ($).	0.00	0.00	3,150.00	6,345.00	953.62
29. Average payment, out-patient ($).	2,422.60	327.28	200.00	433.41	164.80
Physicians	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
30. Number of services.	12	1	19	0	36
31. Total payments ($).	14,835	8	1,519	0	2,459
32. Average payment per service ($).	1,236.25	7.61	151.91	0.00	68.30

Insured Surgical-Dental Services Within Own Province or Territory					
	2001–2002	2002–2003	2003–2004	2004–2005	2005–2006
33. Number of participating dentists.	not available	not available	not available	not available	not available
34. Number of services provided.	not available	not available	not available	not available	not available
35. Total payments ($).	not available	not available	not available	not available	not available
36. Average payment per service ($).	not available	not available	not available	not available	not available



Annex A

Canada Health Act and the Extra-Billing and User Charges Information Regulations

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

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

CODIFICATION ADMINISTRATIVE

Canada Health Act

Loi canadienne sur la santé

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

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

WARNING NOTE

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

AVERTISSEMENT

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

CHAPTER C-6

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

Preamble

Whereas the Parliament of Canada recognizes:

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

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

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

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

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

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

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;

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

« habitant »
"resident"

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

« hôpital »
"hospital"

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

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

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

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

« médecin »
"medical practitioner"

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

« ministre »
"Minister"

« ministre » Le ministre de la Santé.

« professionnel de la santé »
"health care practitioner"

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

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

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

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

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

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

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

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

"insured person" *« assuré »*

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

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

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

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

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

"medical practitioner" *« médecin »*

"Minister" means the Minister of Health;

"Minister" *« ministre »*

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

"physician services" *« services médicaux »*

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

"resident" *« habitant »*

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

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

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

"user charge" *« frais modérateurs »*

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

CANADIAN HEALTH CARE POLICY

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

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

« services hospitaliers » *"hospital services"*

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 » Services médicalement nécessaires fournis par un médecin.

« services médicaux » *"physician services"*

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

« surfacturation » "extra-billing"

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

Primary objective of Canadian health care policy

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

1984, c. 6, s. 3.

PURPOSE

Purpose of this Act

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

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

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health 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.

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

PROGRAM CRITERIA

Program criteria

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

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

(*e*) accessibility.

1984, c. 6, s. 7.

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;

POLITIQUE CANADIENNE DE LA SANTÉ

Objectif premier

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

1984, ch. 6, art. 3.

RAISON D'ÊTRE

Raison d'être de la présente loi

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

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

CONTRIBUTION PÉCUNIAIRE

Contribution pécuniaire

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

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

6. [Abrogé, 1995, ch. 17, art. 36]

CONDITIONS D'OCTROI

Règle générale

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

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

e) l'accessibilité.

1984, ch. 6, art. 7.

Gestion publique

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

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

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

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

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

Designation of agency permitted

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

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

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

1984, c. 6, s. 8.

Comprehensiveness

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

1984, c. 6, s. 9.

Universality

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

1984, c. 6, s. 10.

Portability

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

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

(*b*) must provide for and be administered and operated so as to provide for the payment of

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

Désignation d'un mandataire

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

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

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

1984, ch. 6, art. 8.

Intégralité

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

1984, ch. 6, art. 9.

Universalité

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

1984, ch. 6, art. 10.

Transférabilité

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

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

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.

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.

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.

Accessibility

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

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

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

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

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

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.

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.

Accessibilité

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

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

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

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

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

Reasonable compensation

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

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

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

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

1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

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

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

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

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

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

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

Rémunération raisonnable

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

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

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

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

1984, ch. 6, art. 12.

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

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

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

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

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

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

Referral to Governor in Council

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

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

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

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

Consultation process

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

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

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

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

Where no consultation can be achieved

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

1984, c. 6, s. 14.

