Minister of Health Ministre de la Santé

The Honourable/L'honorable Pierre S. Pettigrew

Ottawa, Canada K1A 0K9

December, 2003

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

May it please Your Excellency:

The undersigned has the honour to present to Your Excellency the Annual Report on the administration and operation of the *Canada Health Act* for the fiscal year that ended March 31, 2003.

Pierre S. Pettigrew

Canada

Preface

The late Justice Emmett M. Hall referred to Canada's Medicare with the words:

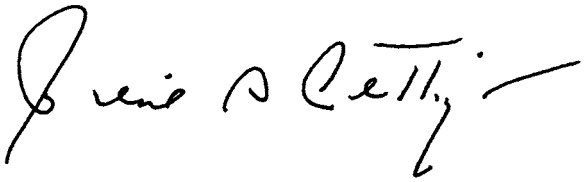
> "Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed."

The adoption of the *Canada Health Act* is an important achievement in the evolution of Canada's health care system. The Act puts into words our commitment to a universal, publicly funded health care system based on the needs of Canadians, not their ability to pay. The five principles of the Act are the cornerstone of the Canadian health care system, and they reflect the values that inspired our system. April 1, 2004, will mark the 20th anniversary of the Act.

In 2003, the provincial premiers and territorial leaders reached a historic agreement with Canada's former Prime Minister, the Right Honourable Jean Chrétien, to improve the quality, accessibility and sustainability of our public health care system. On this occasion, the first ministers reaffirmed their commitment to the five principles of public health insurance in Canada: universality, accessibility, portability, comprehensiveness and public administration.

Our goal in administering the Act is to work with the provinces and territories in a cooperative, fair and open manner, to ensure that the principles of our public health insurance system continue to serve Canadians wherever they may live in Canada.

This report to Parliament on the administration and operation of the Act provides detailed information on the provincial and territorial health care insurance plans for the fiscal year ending March 31, 2003. While some concerns exist with respect to compliance with the Act, discussions to address these issues continue, and I am satisfied that, for the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the Act. Moreover, I am pleased to confirm that deductions made to the province of Nova Scotia under section 20 of the Act came to an end in November 2003.



Pierre S. Pettigrew
Minister of Health

Acknowledgements

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

Newfoundland and Labrador Department of Health and Community Services

Prince Edward Island Health and Social Services

Nova Scotia Department of Health

New Brunswick Department of Health and Wellness

Ministère de la Santé et des Services sociaux du Québec

Ontario Ministry of Health and Long-Term Care

Manitoba Health

Saskatchewan Health

Alberta Health and Wellness

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

Yukon Department of Health and Social Services

Northwest Territories Department of Health and Social Services

Nunavut Department of Health and Social Services

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

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Introduction

The five principles of the *Canada Health Act* are the cornerstone of the Canadian health care system, and reflect the values that inspired Canada's single-payer, publicly-financed health care system, over 40 years ago. This legislation, passed unanimously by Parliament in 1984, affirms the federal government's commitment to a universal, accessible, comprehensive, portable and publicly administered health insurance system. The Act aims to ensure that all residents of Canada have access to necessary hospital and physician services on a prepaid basis. The *Canada Health Act* defines for the provinces and territories the criteria and conditions that they must satisfy in order to qualify for their full share of federal transfers under the Canada Health and Social Transfer (CHST).

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

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

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

Chapter 1 provides an overview of the *Canada Health Act* and the associated regulations and policies that are used in the administration of the Act. Chapter 2 reviews the administration of the *Canada Health Act* during 2002-2003, and includes a summary of compliance issues addressed and deductions levied. Chapter 3 presents descriptions of the provincial and territorial health insurance plans for the year ending March 31, 2003. The annexes to this report provide additional information relevant to the administration of the Act and its place in the Canadian health care system.

Annex A presents statistical data for each province and territory on insured hospital, physician and surgical dental health care services. Annex B is an office consolidation of the *Canada Health Act* and its regulations (unofficial version dated June 2001). Annex C presents the text of two key policy statements that clarify the federal interpretation of the criteria and conditions of the *Canada Health Act* (text originally contained in letters from federal Health Minister to provincial and territorial counterparts). Annex D provides a description of the Canada Health Act Dispute Avoidance and Resolution process which came into effect in 2002. Annex E describes the evolution of federal transfers for health care in Canada. Annex F provides a glossary of terminology used in this report. Inside the back cover you will find contact information for provincial and territorial departments of health.

Chapter 1 – Canada Health Act Overview

"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."

(Roy J. Romanow, Q.C. November, 2002)

In this chapter, the *Canada Health Act,* its requirements and key definitions under the Act are discussed. Also described are the regulations and regulatory provisions of the *Canada Health 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 *Canada Health 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 and Social Transfer (CHST).

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

Key Definitions under the CHA

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the *Canada Health 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 *Canada Health 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 *Canada Health 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 *Canada Health Act* are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Requirements of the Canada Health Act

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

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

The Criteria

1. Public Administration (section 8 of CHA)

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 *Canada Health 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 which 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 one to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, 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 their province or territory.

5. Accessibility (section 12)

The intent of the accessibility criterion is to ensure 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 *Canada Health 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 *Canada Health 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 *Canada Health 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, the fee would be considered a user charge. User charges are not permitted under the Act as, like 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 the administration of the Act in the following areas:

- defining the services included in the CHA definition of "extended health care services."
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require from a province or territory to qualify for a full federal transfer;
- prescribing how provinces and territories are required to give recognition to the Canada Health and Social Transfer in their documents, advertising or promotional materials.

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

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

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

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the *Canada Health Act* is subject to discretionary penalties. The amount of any deduction from federal transfer payments under the CHST 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 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 which fall outside the definition of insured health services (definition on page 3); and
- certain services and groups of persons are excluded from the definitions for insured services and insured persons.

These exclusions are discussed below.

Non-Insured Health Services

In addition to the medically necessary insured hospital and physician services covered by the *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 may be 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, persons serving a term of imprisonment within a federal penitentiary, and persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed 3 months). In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., foreign refugees) or under the workers' compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the *Canada Health 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 Health Ministers to their provincial and territorial counterparts. Both letters are reproduced in Annex C of this report.

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.

Marleau Letter – Federal Policy on Private Clinics

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

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

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *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.

Dispute Avoidance and Resolution Process

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a Canada Health Act Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *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.

Please refer to Annex D for a copy of Minister McLellan's letter.

Chapter 2 – Administration and Compliance

Administration

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

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

The Canada Health Act Division

The Canada Health Act Division (the Division) is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and is responsible for administering the CHA.

Officers of the Division located in Ottawa and in regional Health Canada offices fulfill the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charge provisions of the CHA;
- working in partnership with provinces and territories to investigate and resolve CHA compliance issues and pursue activities that encourage compliance with the CHA;
- informing the Minister of possible non-compliance and recommending appropriate action to resolve the issue;
- developing and producing the Canada Health Act Annual Report on the administration and operation of the CHA;
- developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to share information;
- collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- disseminating information on the CHA and on publicly funded health care insurance programs in Canada;
- responding to information requests and correspondence relating to the CHA; and
- conducting issue analysis and policy research in order to provide policy options and recommendations to the Minister concerning the principles of the CHA.

During 2002-2003, the Division reviewed several new issues concerning provincial and territorial compliance with the CHA. These issues of concern are described in the next section. In addition, the Division was or continues to be involved in the following:

- collaboration with provincial and territorial health department representatives on the Interprovincial Health Insurance Agreements Coordinating Committee (see below);
- implementation of the Dispute Avoidance and Resolution process for addressing issues related to the interpretation of the CHA principles;
- collaboration with provincial and territorial health departments on the supply, demand and delivery of magnetic resonance imaging and computed tomography services in Canada;
- provide information on the Canadian health care insurance system in support for various federal reports and Commissions (Commission on the Future of Health Care in Canada; Senate Standing Committee on Social Affairs, Science and Technology; Auditor General of Canada Status Report on Federal Support for Health Care Delivery);
- production of a revised electronic edition of the Additional Benefits Information System, developed in collaboration with provincial and territorial officials as a means of sharing information on publicly-funded health care services that are outside the scope of the CHA; and
- preparation of responses to ministerial and other enquiries about the CHA and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media. During 2002-2003, the Division responded to

more than 2,000 such enquiries. Media relations staff within the Branch also responded to a number of media enquiries related to the CHA. The Division also makes information concerning the CHA and other health insurance topics available via the Internet at :
http://www.hc-sc.gc.ca/medicare

Interprovincial Health Insurance Agreements Coordinating Committee

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee (previously named the Federal-Provincial/Territorial Coordinating Committee on Reciprocal Billing), and acts as a secretariat for the Committee. The Committee was formed in 1991 to deal with issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the CHA.

The Committee members, who are representatives from Ontario, Quebec, and the eastern and western provinces (and territories), meet three times a year. In addition, conference calls are held as necessary. The Committee contacts, who are representatives from each province and territory, meet with the members once a year. All meetings provide a forum for both information sharing and collaborative problem-solving.

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

In fall 2001, the committee mandated a working group to consult with the Canadian Institute for Health Information (CIHI) to update in-patient hospital billing rates for reciprocal billing purposes using the latest financial and statistical data available. These are the rates provinces and territories use to process claims for hospital services provided to out-of-province/territory residents. The new rates were implemented in summer 2002 to better reflect actual costs of hospital services received across the country. In conjunction with CIHI, a steering committee was formed in fall 2002 to review technical and administrative issues pertaining to the implementation of a Cost Per Weighted Case Methodology upon which to base interprovincial billing rates for insured in-patient services. The IHIACC is also working on revising and updating out-patient service rates.

Compliance

Health Canada's approach to resolving possible compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health care authorities. 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, almost all disputes and issues related to the administration and operation of the CHA have been addressed and resolved without resorting to deductions.

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

Health Canada officials routinely monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Examples of sources of this

information are: officials representing provincial and territorial governments; media reports, provincial and territorial government publications and correspondence from the public and other groups and individuals.

Staff in the Compliance Unit, Canada Health Act Division, assess issues of concern or complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate necessary action. Verification of the facts with provincial and territorial health officials may reveal issues that are not directly related to the CHA while others may pertain to the CHA but are a result of misunderstanding or miscommunication and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials would 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 Arising in 2002-2003

For the following issues, further information and analysis is required by Health Canada before a determination of compliance with the CHA can be made.

Drugs administered in hospital

- Health Canada is concerned about patient payments for drugs administered in hospital out-patient clinics and their appropriateness under the CHA. The concern is illustrated by provincial decisions to cover the drug Remicade under their provincial pharmacare program rather than their hospital insurance program when the drug is administered in hospital out-patient clinics. In order to better understand the provincial rationale for their policy decision, Health Canada officials initiated a fact-finding process with the provinces in 2002-2003.

User charges and extra-billing

- Health Canada is concerned about private surgical clinics that allow individuals to privately pay for medically necessary insured services and thus jump the queue. Following media reports indicating that the province was intervening to stop these charges, Health Canada asked Quebec to confirm that the matter had been resolved. Quebec officials have informed Health Canada that they were investigating this issue and that, if necessary, appropriate action would be taken. Under the CHA, any province that permits charges to insured persons for medically necessary hospital and physician services are in non-compliance and vulnerable to mandatory dollar-for-dollar deductions.
- In 2002, Health Canada learned that two specialist referral clinics in British Columbia had been established. These clinics offer consultations with physician specialists for a fee for patients who choose to bypass their family physicians to obtain a referral for specialized treatment. These clinics may also coordinate diagnostic and/or surgical procedures, which result from the consultations. In March 2003, a one-time deduction of $4,610 was made to British Columbia's Canada Health and Social Transfer (CHST) payment in respect of the two instances of user charges levied at a private surgical clinic during 2000-2001. Another patient reportedly paid $6,000 for surgery at a private surgical clinic in 2003. This issue is the subject of ongoing discussion with British Columbia officials.
- In 2002, Health Canada learned that a Saskatchewan doctor was performing bone density scans following donations to a foundation. Health Canada is concerned that patients may be required to make a donation in order to receive a medically necessary service. This issue is the subject of ongoing discussion with Saskatchewan.
- Tray or disposable materials fees are direct charges to patients by physicians for medical/surgical supplies in the provision of some medically required services. Legislation passed in Manitoba in 1999 and 2001 prohibits user charges in accredited surgical facilities, but continues to permit charging tray fees in physician offices and medical clinics. This issue is currently under review and the subject of ongoing discussion with Manitoba.

In addition to these current issues, Health Canada is continuing to review, monitor and assess the impact and implications of a number of other health issues.

Deductions and Refunds

During fiscal year 2002-2003, a monthly deduction of $2,451 was applied to Nova Scotia's transfer payments under the CHST. The province was in a position of CHA non-compliance with the federal policy on private clinics for refusing to cover the facility fees charged to patients at an abortion clinic. As well, a one-time deduction of $4,610 was applied to the March 2003 CHST payment to British Columbia, as a result of CHA non-compliance in respect of user charges at a surgical facility.

History of Deductions under the *Canada Health Act*

The CHA, 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 user charges and extra-billing, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the CHA provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $246.7 million in deductions were refunded to New Brunswick ($6.886M), Quebec ($14.032M), Ontario ($108.656M), Manitoba ($1.279M), Saskatchewan ($2.107M), Alberta ($29.032M) and British Columbia ($84.749M).

Following the CHA's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the CHA did not reoccur until fiscal year 1994-1995. As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the CHA. For the period between May 1994 until extra-billing by physicians was banned when British Columbia's *Medicare Protection Act* came into effect in September 1995, deductions totalling $2.025 million were applied against British Columbia's transfer payments.