MANQUEMENTS

Renvoi au gouverneur en conseil

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

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

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

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

Étapes de la consultation

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

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

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

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

Impossibilité de consultation

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

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux

any condition set out in section 13, the Governor in Council may, by order,

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

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

Amending orders

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

Notice of order

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

Commencement of order

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

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

Reimposition of reductions or withholdings

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

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

When reduction or withholding imposed

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

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

EXTRA-BILLING AND USER CHARGES

conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

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

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

Modification des décrets

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

Avis

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

Entrée en vigueur du décret

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

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

Nouvelle application des réductions ou retenues

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

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

Application aux exercices ultérieurs

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

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

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.

User charges

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

Limitation

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

1984, c. 6, s. 19.

Deduction for extra-billing

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

Deduction for user charges

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

Consultation with province

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

Surfacturation

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

1984, ch. 6, art. 18.

Frais modérateurs

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

Réserve

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

1984, ch. 6, art. 19.

Déduction en cas de surfacturation

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

Déduction en cas de frais modérateurs

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

Consultation de la province

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

Separate accounting in Public Accounts

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

Refund to province

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

Saving

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

1984, c. 6, s. 20.

When deduction made

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

1984, c. 6, s. 21.

REGULATIONS

Regulations

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

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

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

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

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

Agreement of provinces

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

Comptabilisation

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

Remboursement à la province

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

Réserve

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

1984, ch. 6, art. 20.

Application aux exercices ultérieurs

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

1984, ch. 6, art. 21.

RÈGLEMENTS

Règlements

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

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

b) déterminer les services exclus des services hospitaliers;

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

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

Consentement des provinces

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

Exception

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

Consultation with provinces

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

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

Exception

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

Consultation des provinces

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

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

REPORT TO PARLIAMENT

Annual report by Minister

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

1984, c. 6, s. 23.

RAPPORT AU PARLEMENT

Rapport annuel du ministre

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

1984, ch. 6, art. 23.

OFFICE CONSOLIDATION

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 has no official sanction.

AVERTISSEMENT

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

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(a) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH 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 13a) DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

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

DÉFINITIONS

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

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

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

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

GENRE DE RENSEIGNEMENTS

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

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

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

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

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

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

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.

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

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

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

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

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

Annex B

Policy Interpretation Letters

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

Epp Letter

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

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

Federal Policy on Private Clinics

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

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

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

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

June 18, 1985

OTTAWA, K1A 0K9

Dear Minister:

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

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

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

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

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

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

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

Public Administration

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

Comprehensiveness

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

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

Universality

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

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

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

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

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

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

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

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

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

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

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

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

Reasonable Accessibility

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

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

Conditions

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

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

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

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

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

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

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

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

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

Regulations

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

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

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

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

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

Yours truly,

Jake Epp

Attachments

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

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

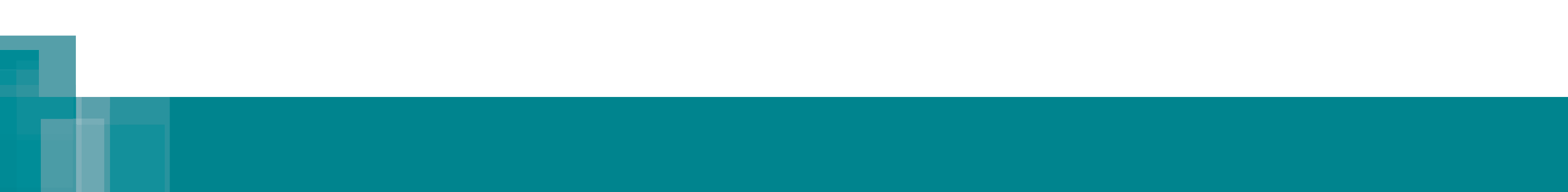
I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