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

During the period from November 1995 to July 1996, total deductions of $3.585 million were made from the Alberta transfer 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 $267,000 was deducted from Newfoundland's transfer payment before these charges were eliminated, effective January 1, 1998. Total deductions from Manitoba's transfer payments amounted to $2,056,000 and ended with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999.

Including the March 2003 deductions, total deductions applied to all provinces in contravention of the federal policy on private clinics since October 1995 have totalled

$6,626,766. This includes total deductions of $362,565 from Nova Scotia.

Many other issues have been resolved over the years without applying penalties. Examples of these include: charges at discharge planning units in British Columbia; de-insurance for non-payment of premiums in British Columbia; and, denial of registration for residents without social insurance numbers in Prince Edward Island. In each instance, discussion and negotiation at the official level were instrumental in bringing these matters to a satisfactory conclusion.

Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2002-2003

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 2002-2003.

Officials in the provincial, territorial and federal governments have worked together to provide and review the information. The information submitted to Health Canada for this report by each provincial and territorial department of health consists of three components:

- a narrative description of the provincial or territorial health care system relating to the five criteria and the first condition of the *Canada Health Act,* which can be found in the following pages of this chapter;
- documents which confirm compliance with the five criteria and both conditions of the Canada Health Act; and
- statistics identifying trends in the provincial and territorial health care systems which are included as part of Annex A of this report.

The first two components are used to assist with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the *Canada Health Act,* while the last component serves to identify and analyze current and future trends in the Canadian health care system.

To assist provinces and territories in determining what information to include in their submissions to the report, Health Canada has developed a *Users' Guide for Submissions to Health Canada.* This guide is revised annually and is designed to help provinces in meeting the reporting requirements of Health Canada. This Guide was developed through discussion with provincial and territorial officials and specifies the information requested for each criterion of the Act. Annual revisions to the guide are based upon an analysis by Health Canada of health plan descriptions from previous annual reports and an assessment of emerging issues relating to insured health services. The Users' Guide also provides examples drawn from previous annual reports to illustrate the organization and type of information required for each reporting area.

The process for reporting to Health Canada for the current annual report was launched in a federal- provincial-territorial conference call held in April 2003, where a timetable was established for providing information to Health Canada and for the production of the report.

Following the federal-provincial-territorial teleconference, Health Canada officials corresponded with health officials in each provincial and territorial government to identify particular information areas requiring improvement in the report. Letters were sent to all provinces and territories identifying issues that were to be addressed in their sections of the report.

Additionally, in spring 2003, Health Canada officials met with health department officials in Nova Scotia, Ontario and Manitoba to discuss the process for the preparation of the *Canada Health Act Annual Report* and those areas of the provincial sections of the report that could be expanded or improved upon. Health Canada appreciates the collaboration of these provinces and hopes to build on that collaboration through meetings with other provinces and territories in the coming years.

Insurance Plan Descriptions

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health insurance plan according to the program criteria areas of the *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 in support of insured and extended health care services and a section outlining the range of extended health care services in their jurisdiction; where extended health care

includes nursing home intermediate care services, adult residential care services, home care services and ambulatory health care services.

Provinces and territories were also requested to include in their narrative a list of published documents and materials that relate to the five criteria of the *Canada Health Act* and to the recognition condition. These documents, or Additional Materials, include health care insurance legislation, regulations, audit and evaluation reports, annual reports of health departments and other documents that permit Health Canada to ensure that provinces and territories are in compliance with the criteria and conditions of the *Canada Health Act*.

Please note that for the *Canada Health Act Annual Report, 2002-2003,* Quebec submitted a description of its health insurance plan according to the format used previous to fiscal year 1999-2000. Quebec does not provide information in the manner and detail requested by Health Canada, as noted in the preface to Quebec's narrative.

Improvements to Accessing Health Care Services

During 2002-2003, provinces and territories continued to implement initiatives to ensure and enhance access by residents to insured health services. Examples of this include:

- contributions of $300,000 in the 2002 budget from the Newfoundland and Labrador government to increase the number of students accepted to the Bachelor of Nursing Collaborative Program by 32 students;
- the introduction of an MRI unit at the Queen Elizabeth Hospital in Prince Edward Island in January 2003 and a linear accelerator at the PEI Cancer Treatment Centre in May 2003;
- an increase in funding of $5 million from Nova Scotia to the Capital District Health Authority to increase cardiac surgery and cardiac catheterization capability as a means of decreasing wait times;
- continuing strategies in New Brunswick to increase recruitment of newly licensed family practitioners and specialists. This strategy includes the purchase of five additional seats at the University of Sherbrooke's medical school in September 2002;
- the creation of 17 Family Medicine Groups in Quebec as part of a new approach to medical practice that will improve access to family practitioners while ensuring a more responsible use of the health care system by individuals;
- the continuation of Telehealth Ontario, which provides access to experienced nurses delivering health advice and information across Ontario 24 hours a day, seven days a week. This helps ensure that emergency departments are used for real emergencies. By March 31, 2003, approximately 1.9 million calls had been made to Telehealth Ontario since services began in 2001;
- the opening of CancerCare in Manitoba. CancerCare is a 205,000 square foot world-class facility for treatment, education and research with an on-site laboratory for the Manitoba Institute of Cell Biology;
- the launch of the Saskatchewan surgical Web site (www.sasksurgery.ca) in January 2003, where patients can obtain information on how long they may expect to wait for their particular procedure;
- the implementation of the Provincial Personal Health Identifier (PPHI) in Alberta. This identifier is unique to each person and remains the same over the person's lifetime. The PPHI can be used to collect demographic information and is a key foundation in the development of Alberta's electronic health record system;
- the implementation of a comprehensive, co-ordinated and strategic approach to rural doctor issues in British Columbia will ensure equitable access to medical services for residents, regardless of where they live;
- a variety of recruitment and retention initiatives implemented in Yukon, including a Physician Relocation Fund which assists with relocation costs for family physicians recruited to Yukon, with a return-in-service commitment to the territory;
- the investment of an additional $8.3 million in human resources for the health and social services system in the Northwest Territories. The new resources create 42 new positions for nurses, physicians, nurse practitioners and midwives as well as training and mentorship programs for current health professionals; and
- the upgrade of Nunavut's five existing telehealth sites and the addition of 10

telehealth communities to its network allowing the delivery of a broad range of services, including: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions, family visitation, and continuing medical education.

Newfoundland and Labrador

Introduction

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

The provincial government appoints health boards, whose members serve as volunteers. These boards are responsible for delivering health services to their regions and, in some cases, to the province as a whole, interacting with the public to determine health needs. 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 Newfoundland and Labrador almost 20,000 health care providers and administrators provide health services to the 512,000 residents.

Healthier Together: A Strategic Health Plan for Newfoundland and Labrador was released in September 2002 following extensive provincial consultation. This plan outlines the objectives and goals of the health system over the next four years. The Plan includes a Wellness Strategy, a Primary Health Care Strategy, a Mental Health Service Strategy, a Long Term Care and Supportive Services Strategy and a Location of Services Strategy.

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

- rapidly rising costs that threaten the affordability of Medicare;
- demographic trends including a declining population, an aging population that generally requires more services than younger groups, and a trend toward migration from rural to urban areas;
- the cost of new drugs and advanced technologies;
- rising salaries and fees in other provinces that cause pressure for raises in Newfoundland and Labrador;
- the need for more investment in early intervention and prevention in order to promote wellness;
- increased demands for home support services;
- a need to expand community mental health services; and
- high rates of heart disease, cancer and diabetes together with high rates of smoking, obesity, alcohol consumption and inactivity.

Healthier Together outlines three priority goals: wellness, community capacity building and sustainability, and quality for the health system.

Additional information about *Healthier Together* and health care in Newfoundland and Labrador is available on the Web site of the Department of Health and Community Services at: **www.gov.nf.ca/health/**

Highlights of Initiatives in 2002-2003

The total Health and Community Services budget for 2002-2003 was $1.5 billion, raising health and community services expenditures to approximately 45 percent of all government program expenditures.

For 2002-2003, expenditures to March 31, 2003, for major capital projects for health facilities were $28 million.

The Province continues its investment in expanding the implementation of Picture Archiving and Communications System technology in the province. Other health information and communication technology initiatives include a Unique Patient Identifier, a Client Registry, a Pharmacy Network and the Client Payment Module.

A total of $1.1 million was committed to wellness initiatives in keeping with the themes identified in *Healthier Together*.

A Primary Health Care Advisory Council was announced and an Office of Primary Health

Care was established to develop a provincial primary care framework.

Government has provided $1.4 million this year under the Give to Feel Good Campaign with the St. John's Health Care Corporation's Health Foundation. This funding brings total payments to $23.6 million towards a $25 million commitment.

Government appointed the province's first Child and Youth Advocate who will focus on public programs and services that affect children and youth under 19 years of age.

In 2002-2003 there were total expenditures of $1.7 million under the Early Childhood Development and National Child Benefit initiatives, including further enhancement of Autism services and Family Resource Programs.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

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

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

The *Medical Care Insurance Act* (1999) was assented to on December 14, 1999, and came into force on April 1, 2000. This Act empowers the Minister to administer a plan of medical care insurance for residents of the province. It allows for the development of Regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to the administration of the medical care insurance plan.

There have been no legislative amendments to the *Medical Care Insurance Act* (1999) or the *Hospital Insurance Agreement Act* in 2002-2003. The Hospital Insurance Regulations were amended in February 2003 to include x-ray services ordered by Chiropractors as an insured service.

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

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

1.2 Reporting Relationship

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

During 2002-2003, work continued on implementation of the Government's Accountability Framework. The focus has been on developing an appropriate method of strategic planning, to achieve uniformity in approach from public bodies and, in the case of health boards, congruence between their respective strategic plans and *Healthier Together*. Direction has been given, by March 31, 2005, to fully implement the Framework by the public bodies that report to the Government.

Health Scope, Reporting to Newfoundlanders and Labradorians on Comparable Health and Health System Indicators was released in September 2002. It reported to the public on a wide range of indicators.

1.3 Audit of Accounts

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

unrestricted access to the MCP records.

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

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

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* (1990) 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 32 facilities (15 hospitals and 17 community health centres) and 17 nursing stations. Insured in-patient services include:

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

Coverage policy for insured hospital services is linked to the coverage policy for insured physician services, although there is no formalized process. Ministerial direction is required to add to or to de-insure a hospital service from the list of insured services. The Department of Health and Community Services manages the process.

In February 2003, x-ray services ordered by Chiropractors were added to the list of insured hospital services covered by the Newfoundland and Labrador health care insurance plan.

2.2 Insured Physician Services

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

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

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

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

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,[1] 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

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

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)."

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.

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

No services were deleted in 2002-2003 from the list of insured physician services covered by the Newfoundland and Labrador health care insurance plan.

Ministerial direction is required to add to or to de-insure a physician service from the list of insured services. This process is initiated following consultation by the Department with various stakeholders, including the provincial medical association. The Department of Health and Community Services manages the process and public consultation is involved.

2.3 Insured Surgical-Dental Services

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

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

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

Because the Surgical-Dental Program is a component of the MCP, management of the Program is linked to the MCP with regard to changes to the list of insured services. The Department of Health and Community Services manages the process.

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by the Plan include:

- preferred accommodation at the patient's request;
- cosmetic surgery and other services deemed to be medically unnecessary;
- ambulance or other patient transportation prior to admission or upon discharge;

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

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

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

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

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

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of 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 are the dentist's, oral surgeon's or general practitioner's fees for routine dental extractions in hospital.

3.0 Universality

3.1 Eligibility

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

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

The Medical Care Insurance Beneficiaries and Inquiries Regulations (Regulation 20/96) identify those residents eligible to receive coverage under the plans. As the administrator of the Regulations, the MCP has established rules to ensure that the Regulations are applied consistently and fairly in processing applications.

Persons not eligible for coverage under the plans include:

- students and their dependants already covered by another province or territory;
- dependants of residents if covered by another province or territory;
- certified refugees and refugee claimants and their dependants;
- foreign workers with Employment Authorizations and their dependants who do not meet the established criteria;
- foreign students and their dependants;
- tourists, transients, visitors and their dependants;
- Canadian Armed Forces and Royal Canadian Mounted Police personnel;
- inmates of federal prisons; and
- armed forces personnel of other countries who are stationed in the province.

3.2 Registration Requirements

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

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

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

As of April 15, 2003, there were 560,644 active beneficiaries registered with the MCP.

3.3 Other Categories of Individual

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

4.0 Portability

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage 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 and the Royal Canadian Mounted Police and

released inmates of federal penitentiaries. For coverage to be effective, however, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada who are authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

Newfoundland and Labrador is a party to the Agreement on Eligibility and Portability with regards to 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 Department of Health and Community Services 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 Province has entered into formal agreements, i.e. the Hospital Reciprocal 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.

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

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

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

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

4.3 Coverage During Temporary Absences Outside Canada

The Province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-

patient services are covered for emergency, sudden illness and elective procedures at established rates. Hospital services will be 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 of Health and Community Services. The referring physicians must contact the Department or the MCP for prior approval.

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

5.0 Accessibility

5.1 Access to Insured Health Services

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

5.2 Access to Insured Hospital Services

As of March 31, 2003, Newfoundland and Labrador had 1,677 staffed hospital beds in 15 hospitals, 17 community health centres and 17 nursing stations.

The supply of health professionals is a high priority issue in this province, especially in rural areas. Through the Provincial Health and Community Services Human Resource Planning Committee, a major human resource planning exercise has been underway for the last few years. The work of this committee will result in an integrated human resource plan for the province. The exercise will identify a planning model to provide five-year forecasts of the demand and supply of various health human resources.

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

There are now approximately 50 Nurse Practitioner positions in the province, with a small number of specialist positions in tertiary care.

Nursing initiatives include: a Northern Incentive package for nurses in remote and northern locations; a Nurse Practitioner Bursary Program, which provides funding of up to $5,000 to each of the nurses enrolled in the Nurse Practitioner training program; the Rural Nursing Incentive Program, which offers payment of up to $1,500

to fourth year Bachelor of Nursing students; and the annual Government Bursary in Nursing Administration for Masters of Nursing graduates in the amount of $500.

Research is ongoing with projects funded by Human Resources Development Canada and the Canadian Health Services Research Foundation. Included are a project on the impacts of health care restructuring, human resource studies and operational reviews. Newfoundland and Labrador is a member of the Atlantic Consortium for Research Utilization in Nursing and is participating as a pilot site with Health Canada to test a human resource simulation model for Registered Nurses and Licensed Practical Nurses.

Shortages continue in other professional groups, such as pharmacy, physiotherapy, speech language pathology, audiology and occupational therapy, as well as psychology. Focussed recruitment and incentive programs such as bursaries and seat purchases are in place.

In Budget 2002, Government provided $300,000 to the Bachelor of Nursing Collaborative Program, to increase, by at least 32, the number of students accepted into the program.

Government provided $800,000 to the Health Care Corporation of St. John's to establish a psychiatric assessment/short stay unit in St. John's.

$2.7 million has been committed to enable home support clients and agencies to increase the wages of home support workers by four percent.

An additional $1.3 million was allocated to personal care homes and clients to increase the number of subsidies for individuals and increase rates to personal care homes.

Service improvements have been made in programs such as cardiac care and pediatric care. Since April 2000, approximately $7 million has been invested to increase the number of weekly cardiac surgeries and a second cardiac catheterization laboratory has been set up to reduce patient wait times for diagnostic testing associated with heart disease.

Government announced public consultations on the Provincial Health Charter, as released in the discussion paper, *Building a Healthier Future*, the provincial strategic health plan.

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

- Magnetic Resonance Imaging (MRI) is located in St. John's;
- Computed Tomography (CT) scanners are available in St. John's, Carbonear, Clarenville, Gander, Grand Falls/Windsor, Corner Brook, St. Anthony and Happy Valley/Goose Bay;
- renal dialysis is provided in St. John's, Clarenville, Grand Falls/Windsor, Corner Brook and Stephenville;
- cancer treatment is provided at the Dr. H. Bliss Murphy Cancer Centre, St. John's, and satellite clinics in Gander, Grand Falls/Windsor, Corner Brook and St. Anthony;
- approximately 80 percent of surgery services are provided in St. John's, Gander, Grand Falls/Windsor, Corner Brook and St. Anthony. A full range of basic and some sub-specialty surgical services is available in all locations. Tertiary surgery, e.g. trauma, cardiac and neuro, is available in St. John's only; and
- an additional 20 percent of surgery services is provided in six mid-sized hospitals at Carbonear, Clarenville, Burin, Stephenville, Happy Valley/Goose Bay and Labrador City. These facilities offer basic surgical services.

5.3 Access to Insured Physician and Surgical-Dental Services

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

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

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

During 2002-2003, 11 new physicians in the province had previously received financial assistance from either the Travelling Fellowship Program, the Medical Specialist Resident Bursary Program, the Medical Student and Resident Practice Incentive Program or the Psychiatry Resident Bursary Program. A total of 40 awards were issued to students and residents in different years of training in that year.

A new Provincial Physician Recruitment office became operational at the Memorial University of Newfoundland Medical School.

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

5.4 Physician Compensation

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

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), with involvement of the Newfoundland and Labrador Health Boards Association, using traditional and formalized negotiation methods. The Physician Services Liaison Committee was formed in October 2002 to provide a mechanism whereby medical issues of mutual concern can be addressed cooperatively between the Government and the NLMA. The dispute resolution mechanism agreed to is mediation. Government and the Medical Association agreed to binding arbitration in October 2002 to conclude an agreement for the next three years. The *Medical Association Agreement Act,* passed on December 19, 2002, required that the decision of the arbitration board would be final and binding on the Province and the Association.

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

5.5 Payments to Hospitals

The Department of Health and Community Services is responsible for funding regional boards for ongoing operations and capital purchases. Funding for insured services is provided to the boards as an annual global budget and is distributed in 12 monthly advance payments. Payments are made to regional boards in accordance with the *Hospital Insurance Agreement Act* (1990) and the *Hospitals Act.* As part of their accountability to the Government, boards are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility and accountability to all appointed boards in the discharge of their mandates.

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

Boards are continually facing challenges in 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. Boards are continuing to work with the Department of Health and Community Services 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 and Social Transfer has been recognized and reported by the Government of Newfoundland and Labrador through press releases, government Web sites, and various other documents. For fiscal 2002-2003, these documents included:

- the 2002-2003 Public Accounts Volume I;
- the Estimates 2003-2004; and
- the Budget Speech 2003.

These reports, tabled by the Government to 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 as alternatives to hospital services. These programs are provided by seven regional boards. Services include the following:

Nursing Home Services

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

Personal Care Homes

Persons requiring protective oversight or minimal assistance with activities of daily living can avail themselves of residential services in personal care homes. There are approximately 2,400 beds located in 110 homes across the province. These homes are operated by the private for-profit sector. Residents pay a maximum of $1,110 per month, based on an individual client assessment using standardized financial criteria. In 2002-2003, an additional 66 subsidies were provided under a five-year plan to enable more elderly people to access this type of residential service.

Home Care Services

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

Non-professional services include personal care, household management, respite and 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 current ceiling for home support services 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 other 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 provided coverage for the ingredient portion of benefit prescription items. Any additional cost, such as dispensing fees, are the client's responsibility. Income support recipients are eligible for the Social Services Drug Plan, which covers the full

cost of benefit prescription items, including a set markup amount and dispensing fee.

Other Programs

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

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

The Dental Health Plan incorporates a children's dental component and a social assistance component. The children's program covers the following dental services for all children up to and including the age of 12: examinations at 6-month intervals; cleanings at 12-month intervals; fluoride applications 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 under the social assistance component to recipients of social assistance 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 social assistance are eligible for emergency care and extractions. Beneficiaries covered under the Dental Health Plan must pay a co-payment amount directly to the dentist for each service provided (e.g. fillings, extractions, etc.), with the exception of examinations, dental cleanings, fluoride applications, radiographs and retention pins for fillings. In circumstances where the beneficiary is receiving income support, the co-payment is paid by the Dental Health Plan.

8.0 Additional Materials Submitted to Health Canada

Healthier Together: A Strategic Health Plan for Newfoundland and Labrador
http://www.gov.nl.ca/health/strategichealthplan/pdf/HealthyTogetherdocument.pdf

Public Accounts (2002-2003)
http://www.gov.nl.ca/ComptrollerGeneral/pubs.htm

Budget 2002-2003 (address presented 3-21-2002). Supporting documents include:

- highlights;
- estimates; and
- the Economy 2002.
  http://www.gov.nf.ca/Budget2003/

Building a Healthier Future: A Public Discussion Paper on a Provincial Health Charter
http//www.gov.nf.ca/health/pdfiles/HealthCharter2003.pdf

Medical Association Agreement Act
http://www.gov.nf.ca/hoa/statutes/m04-1.htm

Prince Edward Island

Introduction

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

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

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

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

Overview of the Health and Social Services System

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

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

In December 2002, the PEI health system underwent restructuring. The Provincial Health Services Agency was created to administer all acute care hospital services including cancer treatment, mental health and addictions. The Eastern Kings and Southern Kings Regional Health Authorities were merged to form the Kings Regional Health Authority.

Facilities

PEI has two referral hospitals and five community hospitals, with a combined total of 474 beds. Along with seven government manors that house 546 long-term care nursing beds, Islanders have access to an additional 407 beds in private nursing homes. The system also operates several addictions and mental health facilities, 1,167 seniors' housing units and 461 family housing units.

Construction of a new $50 million health facility will be completed in Summerside in fall 2003. Computed Tomograhpy (CT) scanning and a wide range of diagnostic imaging services are available at the referral hospitals. New linear accelerator and MRI services are now operational.

Human Resources

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

Structure

The system includes the Department of Health and Social Services, the Provincial Health Services Agency (PHSA) and four Regional

1 Canadian Institute for Health Information, 1997.

Health Authorities, which are governed by the Regional Health Boards. The Department works with the Regional Health Authorities and the PHSA to establish system goals and objectives, develop policy and outcome standards and allocate resources. The Regional Health Authorities plan and deliver primary health care and social services. The PHSA is responsible for the delivery of acute care services.

Financial Resources

During the past 10 years, provincial spending on health and social services increased from $270 million to more than $410 million in 2002-2003, an average increase of about five percent per year. Increased costs are due to inflation, population growth, new technologies and the increasing use of services by all age groups.

Major health and social services expenditures are allocated to: Hospital Services, 31 percent; Social Services, 21 percent; Long Term Care, 10 percent; Physician Services, 12 percent; and other services such as Provincial Drug Programs, Public Health Nursing and Addiction Services, 26 percent.

Critical Issues

Supply of health professionals

Maintaining an adequate supply of workers is one of the most critical issues facing the system. Recruitment and retention of skilled employees are expected to be a challenge throughout the labour market in coming years due to a major demographic shift. The effect of this trend is being felt first in the health sector, which is labour-intensive and depends on a specialized workforce, and particularly in less-populated areas such as Prince Edward Island. The supply of health professionals is now decreasing as the workforce ages, the number of people retiring increases and the supply of available health care graduates declines. To address this issue, the system must increase its focus on workplace wellness and human resource planning to ensure an adequate supply and the right mix of health professionals to meet changing needs.

Public expectation and demand

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

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

Appropriate access to primary health services

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

Personal health practices

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

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

Aging population

As baby boomers age, we will experience the biggest demographic shift in history. It is expected that the proportion of the population aged 65 and over in Prince Edward Island will increase from 13 percent today to 15 percent in 2011 and to 27 percent in 2036. This will affect the health system in several ways. The incidence of diseases such as cancer, heart disease, diabetes and dementia is expected to

increase. Demand is expected to rise for acute care, long-term care, home care, mental health and other services. This issue becomes more critical when we consider that the health workforce will be aging at the same time, there will be fewer family members to support their aging parents, and the amount of resources required to sustain services for seniors could negatively affect other government services that support health. It is critical that the health system be prepared to meet these changing needs.

Disease prevention and management

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

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

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

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

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

- ensure the development and maintenance throughout the province of a balanced and integrated system of hospitals and schools of nursing and related health facilities;
- approve or disapprove the establishment of new hospitals and the establishment of, or additions to, related health facilities;
- approve or disapprove all grants to hospitals for construction and maintenance;
- establish and operate, alone or in cooperation with one or more organizations, institutes for training 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 the medical and other hospital records, including patients' charts with medical records and nurses' notes, reports and accounts of patients who are receiving or have received insured services;
- appoint inspectors with the duty and power to inspect and examine books, accounts and records of employers and collectors to obtain information related to the hospital and insurance plan;
- withhold payment for insured services for any insured person who does not, in the opinion of the Minister, medically require such services;
- act as a central purchasing agent for the purchase of drugs, biologicals or related preparations for all hospitals in the province; to supervise, check and inspect the use of drugs, biologicals or related preparations by hospitals in the province and to withhold or reduce payments under the Act to a hospital that does not comply with Regulations respecting the purchasing of drugs, biologicals or related preparations; and
- supervise and ensure the efficient and economical use of all diagnostic or therapeutic aids and procedures used by or in hospitals and to withhold or reduce payments under the Act to a hospital that does not comply with the Regulations respecting the use of such aids and procedures.

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

- setting overall directions and priorities;
- developing policies and strategies, legislation, provincial standards and measures;
- monitoring provincial health status;
- monitoring and ensuring that the Provincial Health Services Authority (PHSA) and the four Regional Health Authorities comply with Regulations and standards;
- evaluating the performance of the health system;
- allocating funds to the PHSA and the four Regional Health Authorities;
- improving the quality and management of a comprehensive province-wide health information system;
- ensuring access to high-quality health services;
- addressing emerging health issues and examining new technology before implementation; and
- directly administering certain services and programs.

The PHSA and four Regional Health Authorities are responsible for service delivery as allowed under the *Health and Community Services Act* (1993). The Authorities operate hospitals, health centres, manors and mental health facilities, and hire physicians, nurses and other health-related workers. Their responsibilities include:

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

- monitoring, evaluating and reporting on performance to residents and to the Ministry.

In December 2001, Prince Edward Island's health regions were awarded accredited status by the Canadian Council on Health Services Accreditation. The results of the accreditation process were announced following a comprehensive self-assessment process and surveys conducted in June 2001, by a team of 11 physicians and senior health administrators from across the country.

1.2 Reporting Relationship

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

The PHSA and four Regional Health Authorities are required under section 24 of the *Health and Community Services Act* to submit an annual report in the fall to the Minister of Health and Social Services. The Minister has the authority to request other information as deemed necessary on the operations of the Regional Health Authorities and their delivery of health services in their areas of jurisdiction. Regional Health Authorities are required to hold annual public meetings at which information about their operations and the provision of health services is presented.

1.3 Audit of Accounts

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

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

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

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- 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 2003, there were seven acute care facilities participating in the province's insurance plan. In addition to 454 acute care beds, these facilities house 20 rehabilitative beds, 19 day-surgery beds, as defined under the *Hospitals Act* (1988), and seven insured chronic care beds. An additional facility, Prince Edward Home, has 50 insured chronic care beds.

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, 2003, was 204.

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 of the Plan or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2003, 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.

No services were added to the list of insured physician services in 2002-2003.