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

Yours sincerely,

Diane Marleau

Minister of Health



Annex C

Dispute Avoidance and Resolution Process Under the Canada Health Act

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

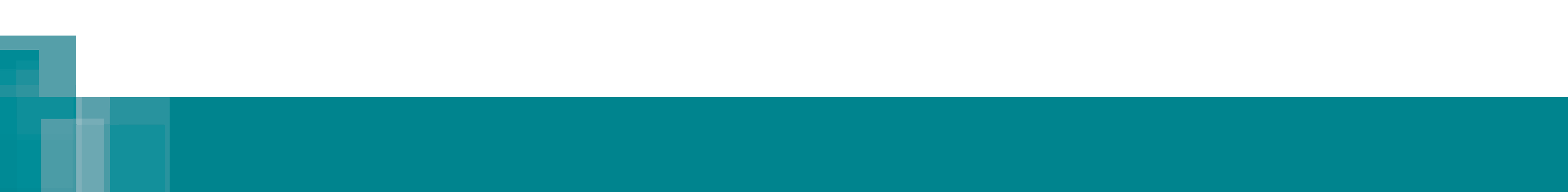
The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and *Canada Health Act*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

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

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

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

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



Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

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

Dear Mr. Mar:

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

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

Dispute Avoidance

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

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

Dispute Resolution

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

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

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

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

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

Public Reporting

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

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

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

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

Yours sincerely,

A. Anne McLellan

Fact Sheet: Canada Health Act Dispute Avoidance and Resolution Process

Scope

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

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

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

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

Dispute Resolution

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

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

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

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

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

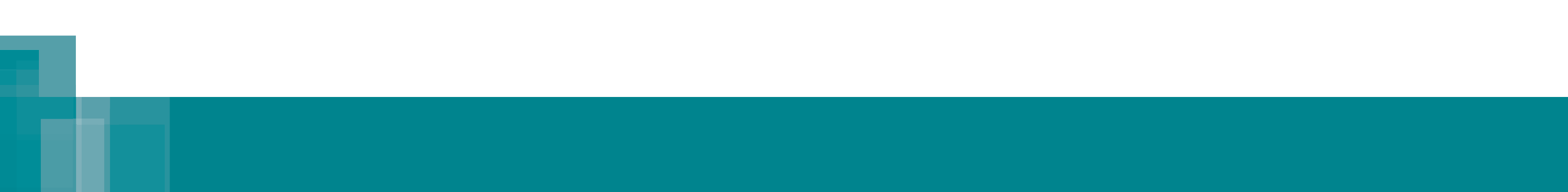
The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

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

Review

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



Annex D

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 a different definition or interpretation.

Term	Description
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Block Fee	This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Diagnostic Imaging:	A procedure that detects or determines the presence of various diseases or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
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.
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.

Term	Description
Fee-for-service	This is a method of physician payment based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*. The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the Canada Health Act in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been five applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.
Hospital Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows for the reciprocal processing of out-of-province or out-of-territory claims for hospital in- and out-patient services from either jurisdiction. Under such an agreement, insured hospital services are payable at the approved rates of the host province or territory or as otherwise agreed upon by the parties involved or by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).
In-patient	This is a patient who is admitted to a hospital, clinic or other health care facility for treatment that requires at least one overnight stay.
Medical Necessity	Under the *Canada Health Act*, the provincial and territorial governments are required to provide medically necessary hospital and physician services to their residents on a prepaid basis, and on uniform terms and conditions. The Act does not define medical necessity. The provincial and territorial health insurance plans, in consultation with their respective physician colleges or groups, are responsible for determining which services are medically necessary for health insurance purposes. If it is determined that a service is medically necessary, the full cost of the service must be covered by the public health insurance plan to be in compliance with the Act. If a service is not considered to be medically required, the province or territory need not cover it through its health insurance plan.

Term	Description
Medical Reciprocal Billing Agreement	This is a bilateral agreement between two provinces, or a province and a territory, or two territories that allows the reciprocal processing of out-of-province/territory claims for medical services provided by a licensed physician to residents of the other jurisdiction. Where a reciprocal billing agreement exists, an insured medical service is payable at the approved rate of the host province or territory.
Non-Participating Physician	This is a physician operating completely outside provincial or territorial health insurance plans. Neither the physician nor the patient is eligible for any cost coverage for services rendered or received from the provincial or territorial health insurance plans. A non-participating physician may therefore establish his or her own fees, which are paid directly by the patient.
Opted-out Physician	These are physicians who operate outside the provincial or territorial health insurance plans, and who bill their patients directly at provincial or territorial fee schedule rates. The provincial or territorial plans reimburse patients of opted-out physicians for charges up to, but not more than the amount paid by the plan under fee schedule agreement.
Out-patient	This is a patient admitted to a hospital, clinic or other health care facility for treatment that does not require an overnight stay.
Out-patient Surgical Facility	This is a health care facility providing short-term (day only) surgical services.
Participating Physician	These are licensed physicians who are enrolled in provincial or territorial health insurance plans.
Private Diagnostic Facility	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures.
Private (for-profit) Health Care Facility	This is a privately owned health care facility that provides laboratory tests, radiological services and other diagnostic procedures, and pays out dividends or profits to its owners, shareholders, operators or members.
Private (not-for-profit) Health Care Facility:	This is a privately owned health care facility providing laboratory tests, radiological services and other diagnostic procedures, recognized as operating on a non-profit basis under the laws of the provincial, territorial or federal governments.
Private Surgical Facility	This is a privately owned health care facility providing surgical health services.
Public Health Care Facility	A public health care facility is a publicly administered institution located within Canada that provides insured health care services under a provincial or territorial health care insurance plan on an in- or out-patient basis.
Rehabilitative Care	Rehabilitative care includes health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. An example is therapy required by a person recovering from a stroke (e.g., physiotherapy and speech therapy).
Specialist	A specialist is a licensed physician in a province or territory whose practice of medicine is primarily concerned with specialized diagnostic and treatment procedures. Specialties include anaesthesia, dermatology, general surgery, gynaecology, internal medicine, neurology, neuropathology, ophthalmology, paediatrics, plastic surgery, radiology, and urology.

Term	Description
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Temporarily Absent	Under the portability criterion of the *Canada Health Act* (section 11(1)(b)), the term “temporarily absent” is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.

Contact Information for Provincial and Territorial Departments of Health

Newfoundland and Labrador
Department of Health and Community Services
Confederation Building
P.O. Box 8700
St.John's, NL A1B 4J6
(709) 729-6130
www.gov.nl.ca/health

Prince Edward Island
Department of Health
P.O. Box 2000
Charlottetown, PE C1A 7N8
(902) 368-6130
www.gov.pe.ca/

Nova Scotia
Nova Scotia Department of Health
P.O. Box 488
Halifax, NS B3J 2R8
(902) 424-5818
www.gov.ns.ca/health/

New Brunswick
Department of Health
P.O. Box 5100
Fredericton, NB E3B 5G8
(506) 457-4800
http://www.gnb.ca/

Quebec
Department of Health and Social Services
1075 Sainte-Foy Road, 5th Floor
Québec, QC G1S 2M1
(418) 266-7005
www.msss.gouv.qc.ca

Ontario
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1R3
1-800-268-1153
www.health.gov.on.ca

Manitoba
Manitoba Health
300 Carlton Street
Winnipeg, MB R3B 3M9
1-800-392-1207
www.gov.mb.ca/health

Saskatchewan
Saskatchewan Health
3475 Albert Street
Regina, SK S4S 6X6
1-800-667-7766
www.health.gov.sk.ca

Alberta
Alberta Health and Wellness
P.O. Box 1360, Station Main
Edmonton, AB T5J 2N3
(780) 427-1432
www.health.gov.ab.ca/

British Columbia
Ministry of Health
1515 Blanchard Street
Victoria, BC V8W 3C8
1-800-465-4911
www.gov.bc.ca/health

Yukon
Health and Social Services
204 Lambert Street, 4th Floor
Financial Plaza
Whitehorse, YT Y1A 2C6
1-867-667-3096
www.hss.gov.yk.ca/

Northwest Territories
Department of Health and Social Services
P.O. Box 1320
Yellowknife, NWT X1A 2L9
1-800-661-0830 or 1-867-777-7413
www.hlthss.gov.nt.ca

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