The process to add a physician service to the list of insured services involves negotiation between the Department of Health and Social Services and the medical society of the province.

2.3 Insured Surgical-Dental Services

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

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

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

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by the Department;
- advice or prescriptions by telephone, except anticoagulant therapy supervision;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from the Department;

- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;
- testimony in court;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- physiotherapy, chiropractic, podiatry, optometry, chiropody, osteopathy, psychology, naturopathy, audiology, acupuncture and similar treatments;
- reversal of sterilization procedures;
- *in vitro* fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from the Department; and
- any other services that the Department may, upon the recommendation of the Medical Advisory Committee, declare non-insured.

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

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

All PEI 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.

PEI has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Department of Health and Social Services to monitor usage and service concerns.

3.0 Universality

3.1 Eligibility

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

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for coverage under the health care insurance plan in Prince Edward Island are members of the Canadian Armed Forces (CAF), Royal Canadian Mounted Police (RCMP), inmates of 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 the following cases: members of the CAF, RCMP and penitentiary prisoners on discharge, release or release following the termination of rehabilitation leave. Where such is granted by the CAF, the province, where incarcerated or stationed at time of release or discharge, or the province where resident on the completion of rehabilitation leave as may be appropriate, will provide initial coverage for the customary waiting period of up to three months. Parolees

from penitentiaries will be treated in the same manner as discharged parolees.

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

3.2 Registration Requirements

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

The number of residents registered for the health care insurance plan in Prince Edward Island as of March 31, 2003, was 141,031.

3.3 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for health and medical coverage. Kosovar refugees are an exception to this category and are eligible for both health and medical coverage in Prince Edward Island. There were 61 Kosovar refugees registered for Medicare as of March 31, 2003.

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

4.3 Coverage During Temporary Absences Outside Canada

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

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

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

For Island residents travelling outside 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 2002-2003 was $105,531.

4.4 Prior Approval Requirement

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

5.0 Accessibility

5.1 Access to Insured Health Services

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

5.2 Access to Insured Hospital Services

The seven acute care facilities in Prince Edward Island have a total of 474 (454 acute care and 20 rehabilitative) approved beds. There are also 23 acute care beds providing insured hospital services in a psychiatric facility. There are no admission data for these beds. During the 2002-2003 fiscal year, the total number of in-patient admissions was 16,335. The number of in-patient days in Prince Edward Island hospital acute care beds totalled 133,391 days (excluding newborns), with an average stay of 7.7 days. There are no data available on admissions, length of stay and in-patient days for chronic care beds.

Linear Accelerator

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

Magnetic Resonance Imaging (MRI)

In April 2000, the Government announced that diagnostic imaging services for Islanders would be expanded through the purchase of a Magnetic Resonance Imaging (MRI) unit for the Queen Elizabeth Hospital. The MRI service became operational in 2002-2003.

Ambulance Services

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

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

Accessibility – New Initiatives

The Nurse Recruitment Strategy, announced in the 2000 PEI Budget, is in its fourth year of the four-year plan. All strategies have been implemented in PEI. While the Nurse Recruitment Strategy addresses all sectors of health care, priority is given to the institutional sector, which covers acute and long-term care services. The Department will be evaluating results of the strategies.

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 were undertaken for family physicians, anaesthetists, radiologists, radiation oncologists, psychiatrists and a 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. A three-year agreement is in effect until March 31, 2004.

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

Most physicians work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are growing and seem to be the preference for new graduates.

5.5 Payments to Hospitals

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

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

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

6.0 Recognition Given to Federal Transfers

The Government of Prince Edward Island acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2002-2003 Annual Budget and related budget documents and its 2001-2002 Public Accounts, which were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

7.0 Extended Health Care Services

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

In addition to nursing home facilities, there are 36 licensed community care facilities in Prince Edward Island. As of March 31, 2003, the total number of licensed community care facility beds was 949. The 35 percent of residents who are subsidized require a financial assessment as per the *Social Assistance Act*, Part 1. The remaining 65 percent finance their own care. Community Care facilities provide Levels 1 to 3 care.

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

a sliding fee scale based on an individual's income assessment. The demand for home care continues to increase in PEI.

8.0 Additional Materials Submitted to Health Canada

- Department of Health and Social Services Annual Report 2001-2002 (published May 2003)
  http://www.gov.pe.ca/photos/original/hss_ann_2001-02.pdf
- Public Accounts 2001-2002
  http://www.gov/pe.ca/publications/findpublications/php3?keyword=public+account&dept=&month+&year=
- Budget 2002-2003
  supporting documents include:
  - highlights
  - estimates;
  - papers; and
  - schedules

  http://www.gov.pe.ca/budget/
- PEI Health Indicators: Provincial and Regional Common Health Indicators (published September 2002)
  http://www.gov.pe.ca/photos/original/hss_healthind02.pdf

Nova Scotia

Introduction

The management of day-to-day health services delivery in Nova Scotia is the responsibility of the Province's nine District Health Authorities (DHAs). These DHAs were created under the *Health Authorities Act*, which came into effect on January 1, 2001. The passage of this Act brought Nova Scotia closer to its goal of developing an affordable, high-quality, sustainable health care system.

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 the implementation of 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 2002-2003 accountability report will be available in late 2003.

Nova Scotia continues to be committed to the delivery of medically necessary services that are consistent with the principles of the *Canada Health Act*.

In March 2003, the Department of Health released a plan for better health care entitled, "Your Health Matters". This plan focusses on health promotion, more doctors and nurses, shorter wait lists, seniors' care and health services within communities.

Additional information related to health care in Nova Scotia may be obtained from the Department of Health Web site 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, passed by the Legislature in 1958.

The MSI is administered and operated on a non-profit basis by an authority consisting of the Department of Health and Maritime Medical Care Incorporated (now known as Atlantic Blue Cross Care), under the legislation previously mentioned (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, and that all residents of the province are insured upon uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. Section 8 of the Act gives the Minister of Health, with approval of the Governor in Council, the power to, from time to time, enter into agreements and vary, amend or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

Maritime Medical Care Incorporated (now known as Atlantic Blue Cross Care), by virtue of the 1992 Memorandum of Agreement, is mandated to:

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

entitlements and responsibilities under the Plan;

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

1.2 Reporting Relationship

Atlantic Blue Cross Care is required to submit to the Province, no later than the 20th day of each month, monthly expenditure reports, including such detail as determined by the Province. Within 30 days of the end of the fiscal quarter, Atlantic Blue Cross Care is required to provide a report that includes expenditures to the end of the quarter and a forecast of expenditures to the end of the year. Atlantic Blue Cross Care is required to provide minutes and any information necessary to keep the Province informed of all meetings, conferences, etc., that are charged to the MSI Plan. Reports prepared by Atlantic Blue Cross Care are forwarded to the respective Insured Program areas of the Department of Health for review and follow-up.

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

1.3 Audit of Accounts

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

Under section 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 Report of the Auditor General of Nova Scotia, tabled on December 6, 2002, contained five audits that are relevant to the *Canada Health Act*:

- Accountability of District Health Authorities;
- Procurement;
- Home Care Nova Scotia;
- Nova Scotia Health Research Foundation; and
- Audit of Performance Indicators.

1.4 Designated Agency

Atlantic Blue Cross Care administers and has the authority to receive monies to pay physician accounts under a Memorandum of Agreement with the Department of Health. Atlantic 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 the Medical Society of Nova Scotia and the Department of Health.

There is no legislation governing the role of Atlantic Blue Cross Care. Atlantic Blue Cross Care abides by the terms and conditions of the 1992 contract and its payment mechanism. Under this contract, Atlantic Blue Cross Care is required to submit to the Province:

- annual audited financial statements;
- detailed line-by-line Full-Time Equivalent counts on budget requests in which the Department actually approves staffing levels;
- line-by-line budgets showing salary, benefits, travel, postage, etc.; and
- a copy of the Annual Report.

All Atlantic 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 District Health Authorities and the IWK Health Centre (Women and Children's Tertiary Care Hospital) deliver insured hospital services to both in- and out-patients in Nova Scotia in a total of 35 facilities.[1]

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

In-patient services include:

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

Out-patient services include:

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

In order to add a new hospital service to the list of insured hospital services, District Health Authorities are required to submit a New and/or Expanded Program Proposal to the Department of Health. This process is carried out annually through the business planning process. A Department-developed process format is forwarded to the Districts for their guidance. A Department 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."

1. The number of facilities reported in other documents may differ from 35 as a result of using different definitions.

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 2002-2003, 2,026 physicians and 36 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, 2003, 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 2002-2003. On a quarterly, ongoing basis, new specific fee codes are approved that represent either enhancements, new technologies or new ways of delivering a service.

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

The proposal is then passed to the Joint Fee and Tariff Committee for review and approval. The Joint Committee is comprised of equal representation from the Medical Society and Department of Health. When approved by the Joint Fee Schedule Committee, the approved proposed new fee is forwarded to the Department of Health for final approval and Atlantic 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 *Health Services and Insurance Act,* a dentist is defined as a person lawfully entitled to practise dentistry in a place where such practice is carried on by that person.

To be permitted to provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the 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, 2003, no dentists had opted out. In 2002-2003, 36 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. Additions to the list of surgical-dental services that are insured are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health for the addition of a new procedure. The Department of Health, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

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

Uninsured physician services include:

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

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as the foldable interocular lens or a fibreglass 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 the Medical Society of Nova Scotia and the Department of Health representatives, who jointly evaluate a procedure or process to determine its medical necessity. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant amount of de-insurance of services was in 1997.

3.0 Universality

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Regulations 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.

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

Members of the Royal Canadian Mounted Police, members of the Canadian Forces,

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

3.2 Registration Requirements

To obtain a health card in Nova Scotia, residents must register with MSI. 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. Each health card number is unique and is issued for the lifetime of the applicant. 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 2002-2003, there were 955,475 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 to Nova Scotia from another country to live permanently, are eligible for health care on the date of arrival. They must possess a landed immigrant document. These individuals, formerly called “landed immigrants”, are now referred to as “Permanent Residents”.

Non-Canadians who are married to a Canadian citizen or a Permanent Resident, and Convention Refugees who have applied in Canada for Permanent Residence status, are eligible for insured services as of the date of application for Permanent Resident status. Applicants must possess a letter from Citizenship and Immigration Canada verifying their status. A Convention Refugee is a person designated by the Immigration Refugee Board to have been found to fear persecution in his or her country of origin because of race, religion, nationality, membership in a social group or political opinion.

Persons from outside Canada, who have applied for Permanent Resident status, cannot register until they become Permanent Residents. Coverage will be retroactive to their date of arrival in Nova Scotia.

In 2002-2003, there were 18,097 Permanent Residents registered with the health care insurance plan.

Employment Authorizations: Persons moving to Nova Scotia from another country, who possess an Employment Authorization, are eligible to apply for MSI on the first day of the seventh month following the date of arrival as a worker, provided they have not been absent from Nova Scotia for 31 consecutive days, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia, which is indicated on their health cards. Coverage is retroactive to the day of arrival. Each year a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons will be granted coverage on the same basis, once the worker has gained entitlement.

In 2002-2003, there were 398 individuals with Employment Authorizations covered under the health care insurance plan.

Student Authorizations: Persons moving to Nova Scotia from another country, who possess a Student Authorization will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days. 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 will be granted coverage on the same basis, once the student has gained entitlement.

In 2002-2003, there were 460 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either an employment or student authorization, or if they have applied for Permanent Resident status. They are governed by the eligibility provisions for the type of immigration document that they possess.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

The Agreement of Eligibility and Portability is followed in all matters pertaining to portability of insured services.

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 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, obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Workers who leave Nova Scotia to seek employment elsewhere will remain covered by MSI for up to 12 months, provided they do not establish residence in another province, territory or country. Services provided to Nova Scotia residents in other provinces or territories, are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement 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 and 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 2002-2003, for in- and out-patient hospital services received in other provinces and territories were: $12,685,659 for out-of-province, in-patient services and $4,447,816 for out-of-province, out-patient services. Nova Scotia pays the host province rates for insured services in all reciprocal-billing situations.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident 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 order to be covered, procedures of a non-emergency basis must have prior approval before they will be covered by MSI.

Students 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.

Workers who leave Nova Scotia to seek employment elsewhere remain covered by MSI

for up to 12 months, provided they do not establish residence in another country.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. The total amount spent in 2002-2003 for insured in-patient services provided outside Canada was $938,092.

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

5.0 Accessibility

5.1 Access to Insured Health Services

Insured services are provided to Nova Scotia residents on uniform terms and conditions. There are no user charges or extra charges under either plan.

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. The Department of Health accepted the recommendations of the Provincial Osteoporosis Committee report, which included placing new bone density units in Sydney and Yarmouth and operating the Truro unit at full capacity. During the 2002-2003 fiscal year, approval was given to purchase an MRI for Cape Breton to increase access and reduce wait times.

In fiscal 2002-2003, an additional $5 million was allocated to the Capital District Health Authority to increase cardiac surgery and cardiac catheterization capability to decrease wait times.

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.

There were a total of 2,853 hospital beds in Nova Scotia in the most recent count of the 2002-2003 fiscal year.

In 2002-2003, a total of $8.8 million in funding was provided to train, recruit and retain nurses. Eighty percent of the nurses from the class of 2002 renewed their licences, compared with only 51 percent in 2001. This is the highest retention ratio since 1999.

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

In Nova Scotia in 2002-2003, Telehealth was also used to provide the services listed in Table 2.

Table 1:
Health Personnel in Nova Scotia (2001)

Health Occupation	Registered/ Licensed to Practise[1]
Physicians	2,045[a]
Dentists[2]	464
Registered Nurses	9,165[a]
Licensed Practical Nurses	3,329[a]
Medical Radiation Technologists	483
Respiratory Therapists	186
Pharmacists	1004
Occupational Therapists	234
Speech-Language Pathologists	155
Chiropractors	74[a]
Opticians	173
Optometrists	76
Denturists	61
Dietitians	402
Psychologists	371

1 Not all professionals licensed to practise actually work.

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

a Data is for year 2002.

Table 2:
Telehealth Services in Nova Scotia (2002-2003)

Type of Telehealth Event	Number of "Events"
Tele-radiology Cases	6,169
Education Sessions	603
(Attendance)	(3,110)
Clinical Consultations	2,549
Administrative Meetings	299
(Attendance)	(850)
Clinical Case Conferences	62

5.3 Access to Insured Physician and Dental-Surgical Services

In 2002-2003, 2,026 physicians and 36 dentists actively provided insured services under the *Canada Health Act* or provincial legislation. Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

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

5.4 Physician Compensation

The *Health Services and Insurance Act* RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between the Medical Society of Nova Scotia and the Nova Scotia Department of Health. The Medical Society of Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from the Medical Society and the Department of Health negotiate the total funding and other terms and conditions. The current master agreement negotiated April 1, 2001, and expiring March 31, 2004, contains an alternate dispute resolution mechanism.

The agreement lays out what the medical service unit value will be for physician services and addresses issues of stand-by or call-back compensation, members' benefit fund, Canadian Medical Protective Association funding and rural stabilization funding. Fee-for-service is still the most prevalent method of payment for physician services, followed by alternative funding arrangements. Other payment methods include hourly funding and sessional funding.

In 2002-2003, total payments to physicians for insured services in Nova Scotia was $398,328,665. The Department paid an additional $5,562,125 for insured physician services provided to Nova Scotia residents outside the province, but within Canada.

Payment rates for dental services in the province are negotiated between the Department of Health and the Dental Association of Nova Scotia and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. The current agreement expires on March 31, 2004.

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 District Health Authorities (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* was given Royal Assent on June 8, 2000. The 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. The DHAs are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health.

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

In 2002-2003, there were 2,853 hospital beds in Nova Scotia (3.01 beds per 1,000 population). Department of Health direct expenditures for insured hospital services' operating costs were increased to $926.8 million. Total separations from all hospitals decreased slightly to 200,213.

6.0 Recognition Given to Federal Transfers

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

The Government of Nova Scotia also recognized the federal contribution under the CHST in various published documents including the following documents released in 2002-2003:

- Public Accounts 2001-2002; and
- Budget Estimates 2002-2003 and 2003-2004.

7.0 Extended Health Care Services

Home Care Services

Broad-based, provincially funded home care services were introduced in Nova Scotia in 1995. Home care is part of the continuum of services available through the Department of Health's Continuing Care Branch. Home care services are available to Nova Scotians of all ages and assist individuals reach and maintain their maximum level of health and prolong independent community living. Home care can be provided to people who are chronically ill, disabled, convalescent or to individuals with an acute illness. Services can delay admissions to long-term care facilities or hospitals as well as facilitate early release from an acute care facility. The health care and support services available to individuals in the community through home care include nursing care, assistance with personal care, aid with home support activities, home oxygen services and respite. Both chronic services over the longer term and short-term acute services are provided

through home care. Home care services in Nova Scotia continue to mature and, as resources allow, additional services will be added in the future. These may include services such as occupational therapy, physiotherapy, palliative care, pediatric services and others as deemed necessary.

The Nova Scotia Department of Health has implemented a Single Entry Access to its Continuing Care services. Nova Scotians connect with home care, long-term care placement and adult protection services through a single toll-free number.

8.0 Additional Materials Submitted to Health Canada

Annual Reports

- Department of Health 2002-2003 Business Plan:
  http://www.gov.ns.ca/health/downloads/2002plan.pdf
- Department of Health 2003-2004 Business Plan:
  http://www.gov.ns.ca/health/downloads/2003-2004%20DoH%20Business%20Plan.pdf
- Office of Health Promotion 2003-2004 Business Plan:
  http://www.gov.ns.ca/health/downloads/2003-2004%20OHP%20Business%20Plan.pdf
- Department of Health Annual Accountability Report for the year 2001-2002:
  http://www.gov.ns.ca/health/downloads/2001-2002AnnualAccountability.pdf
- Province of Nova Scotia's Annual Accountability Report for the fiscal year 2001-2002:
  http://www.gov.ns.ca/govt/accountability/Accountability.pdf

Audit Reports

- Chapters from the annual reports of 1996-2002 by the Auditor General of Nova Scotia relating to health:
  http://www.gov.ns.ca/audg/health.html
- Report of the Auditor General, 2002:
  http://www.gov.ns.ca/audg/2002/ag02_all.pdf
- 2002 Performance Report and 2003 Business Plan, Office of Auditor General (in accordance with section 9A of the *Auditor General Act*):
  http://www.gov.ns.ca/audg/busplan0203.pdf

Financial Reports

- Budget documents for the fiscal year 2003-2004:
  http://www.gov.ns.ca/finance/budget03/
- Budget documents for the fiscal year 2002-2003:
  http://www.gov.ns.ca/finance/budget02/
- Public Accounts, 2001-2002:
  http://www.gov.ns.ca/finance/publish/publicationsb.asp?id=Pub22
- Department of Finance, Fiscal 2003-2004 Forecast Update (and for previous years):
  http://www.gov.ns.ca/finance/publish/publicationsb.asp?id=Pub30

Legislation

- *Atlantic Blue Cross Care Inc. Act*
- *Health Authorities Act*
- *Health Services and Insurance Act*
- *Provincial Finance Act*

Please note that Nova Scotia Statutes and Regulations are available at:
http://www.gov.ns.ca/legislature/legc/

Other Documents

- Strong Leadership, a clear course, three years later:
  http://www.gov.ns.ca/prem/publications/STRONG3.pdf
- Making Better Health Care decisions for Nova Scotia, a Report by the Clinical Services Steering Committee (February 2001):
  http://www.gov.ns.ca/health/downloads/CSSC_Report.pdf
- Your Health Matters, Working Together Toward Better Care (2003). (This is a plan for the direction of health care in Nova Scotia and is a key departmental initiative.):
  http://www.gov.ns.ca/health/initiatives.htm

- Comprehensive Report on Injuries in Nova Scotia (May 2002): **http://www.gov.ns.ca/health/downloads/injuries_technical_rpt.pdf**
- The Cost of Chronic Disease in Nova Scotia (October 2002): **http://www.gov.ns.ca/health/downloads/chronic.pdf**
- Health Protection Legislative Review: Discussion Paper (Fall 2003): **http://www.gov.ns.ca/health/downloads/health_protection_review.pdf**
- Managing Osteoporosis: A Nova Scotia Approach (June 2002): **http://www.gov.ns.ca/health/downloads/Osteoporosis_Report.pdf**
- Nova Scotia Health Information Management Strategy Overview (February 2003): **http://www.gov.ns.ca/health/downloads/HIM_Vision.pdf**
- Nova Scotia's Nursing Strategy Update (March 2003): **http://www.gov.ns.ca/health/downloads/Nursing_Update_2003.pdf**
- Nova Scotia Student Drug Use 2002 Survey (November 2002): **http://www.gov.ns.ca/health/downloads/2002_NSDrugTechnical.pdf**
- Primary Health Care Renewal: Action for Healthier Nova Scotians (May 2003): **http://www.gov.ns.ca/health/phcrenewal/Final%20Report%20May%202003.pdf**

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 in a number of ways during the 2002-2003 fiscal year.

During the year, the Province took action to make health care more accessible through the introduction of new health care venues and new health providers; enhanced accountability through new reports to its citizens and the introduction of Canada's first stand-alone *Health Charter of Rights and Responsibilities*; and made the health system more accessible through the introduction of new legislation governing official languages in the province.

Community Health Centres

The Province embarked on a new course toward community-based, patient-focused primary health care during 2002-2003 with the establishment of its first Community Health Centres. These facilities will offer a new approach to primary health care, with physicians working collaboratively with nurses, nurse practitioners and other health care providers to serve community health needs. The establishment of Community Health Centres to deliver primary health care services was a key recommendation of the final report of the Premier's Health Quality Council, released in January 2002.

During the spring 2002 session of the Legislative Assembly, legislators approved amendments to the *Regional Health Authorities Act* to include Community Health Centres in the definition of health care facilities in the province.

The first four Community Health Centres will be located in Saint John, Minto, Doaktown and Lameque. Community health needs assessments, to determine the health care needs of the community and the mix of health professionals to be located at each centre, were begun during the last quarter of 2002-2003. The first four centres, along with a physician/nurse practitioner collaborative practice unit in Fredericton, are to open during 2003-2004.

Nurse Practitioners

During the year, the Province approved legislation to introduce nurse practitioners to New Brunswick's health care team. Nurse practitioners, who have advanced training in patient assessment, diagnosis and health care management, will play a significant role in enhancing access to primary health care services in New Brunswick.

The Legislative Assembly approved amendments to *The Nurses Act* to establish the duties of nurse practitioners and provide for their licensure within New Brunswick, as well as *An Act Respecting Nurses and Nurse Practitioners*, which gave legal standing to nurse practitioners who will work in the province's health care facilities. Both bills received Royal Assent on June 7, 2002.

In addition to the establishment of nurse practitioners, this legislation included provisions to enhance the role of Registered Nurses delivering primary health care services to New Brunswickers.

Following the proclamation of the enabling legislation, the Province hired its first nurse practitioner in January 2003 to work in the health care facility in Minto. The Province expects to hire more nurse practitioners as it expands its network of Community Health Centres and collaborative practice facilities to provide enhanced access to primary health care services.

Official Languages Act

In June 2002, the New Brunswick Legislative Assembly unanimously passed a new Official Languages Act, designed to reaffirm the right of all New Brunswickers to have access to services from their government in both of the province's official languages. The Act affirms the right of New Brunswickers to have access in both English and French to available health care services through a network of health facilities, services and programs under the jurisdiction of

the Department of Health and Wellness and the eight Regional Health Authorities(RHAs).

Section 33 (2) of the Act requires that, in establishing a provincial health plan under the Regional Health Authorities Act, the Minister of Health and Wellness shall ensure that the principles upon which the provision of health services are based include the delivery of health services in both of the official languages of the province.

Regional Health Authorities Act

The *Regional Health Authorities Act*, which provides for the delivery and administration of health services within specified geographic regions of the province, came into force on April 1, 2002. The eight RHAs are responsible for managing and delivering acute care hospital services, extra-mural services and addictions services.

The Minister of Health and Wellness appointed members to serve on the eight new boards for terms of two to four years. With the expiry of the two-year terms in May 2004, eight members of each RHA board will be elected by the voters of each health region in conjunction with scheduled municipal and school board elections. The Minister will continue to appoint the seven remaining members of each 15-member board.

Health Charter of Rights and Responsibilities

In the Speech From the Throne opening the fifth session of the 54th Legislative Assembly, the Government pledged to introduce legislation to create Canada's first *Health Charter of Rights and Responsibilities*. The *Health Charter of Rights and Responsibilities Act* was introduced in the Legislature on April 8, 2003 by the Minister of Health and Wellness. The Act would ensure that all New Brunswickers have a right to timely access to health care services; to safe, comfortable and considerate treatment; to take informed health care decisions; and to have their complaints investigated. The Act confirms that New Brunswickers have a responsibility to use health care services responsibly; to learn about and make healthy lifestyle choices; to participate actively in decisions regarding their health care; and to use complaint mechanisms appropriately and effectively. The Act would also establish a Health and Wellness Advocate, reporting directly to the Legislative Assembly, to help New Brunswickers deal with the health care system. Following Second Reading, the Act was referred to the Select Committee on Health Care for further study.

Reporting To Our Citizens

The Province also took action to make New Brunswickers better informed on the state of their own health and the status of their health care system.

In September 2002, New Brunswick joined with other jurisdictions in reporting to its population on a set of common health indicators, as agreed to by the First Ministers in September 2000. The First Ministers had identified 14 areas of comparable reporting on population health and health service delivery, including life expectancy, self-reported health, patient satisfaction, access to first-contact health services, health promotion and disease prevention. The report showed that New Brunswickers have a high rate of satisfaction with the health services they receive, but performed relatively poorly on measures related to personal health. Jurisdictions will issue a follow-up report on health indicators in fall 2004.

In January 2003, the Province released the first New Brunswick Health Care Report Card, reporting to the province's citizens on the status of health care services and the overall health of New Brunswickers. The report examined key determinants of health within the province's population and considered the challenges that face New Brunswickers in sustaining the health care services they have come to cherish.

Other Developments

On March 26, 2003, the Minister of Health and Wellness tabled amendments to the *Hospital Services Act* and *Medical Services Payment Act* that would provide full hospital privileges to oral and maxiofacial surgeons providing insured services in hospital facilities. The amended legislation received Royal Assent on April 11, 2003.

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 and Wellness, whose authority rests under the *Medical Services Payment Act* and its Regulations, which were proclaimed on January 1, 1971.

The Act and Regulations specify eligibility criteria, the rights of the beneficiary and the responsibilities of the provincial authority, including the establishment of a medical service plan, the insured and the uninsured services. The legislation also stipulates the 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 and Wellness 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 Public Health and Medical Services Division of the Department of Health and Wellness is mandated with the administration of the Medical Services Plan. The Minister reports 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 Regional Health Authorities (RHAs) and the Department of Health and Wellness. Under the Act, RHAs must prepare regional health and business plans that are in concert with the provincial health plan developed by the Department of Health and Wellness. 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 and Wellness. Under sections 7(1) and 7(2) of the Act, the Minister of Health and Wellness 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 in the area of the Medical Services Plan.

The Auditor-General of New Brunswick

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 and Wellness. For 2002-2003, all 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 sees fit. During 2002-2003, the Auditor General did not review Medical Services programs provided by the Department of Health and Wellness.

The Office of the Comptroller

The Comptroller is the chief internal auditor for the Province of New Brunswick and carries out internal audit activity in accordance with responsibilities and authority set out in the *Financial Administration Act*. The objective of an internal audit is to fulfill the Comptroller's mandate as it relates to the 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. During 2002-2003, the Office of the Comptroller gathered risk assessment data on a number of programs offered by the Department of Health and Wellness.

Department of Health and Wellness Internal Audit

The Department's Internal Audit Group was established to independently review and evaluate departmental activities as a service to all levels of management. This group is responsible for providing management with information about the adequacy and the effectiveness of its system of internal controls and adherence to legislation and stated policy. The unit performs program audits to report on the effectiveness of programs in meeting departmental objectives. Reviews of program areas are usually done on a cyclical basis, with a major program covered once every three to four years. No reviews were performed on these programs during 2002-2003.

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 to 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 (see Appendix 1). Note that facilities are categorized as those providing in-patient beds and those that do not provide in-patient services.

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

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

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

(ii) necessary nursing service,

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

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

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

(vi) routine surgical supplies,

(vii) use of radiotheraphy facilities, where available,

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

(ix) services rendered by persons who receive remuneration therefor from the regional health authority.

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

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

(i.1) 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 and Wellness,

(ii) 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 regional health authority for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability, excluding the following services:

(A) the provision of any proprietary medicines;

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

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

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

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

2.2 Insured Physician Services

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

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

No changes to this Act and Regulations were introduced during 2002-2003.

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:

- to maintain current registration with the New Brunswick College of Physicians and Surgeons;
- to maintain membership in the New Brunswick Medical Society;
- to hold privileges in a Regional Health Authority; and
- to have signed the Participating Physicians Agreement.

The number of practitioners participating in New Brunswick's Medical Services Plan as of March 31, 2003, was 1,486.

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

The opting-out provision may not be invoked in the case of an emergency or for continuation of care commenced on an opted-in basis. 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. 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 are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the service that:
  - they are opting out and charging fees above the 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, 2003, 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.

An individual, a physician or the Department of Health and Wellness may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department of Health and Wellness. 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 the purposes of maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

2.3 Insured Surgical-Dental Services

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

The number of dental practitioners registered with New Brunswick Medicare is 52, although many do not provide insured services.

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

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include the following:

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

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

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

Uninsured Physician and Surgical-Dental Services

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

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

(a.01) correction of inverted nipple;

(a.02) breast augmentation;

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

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

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

(a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;

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

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

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

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

(f) dental services provided by a medical practitioner;

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

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

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

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

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

(k) psychoanalysis;

(l) electrocardiogram (ECG) where not performed by a specialist in internal medicine or paediatrics;

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

(n) refractions;

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

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

(p) transsexual surgery;

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

(q) acupuncture;

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

(s) circumcision of the newborn;

(t) reversal of vasectomies;

(u) second and subsequent injections for impotence;

(v) reversal of tubal ligations;

(w) intrauterine insemination;

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

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

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

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

No medical or surgical-dental services were removed from the insured service list in 2002-2003.

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 of Canada) have a waiting period prior to 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;
- inmates of Federal prisons;
- persons moving to New Brunswick as temporary residents;
- a family member who moves from another province to New Brunswick in advance of other family members;
- persons who have entered New Brunswick from another province for the purpose of furthering their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian 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 prior to 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 receipt of the completed form, the file is updated and new card(s) issued bearing a revised expiry date.

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

The number of residents registered as of March 31, 2003, was 738,744.

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 remain in possession of a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document. In 2002-2003, approximately 541 individuals were covered under immigration permits.

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 of 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 the following:

- 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 13th 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.

During 2002-2003, New Brunswick paid the following amounts to other provinces and territories for insured health services:

Hospital in-patient	$23,477,103
Hospital out-patient	$5,387,946
Medical Services	$9,303,055

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 enrolment;

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

Temporary Workers: Residents temporarily employed outside the country are granted coverage for up to 12 months, regardless if it is known beforehand that they will be absent beyond the 12- month period, provided they do not establish residence outside of Canada. Any absence over 182 days, whether it be for work purposes or vacation, would require Director's Approval. This approval can only be up to 12 months in duration and will 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 to Temporary Workers: Mobile workers are residents whose employment requires them to travel frequently outside the province. Certain guidelines must be met to receive Mobile Worker designation. These are as follows:

- 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; and
- the worker must return to New Brunswick during their off-time.

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

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

- letter of request from the New Brunswick resident with their signature, detailing their absence, including Medicare number, New Brunswick address, date of departure, destination and forwarding address, reason for absence and date of return; and
- copy of 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 (2) 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; 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. In 2002-2003, New Brunswick paid the following amounts for services received outside of Canada:

Hospital in-patient	$351,945 (U.S.)
	$68,714 (CDN)
Hospital out-patient	$226,818 (U.S.)
	$17,399 (CDN)
Medical Services	$395,061(CDN)

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 CDN 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 for referral of 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 and Wellness.

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. The number of approved beds is shown in the following table:

Approved Beds as of March 2003

Bed Type	Number of Beds	Percentage of Total Beds
Non-Tertiary:		
Acute	2,899	72
Restorative	397	10
Addictions	174	4
Corrections Canada	2	-
Veterans Affairs Canada	187	5
Sub-total	3,659	91
Tertiary:		
Oncology	78	2
Cardiac Surgery	26	1
Neurosurgery	46	1
Tertiary Psychiatry	206	5
Tertiary Rehabilitation	20	-
Sub-total	376	9
Provincial Total	4,035	100

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, 2003, there were nine (9) 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 a mobile Magnetic Resonance Imaging (MRI) unit in operation and three fixed-site MRI systems.

5.3 Access to Insured Physician and Dental-Surgical Services

A total of 675 general/family practitioners, 731 specialists, eight dentists and three orthodontists provided insured services in New Brunswick in 2002-2003.

In fiscal 2002-2003, the Department of Health and Wellness 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 2002-2003 marked the first 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.

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 96-113.

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

5.5 Payments to Hospitals

The 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 2002-2003 fiscal year affecting the hospital payment process.

The Department of Health and Wellness 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 2000-2001, remained in use in fiscal 2002-2003. 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 and Social Transfer (CHST) in public documentation presented through legislative and administrative processes. These include the following:

- the Budget Papers presented by the Minister of Finance on December 10, 2002;
- the Public Accounts presented by the Minister of Finance on December 19, 2002; and
- the Main Estimates presented by the Minister of Finance on December 10, 2002.

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

The table below identifies residential and extended care services available in New Brunswick as of March 31, 2002. Nursing homes are private, not-for-profit organizations, with the exception of 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.

Availability of Residential and Extended Care

Service	Number of Units or Beds
Nursing Home Beds	4,102
Adult Residential Facilities[1] (beds)	5,104
Public Housing (units)	2,085
New Brunswick Total	11,291

1 Includes Special Care Homes and Community Residences.

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 as 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/night care in hospitals and in clinics as may be 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 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.

8.0 Additional Materials Submitted to Health Canada

Health Performance Indicators
http://www.gnb.ca/0391/pdf/HEALTHPerformanceIndicators2002-e.pdf

Health Care Report Card 2003
http://www.gnb.ca/0051/pub/pdf/hrepcard-e.pdf

2002-2003 Budget
http://www.gnb.ca/hw-sm/pub/budgets/02-03

Health Charter of Rights and Responsibilities Act
http://www.gnb.ca/legis/bill/editform-e.asp?ID=208&legi=54&num=5

Appendix

New Brunswick Hospital Facilities, 2002-2003 (as of March 31, 2003)

Regional Health Authority	Facilities Providing Insured Health Services *(Location):*	Other Facilities / Health Centres (Location):
Regional Health Authority 1 (South-East):	The Albert County Hospital Inc. *(Riverside-Albert)* The Moncton Hospital *(Moncton)* The Sackville Memorial Hospital *(Sackville)*	Petitcodiac Health Centre *(Petitcodiac)* Rexton Health Centre (Rexton)
Regional Health Authority 1 (Beausejour): (South-East)	Hopital Docteur Georges L. Dumont *(Moncton)* L'Hopital Stella Maris de Kent *(Sainte-Anne-de-Kent)*	Centre Medical Regionale de Shediac (Shediac)
Regional Health Authority 2:	Saint John Regional Hospital *(Saint John)* The Charlotte County Hospital *(St. Stephen)* Sussex Health Centre *(Sussex)* St. Joseph's Hospital *(Saint John)* The Grand Manan Hospital *(Grand Manan Island)* Centracare Saint John Inc.[1] *(Saint John)*	Campobello Health Centre *(Campobello Island)* Deer Island Health Centre *(Deer Island)* Fundy Hospital Association Ltd. *(Black's Harbour)*
Regional Health Authority 3:	Northern Carleton Hospital (Bath) Queens North Health Complex (Minto) L'Hotel-Dieu Saint-Joseph de Perth-Andover Inc. (Perth-Andover) Dr. Everett Chalmers Hospital (Fredericton) The Tobique Valley Hospital (Plaster Rock) Stan Cassidy Centre for Rehabilitation[1] (Fredericton) The Carleton Memorial Hospital (Woodstock)	MacLean Memorial Hospital (McAdam) Chipman Health Services Centre (Chipman) Upper Miramichi Health Services Centre (Doaktown) Upper Miramichi Health Services Centre (Boisetown) Stanley Health Services Centre (Stanley) Fredericton Junction Health Services Centre (Fredericton Junction) Harvey Community Hospital (Harvey Station)
Regional Health Authority 4:	L'Hopital regional d'Edmundston *(Edmundston)* Grand Falls General Hospital Inc. *(Grand Falls)* L'Hotel-Dieu Saint-Joseph de Saint-Quentin Inc. *(Saint-Quentin)*	Centre de Sante de Sainte-Anne-de-Madawaska *(Sainte-Anne-de-Madawaska)*
Regional Health Authority 5:	L'hopital regional de Campbellton *(Campbellton)* Restigouche Hospital Centre Inc.* *(Campbellton)* L'Hopital Saint-Joseph de Dalhousie *(Dalhousie)*	Centre de Sante de Jacquet River *(Belledune)*
Regional Health Authority 6:	L'hopital regional Chaleur *(Bathurst)* Centre hospitalier de l'Enfant-Jesus Inc. *(Caraquet)* Centre hospitalier de Lameque *(Lameque)* Centre hospitalier de Tracadie *(Tracadie-Shiela)*	Centre de Sante de Paquetville *(Paquetville)* Centre de Sante de Chaleur *(Pointe Verte)*
Regional Health Authority 7:	Miramichi Regional Hospital *(Miramichi)*	Baie-Ste-Anne Health Centre *(Baie-Ste-Anne)* Neguac Health Centre *(Neguac)* Blackville Health Centre *(Blackville)* Rogersville Health Centre *(Rogersville)*

Notes: "Insured Health Services" are defined in the Canada Health Act. This list does not identify Addictions Services, Veterans' Units and Extra-Mural Program units.

1 indicates provincial tertiary centre

Quebec

Statement from Quebec

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

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

Federal Response to Quebec

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

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

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

The federal government is concerned that Quebec is not providing sufficient information to effectively assess compliance with the *Canada Health Act* and satisfy the recommendations of the Auditor General. The federal government will continue to work with Quebec to ensure that information is made available to demonstrate compliance with the *Canada Health Act*.

Quebec

Public Administration

Hospital Insurance and Medical Care Plans

The hospital insurance plan, the *Régime d'assurance-hospitalisation du Québec*, is administered by the Ministère de la Santé et des Services sociaux [Quebec department of health and social services] (MSSS).

The health insurance plan, the *Régime d'assurance-maladie du Québec*, is administered by the *Régie de l'assurance maladie du Québec* [Quebec health insurance board], a public body established by the provincial government and responsible to the Minister of Health and Social Services. Both plans are operated on a non-profit basis, and all books and accounts are audited by the Auditor General of Quebec.

Comprehensiveness

Hospital Insurance Plan

The network of institutions under the Ministère de la Santé et des Services sociaux includes the hospital centres, certain residential and long-term care centres (formerly hospital centres for long-term care)[1] and the local community service centres (CLSCs).

The treatment of physical and mental illness is provided by the hospital centres and by some of the residential and long-term care centres.

Insured in-patient services are provided in the in-patient units of the hospital centres, whereas insured out-patient services are available mainly in hospitals and CLSCs.

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 anaesthetic 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 centre 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 (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 free of charge to persons aged 65 or older.

Uninsured hospital services include: plastic surgery; in-vitro fertilization; private or semi-private room at the patient's request; televisions; telephones; drugs and biologicals ordered after discharge from hospital; and services covered by the *Act respecting industrial accidents and occupational diseases* or other federal or provincial legislation.

Medical Care Plan

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

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

The following services are not considered 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 purposes by MSSS;
- any service rendered solely for aesthetic purposes;
- any refractive surgery, except in cases where there is documented failure for 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 the 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 eyeglasses 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 centre in certain cases;
- all acupuncture procedures;
- injection of sclerosing substances and the examination done at that time;
- thermography or mammography used for screening purposes, unless this service is delivered on a doctor's order in a place designated by the Minister, in either case, to a recipient who is age 35 or older, on condition that such an examination has not been performed on the recipient in the previous year;
- tomodensitometry, magnetic resonance imaging and use of radionuclides *in vivo* in a human, 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 anaesthetic 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 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.

In addition to the basic insured services, the Régie 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, orthopaedic 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 *Régie* 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 new drug insurance plan covers 3.2 million insured persons.

Universality

Hospital Insurance and Medical Care Plans

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

Portability

Hospital Insurance and Medical Care Plans

Minimum Period of Residence

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 the Province of origin, provided they register with the Régie.

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

This is also the case for persons living in another province for the purpose of holding temporary employment or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons employed or working on contract outside Quebec for a company or corporate body having its headquartered or 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 *Régie* of the absence.

Certain categories of resident, notably permanent residents under the *Immigration Act* and persons returning to Canada to live, 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 Royal Canadian Mounted Police who have not acquired the status of Quebec resident become eligible upon their arrival, and inmates of federal penitentiaries become eligible upon release. Immediate coverage is provided to 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* [Quebec department of education], 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.

Payment for Services in Canada

Hospital costs incurred in another province or in a territory of Canada are paid in accordance with the terms and conditions of the interprovincial agreement on reciprocal billing in the area of hospital insurance that was 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 standard interprovincial/territorial rates. However, since November 1, 1995, Quebec reimburses the Ottawa hospital at a maximum amount of $450 per day of hospitalisation when an Outaouais resident is hospitalized in a hospital in Ottawa for non-urgent care or services available in the Outaouais.

The costs of medical services incurred in another province or a territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the Régie 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 Témiscamingue health centre and North Bay.

Payment for Services Outside Canada

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

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

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

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

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

Permanent Moves out of the Province

Insured persons who leave Quebec to settle in other parts of Canada are covered for up to three months after leaving the Province.

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

Accessibility

Hospital Insurance and Medical Care Plans

Reasonable Access

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

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

On March 31, 2003, Quebec had 123 institutions operating as hospital centres for a clientele suffering from acute illness, with 21,794 acute and psychiatric care beds for persons with physical or psychiatric ailments

allotted to these institutions. From April 1, 2001, to March 31, 2002[2], Quebec hospital institutions had nearly 706,400 admissions for short stays and close to 286,300 registrations for day surgeries. These hospitalizations and registrations accounted for more than represented a total number of more than 5,000,000 patient-days.

Payment to Hospital Centres

The funding of a hospital centre by the Minister of Health and Social Services is done by means of payments in respect of the cost of insured services provided.

The payments made in 2001-2002[3] to institutions operating as hospital centres for insured health services provided to persons living in Quebec amounted to more than $6.4 billion; payments to hospital centres outside Quebec amounted to approximately $65 million.

Payment for Medical Care

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

Reasonable Compensation

Provision is made in law for reasonable compensation for all insured health services rendered by health professionals. The Minister may enter into, with the organizations representing any class of health professional, an agreement prescribing 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 2002-2003, the *Régie* paid $2,894.9 million to doctors in the povince, while the amount evaluated for medical services outside the province reached $9.0 million.

Extended Health Care Services

Intermediate care, adult residential care and home care services are available, with admission coordinated on a regional level and based on a single assessment tool. The local community service centres (CLSCs) receive individuals, evaluate their care requirements and either arrange for the provision of such services as day-centre programs or home care, or refer them to the appropriate agencies.

MSSS offers some home care services, including nursing care and assistance, homemaker services and medical surveillance.

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

2 Latest year for which figures are available.

3 Latest year for which figures are available.

Ontario

Introduction

Ontario has one of the largest and most complex publicly funded health care systems in the world, which is administered by the province's Ministry of Health and Long-Term Care (MOHLTC) and was supported by $25.9 billion in spending for 2002-2003.

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;
- public health; and
- health promotion and disease prevention.

MOHLTC also regulates and funds hospitals and long-term care facilities (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.

There were no amendments to the *Health Insurance Act* or its regulations in 2002-2003, which changed the name or public authority of OHIP.

1.2 Reporting Relationship

OHIP is administered by MOHLTC, which regularly reports to the public. For example, as a core business, activities associated with Ontario health insurance are included in MOHLTC's annual Business Plan.

1.3 Audit of Accounts

MOHLTC is audited annually by the Provincial Auditor. The Provincial Auditor's 2003 Annual Report, which was released on December 2, 2003, examined the ministry's public health activities.

MOHLTC's accounts and transactions are published annually in the Public Accounts of Ontario. The 2002-2003 Public Accounts of Ontario was released on November 21, 2003.

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:

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

Insured out-patient services include:

- laboratory, radiological and other diagnostic procedures;

- use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- use of diet counseling services;
- use of home renal dialysis and home hyperalimentation equipment, supplies and medication;
- provision of equipment, supplies and medication to haemophiliac patients for use at home;
- cyclosporine to transplant patients;
- zidovudine, didanosine, zalcitabine and pentamidine to patients with HIV infection;
- biosynthetic human growth hormone to patients with endogenous growth hormone deficiency;
- drugs for treatment of cystic fibrosis and thalassemia;
- erythropoeitins to patients with anaemia of end-stage renal disease;
- alglucerase to patients with Gaucher disease;
- clozapine to patients with treatment-resistant schizophrenia; and
- the administration of a rabies vaccine.

In 2002-2003 there were 154 public hospital corporations (excluding specialty hospitals, private hospitals, provincial psychiatric hospitals, federal hospitals and long-term care facilities) staffed and in operation in Ontario. This includes 139 acute care hospital corporations, 11 chronic care hospitals and four general and special rehabilitation units.

Hospitals are categorized by major activity, though they provide a mix of services. For example, many acute care hospitals offer chronic care services, just as many chronic care facilities also offer rehabilitation.

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

When insured physician services are provided in licensed facilities outside of 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* (IHFA). Facility fees cover the cost of the premises, equipment, supplies and personnel utilized to render an insured service. Under the IHFA, patient charges for facility fees are prohibited.

Facility fees are charged to the government only by facilities that are licensed under the IHFA. Examples of facilities that are licensed under the IHFA 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 rendered by a physician in Ontario is an insured service if it is medically necessary, contained in the Schedule of Benefits and rendered in such circumstances or under such conditions as outlined in the Schedule of Benefits.

Physicians provide primary health care services as well as medical, surgical and diagnostic services. Services are provided in a variety of settings including private physician offices, health service organizations, community health centres, hospitals, mental health facilities, independent health facilities, walk-in clinics and long-term care facilities.

In general terms, insured physician services include:

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

The Schedule of Benefits is continually 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 Central Tariff Committee of the Ontario Medical Association.

Physicians may submit claims for all insured services rendered to insured persons directly to OHIP, in accordance with section 15 of the *Health Insurance Act*, or they may bill the insured person, as specified in section 15 of the Act (see also the *Health Care Accessibility 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.

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

There were approximately 21,000 physicians who submitted claims to OHIP in 2002-2003.

2.3 Insured Surgical-Dental Services

Insured surgical-dental services are prescribed under section 16 and the Dental Schedule of Benefits under Regulation 552 of the Health Insurance Act. These services, for which hospitalization is medically necessary, include the following:

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

Approximately 320 dentists and dental/oral surgeons provided insured surgical-dental services in Ontario in 2002-2003.

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

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;
- cosmetic surgery under most circumstances;
- provision of medications for patients to take home from hospital, with certain exceptions; and
- in-province hospital visits solely for the administration of drugs, subject to certain exceptions.

Uninsured physician services include:

- services that are not medically necessary;
- toll charges for long-distance telephone calls;
- preparing or providing a drug, antigen, antiserum or other substance unless the drug, antigen or antiserum is used to facilitate a procedure;
- advice given by telephone at the request of the insured person or the person's representative;
- an interview or case conference (in limited circumstances);
- preparation and transfer of records at the insured person's request;
- a service that is received wholly or partly for the production or completion of a document or the transmission of information to a "third party" in specified circumstances;
- the production or completion of a document or the transmission of information to any person other than the insured person in specified circumstances;
- provision of a prescription when no concomitant insured service is rendered;
- cosmetic surgery;
- acupuncture procedures;

- psychological testing;
- group screening programs; and
- research and survey programs.

The *Health Care Accessibility Act* prohibits physicians from charging patients or accepting payments from patients for more than the amount payable by OHIP for the insured service. A physician may charge for services that are not insured under OHIP. MOHLTC does not regulate charges for uninsured services. However, the Ontario Medical Association publishes a schedule of suggested fees for uninsured services.

3.0 Universality

3.1 Eligibility

With certain exceptions in which the waiting period is waived, all Ontario residents are eligible for OHIP coverage, subject to a three-month waiting period. Regulations under the *Health Insurance Act* define those types of persons who are residents of Ontario, as well as those who are and are not subject to the three-month waiting period.

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

- hold prescribed citizenship or immigration status;
- make his or her permanent and principal home in Ontario; and
- generally speaking, be physically present in Ontario for at least 153 days in any 12-month period.

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

Among those who are ineligible for Ontario health coverage are individuals without citizenship or immigration status as prescribed under Regulation 552, such as refugee claimants (who are not Convention Refugees). Other categories of individuals such as federal penitentiary inmates are generally not provided with coverage if they are entitled to services under federal legislation as prescribed under Regulation 552. Persons previously ineligible for coverage but whose status has changed (e.g. change in immigration status or release from a federal penitentiary) may, upon application, be eligible for OHIP coverage subject to the requirements of Regulation 552.

3.2 Registration Requirements

Every resident of Ontario who seeks OHIP coverage is required to register for health insurance.

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

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

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

MOHLTC is the sole payer for insured health services. An eligible Ontario resident may not register with or obtain any benefits from another insurance plan for any insured service covered by OHIP.

Approximately 12 million Ontario residents were registered with OHIP and held valid and active Health Cards as of as of December 3, 2002.

3.3 Other Categories of Individual

MOHLTC provides coverage to several categories of individuals other than Canadian citizens and landed immigrants/permanent residents. Generally, these individuals are required to provide acceptable documentation to support the category to which they belong, along with residency and identity information in the same manner as individuals with permanent resident status who apply for Ontario health coverage. Clients applying for coverage under any of these categories should contact their local OHIP office for details. A general overview of eligibility for applicants in other categories is included below.

The following categories of individuals who are ordinarily resident in Ontario will be eligible in accordance with Regulation 552 and prevailing Ministry policy:

Applicants for Landing/Applicants for Permanent Residence – Applicants for Landing/Applicants for Permanent Residence are persons who are being processed toward landing by Citizenship and Immigration Canada (CIC) and, generally speaking, have met CIC medical requirements. An immigrant who has been "landed" is a permanent resident of Canada.

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

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

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

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

Eligible accompanying family members are the spouses, same sex partners and dependent children (under 19 years of age) of an eligible foreign member of the clergy or an eligible foreign worker who is to be employed for at least three consecutive years and who is ordinarily a resident of Ontario.

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

The following category of workers who may or may be not ordinarily resident in Ontario will be eligible in accordance with Regulation 552 and prevailing Ministry policy:

Migrant Farm Workers – Migrant farm workers are persons who have been issued an Employment Authorization/Work Permit 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 not required to present residency documents generally required to establish eligibility for OHIP coverage. Members of this group are also exempt from the three-month waiting period.

4.0 Portability

4.1 Minimum Waiting Period

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

4.2 Coverage During Temporary Absences in Canada

Out-of-province services are covered under sections 28, 30(1) and 32 of Regulation 552 of the *Health Insurance Act*.

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

An insured person who leaves Ontario temporarily to travel within Canada without establishing residency in another province or territory will 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 will continue to be covered 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, are eligible for continuous health coverage for the duration of their studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide MOHLTC with letters 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.

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

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

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

Ontario residents who may be required to pay for doctors' services received in Quebec can submit their receipts to the Ministry of Health and Long-Term Care for repayment.

4.3 Coverage During Temporary Absences Outside Canada

Coverage during temporary 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 OHIP eligibility for absences of longer than 212 days in a 12-month period. In most cases, applicants must provide MOHLTC with a document explaining the reason for their absence from Ontario to qualify for an approved absence. In accordance with the regulations and Ministry policy, most applicants must also have been present for at least 153 days in each of the two consecutive 12-month periods prior to the expected date of departure in order to be approved for an extended absence.

Approved absences vary in duration depending on the reason for the absence. Please refer to the table below for further details.

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

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

Out-of-country services are covered under section 28.1 to 28.6 inclusive, and 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 Canadian for in-patient services;
- a maximum $50 Canadian for out-patient services (except dialysis); and
- a maximum $210 Canadian per dialysis treatment.

Emergency medically necessary out-of-country physician and other eligible practitioner services (chiropractors, dentists, optometrists, podiatrists and osteopaths) are reimbursed only at the rates listed in the physician Schedule of Benefits, Regulation 552, or the amount billed, whichever is less. Charges for medically necessary emergency out-of-country in-patient and out-patient services are reimbursed only when rendered in a licensed or approved hospital or 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 2002-2003 payments for out-of-country in-patient and out-patient insured hospital and medical services amounted to $37.4 million for emergency services.

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 elective 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 of out-of-country health services.

Under section 28.5 of Regulation 552 of the *Health Insurance Act*, laboratory tests performed outside of 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 2002-2003, total payments for prior approved treatment outside of Canada were $33.4 million.

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

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*.

Public hospitals in Ontario are not permitted to refuse to provide services in life-threatening situations by reason of the fact that the person is not insured.

Under the *Health Care Accessibility Act* and *Health Insurance Act*, extra billing is prevented because physicians (both opt-in and opt-out) are prohibited from charging more than the amount for an insured service prescribed in the Schedule of Benefits for Physician Services. Under that same legislation, hospitals are also prohibited from charging insured residents for insured services.

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

In 2002-2003, there were 154 public hospital corporations staffed and in operation in Ontario, which included chronic, general and special rehabilitation units. There were 7,497,394 acute patient days, 2,218,358 chronic patient days and 749,159 rehabilitation patient days delivered by public hospitals during fiscal year 2002-2003.

Priority services are designated highly specialized hospital-based services that respond to life-threatening conditions. These services are often high-cost and rapidly growing which makes access of concern. Generally, these programs are managed provincially and are designed to ensure equitable access.

Priority services include:

- bone marrow transplantation;
- selected cardiovascular services;
- selected cancer services;
- end stage renal disease; and
- selected organ transplants.

In addition, the Ministry supports a number of major provincial strategies, including:

- The Ontario Stroke Strategy;
- Organ and Tissue Donation and Transplantation Action Plan;
- Visudyne Therapy Service;
- Ontario Joint Replacement Registry (OJRR);
- Telemedicine;
- Provincial Cancer Plan & Ontario Cancer Quality Council; and
- Paediatric Oncology.

5.3 Access to Insured Physician and Dental-Surgical Services

The Underserviced Area Program (UAP) is one of a number of supports provided by MOHLTC to help communities across Ontario recruit and retain health care professionals. It offers recruitment and retention tools (financial incentives) to underserviced communities. In order to access the UAP's recruitment and retention benefits, a community must be designated as underserviced.

Through the UAP, a number of programs enhance access to health care services for residents of northern and rural remote areas of Ontario:

- the Community Sponsored Contracts provide alternative funding arrangements that pay a group of physicians a global amount (not fee-for-service) for primary care services;
- the Incentive Grant Program for Physicians provides financial incentives to general practitioners and specialists who establish practice in designated underserviced areas;
- the Free Tuition Program provides up to $40,000 in tuition reimbursement to eligible final-year medical students, residents and newly graduated physicians in exchange for a three or four-year full-time return-of-service commitment in an underserviced community;

- the Northern Physician Retention Initiative provides eligible family practitioners and specialists who have maintained practices in northern Ontario for at least four years with a retention incentive and also provides access to funding for continuing medical education; and
- the Northern Health Travel Grant helps to defray transportation costs for the 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 the use of specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.

Currently, there are 132 communities in Ontario designated as underserviced for general/family practitioners and 15 communities designated as underserviced for specialists.

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

During 2002-2003 Ontario continued to be at the forefront of Primary Care Renewal. Ontario has a number of innovative primary care delivery models, during this year the province began to align its new and existing primary care models to ensure that they all provide the same key elements including: comprehensive and preventative care, 24/7 access through telephone advisory services, and increased after hours coverage.

5.4 Physician Compensation

Physicians are paid for the services they provide through a number of mechanisms. Most physician payments are provided through fee-for-service arrangements, with remuneration based on the Schedule of Benefits under the *Health Insurance Act*. Other physicians are paid through Alternate Payment Plans, such as capitation, global budget and volumes-based arrangements. In partnership with the Ontario Medical Association, the MOHLTC is implementing new payment mechanisms through primary care reform initiatives, such as Family Health Networks and Family Health Groups.

MOHLTC negotiates payment rates and other changes to the Schedule of Benefits with the Ontario Medical Association. The current four-year Physician Services Agreement with the Ontario Medical Association expires on March 31, 2004. The Agreement provided an annual increase of 1.95 percent, effective April 1, 2000 and two percent for each of the following three years. The Agreement also introduced new fees aimed at easing the pressure on hospital emergency wards, providing improved access to specialists, facilitating the expansion of in-home health services and providing better care to an aging population. In addition, the Agreement included provisions for maternity benefits for female physicians.

The Physician Services Agreement reached between MOHLTC and the Ontario Medical Association committed the parties to meet in March 2003 regarding the fourth year commitments. A Memorandum of Agreement was reached in April 2003. The Memorandum of Agreement provided for additional investment beyond the previously committed funding.

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

5.5 Payments to Hospitals

Hospitals submit annual Hospital Planning Brief Submissions that are the product of a broad consultation within the facilities (e.g. all levels of staff, unions, physicians and board) and within the community and region. The business plan is first and foremost a planning document but it also has a substantial budget component, both financial and statistical. The District Health Council and MOHLTC staff then review this business plan. MOHLTC's review is conducted by regional staff, specialized program staff and senior management, and follows standard guidelines. It may involve extensive discussions and clarification with the facility.

Payments made by the health care plan to hospitals for insured services come under the

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

MOHLTC reviews chronic care co-payment regulations and rates annually, taking into account changes in the Consumer Price Index, Old Age Security, Guaranteed Income Supplement and Guaranteed Annual Income Supplement each year, and determines whether revisions to the regulations and rates are appropriate.

MOHLTC is beginning to measure and reward relative cost efficiency in hospitals through the Integrated Population-Based Allocation model. Payments are made to those hospitals that spend less than expected, taking into consideration the individual characteristics of the hospital.

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

Funding for hospital operations was in excess of $10 billion for 2002-2003.

6.0 Recognition Given to Federal Transfers

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in its 2002-2003 publications.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential Care Services

MOHLTC funds 563 long-term care facilities and over 68,000 beds. MOHLTC also conducts the compliance monitoring program for long-term care facilities, which includes monitoring resident health and well-being, safety, security, environmental and dietary services to determine compliance with legislation, regulations and standards. MOHLTC receives and monitors the implementation of corrective action plans to achieve compliance, where necessary.

7.2 Home Care Services

Ontario home and community care programs provide a range of services that support independent community living. These services are available through Community Care Access Centres (CCAC), Community Support Service (CSS) agencies, and Children's Treatment Centres (CTC).

CCACs provide simplified access for eligible Ontario residents of all ages to community-based health care and support services. CCACs assess individual care needs and arrange professional and personal support services in the home or school. CCACs also provide information and refer persons to other community services and arrange admission to institutional care when necessary.

Community Support Service (CSS) agencies provide support services, including homemaking, attendant care, adult day programs, caregiver support, meal services, home maintenance and escorted transportation. These services complement in-home and other health services and the assistance provided by family and friends.

Children receive out-patient rehabilitative and habilitative therapy services from Children's Treatment Centres. All CTCs provide occupational therapy, physiotherapy, and speech-language pathology services. A wide range of other services may be provided, depending on community needs and the

availability of other services locally. Children too ill to leave home are served through CCAC in-home services.

8.0 Additional Materials Submitted to Health Canada

Business Plan:

- Ministry of Health and Long-Term Care 2002-2003 Business Plan
  http://www.health.gov.on.ca/english/public/pub/ministry_bplans/bplan02/bplan02.html

Performance Reports:

- Ontario's Health System Performance Report, September 2002
  http://www.health.gov.on.ca/english/public/pub/ministry_reports/pirc/pirc_mn.html
- Hospital Report 2002: Acute Care
  http://www.health.gov.on.ca/english/public/contact/hosp/hosprep.html

Financial and Audit Reports:

- 2003 Ontario Budget
  www.gov.on.ca/FIN/english/budeng.htm#Budget
- Public Accounts 2002-2003
  http://www.gov.on.ca/FIN/english/pacct/2003/03_are.htm
- 2002 Annual Report of the Office of the Provincial Auditor of Ontario
  http://www.gov.on.ca/opa/english/r02t.htm

Legislation

- *Health Insurance Act* and Regulations
- *Public Hospitals Act* and Regulations
- *Independent Health Facilities Act* and Regulations
- *Health Care Accessibility Act* and Regulations
- *Health Cards and Numbers Control Act* and Regulation
- *Long-Term Care Act* and Regulations

Please note that Ontario statutes and regulations are available at **http://www.e-laws.gov.on.ca**

Manitoba

Introduction

The mission of Manitoba Health is to provide leadership and support to protect, preserve and promote the health of all Manitobans. In 2002-2003, Manitoba Health implemented an administrative restructuring plan to shift from a service provider role to a leadership role in policy, program and standards development and fiscal and program accountability and evaluation. The new organizational structure reflects five distinct but interrelated functional areas: Finance; Regional Affairs; Provincial Health Programs; Health Accountability, Policy and Planning; and Health Workforce. The mandate(s) of these functional areas are derived from established legislation and policy pertaining to health and wellness issues.

Health services are delivered through 10 Regional Health Authorities, hospitals and other health care facilities.

Manitoba Health remains committed to the ongoing implementation of the five point plan to end hallway medicine (opening new beds, improving admission and discharge procedures, expanding community- based services, strengthening prevention programs such as flu immunization and increasing home care and adult day-care programs).

Primary health care reform has been a major focus of the Department of Health. A policy framework, which creates common definitions and key goals and objectives to guide reform in this area, has been approved. A number of provincial strategies have been initiated (e.g., expansion of the Provincial Health Call Centre, enhanced emergency Medical Services training, development of necessary technology tools to enable the sharing of information and to remove the technical barriers between existing, disparate information systems, development of a formal and sustainable model for collaborative practice training in Manitoba and development and implementation of a comprehensive public education and awareness initiative regarding primary health care reform. In addition, a formal request for proposals was held with Regional Health Authorities and their partners. Seventeen proposals addressing the themes of:

- advancing primary care access;
- community capacity building;
- RHA organizational strengthening;
- creating integrated service delivery systems; and
- Primary Health Care capital investments;

were approved and are currently underway.

Mental Health Renewal has focused on improved integration of mental health services within the primary health care system as well as enhanced consumer and family participation in the design and delivery of mental health services.

Manitoba's Pharmacare Program has been enhanced by the addition of new drugs to the formulary, streamlining administration and interaction with other provinces regarding common approaches, such as a common drug review mechanism.

Patient safety and quality care continue to be high priorities for Manitoba Health. An integrated patient safety strategy based on priorities identified by the National Patient Safety Steering Committee and the recommendations of the Sinclair Inquiry[1] and Thomas Report[2] is under development.

Overall, Manitoba Health is building a culture of accountability for both the work of the Department of Health and the work of various stakeholders in the health care system.

1. The Sinclair Inquiry (Pediatric Cardiac Surgery Inquest) was tasked with conducting an inquiry into the deaths of 12 infants in cardiac care in Winnipeg. Associate Chief Justice Murray Sinclair headed the inquiry and wrote the recommendations contained in the Pediatric Cardiac Surgery Inquest Report.
2. University of Manitoba Prof. Paul Thomas headed the Review and Implementation Committee that was appointed to respond to the recommendations of the Sinclair Inquiry.

The Role of Manitoba Health

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

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

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

It is also the role of Manitoba Health to foster innovation in the health care system. This is accomplished through developing mechanisms to assess and monitor quality of care, utilization and cost effectiveness; fostering behaviours and environments that promote health; and promoting responsiveness and flexibility of delivery systems and alternative, 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[3] 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 services and other health services referred to in acts of the Legislature or regulations thereunder. The Act was amended on January 1, 1999, to provide insurance for out-patient services in relation to insured medical services provided in surgical facilities.

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

> "(a) to provide insurance for residents of the province in respect of the costs of hospital services, medical services and other health services, and personal care;
>
> (b) to plan, organize and develop throughout the province a balanced and integrated system of hospitals, personal care homes and related health facilities and services commensurate with the needs of the residents of the province;
>
> (c) to ensure that adequate standards are maintained in hospitals, personal care homes and related health facilities, including standards respecting supervision, licensing, equipment and inspection, or to make such arrangements as the minister considers necessary to ensure that adequate standards are maintained;
>
> (d) to provide a consulting service, exclusive of individual patient care, to hospitals and personal care homes in the province or to make such arrangements as the minister considers necessary to ensure that such a consulting service is provided;
>
> (e) to require that the records of hospitals, personal care homes and related health facilities are audited annually and that the returns in respect of hospitals which are

3 Where reference is made to "the Act" in the text, this refers to *The Health Services Insurance Act* (1999).

required by the Government of Canada are submitted; and

(f) in cases where residents do not have available medical and other health services, to take such measures as are necessary to plan, organize and develop medical services and other health services commensurate with the needs of the residents."

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

There were no legislative amendments to the Act or the Regulations in the 2002-2003 fiscal year that affected the public administration of the Plan.

1.2 Reporting Relationship

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

1.3 Audit of Accounts

Section 7 of the 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 of that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2002-2003 fiscal year and is contained in the *Manitoba Health Annual Report, 2002-2003.*

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, 2003, there were 97 facilities in Manitoba 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, 2003, there were 2,095 physicians on the Manitoba Health Registry.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with 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, rendered to an insured person by a physician, that are not excluded under the Excluded Services Regulation (M.R. 46/93) of the Act. During fiscal year 2002-2003, 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 proposals are forwarded to the Manitoba College of Physicians and Surgeons for review to ensure the service is scientifically valid and not developmental or experimental. The MMA will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (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 in respect of the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist. As of March 31, 2003, 576 dentists were registered with Manitoba Health.

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, 2003.

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 2002-2003.

3.0 Universality

3.1 Eligibility

The Health Services Insurance Act defines the eligibility of Manitoba residents for coverage under the health care insurance plan of the Province. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, resides in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the Regulations, but does not include a person who holds a Minister's permit under the *Immigration Act* (Canada), unless the Minister determines otherwise, or 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 an employment authorization of 12 months or more.

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

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

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan excludes residents covered under the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Royal Canadian Mounted Police Act* or under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). The excluded are residents who are members of the Armed Forces, the Royal Canadian Mounted Police and federal inmates. These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Armed Forces; the RCMP; or an inmate of a penitentiary who has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health (Residency and Registration Regulation (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 certificate for the individual and all qualifying dependants.

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

During 2002-2003, there were 1,156,217 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, subsection 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.

In 2002-2003, 1,693 individuals with work permits were covered under the Manitoba Health Services Insurance Plan.

The definition of “resident” under *The Health Services Insurance Act* allows the Minister of Health or the Minister’s designated representative to provide coverage for holders of a Minister’s permit under the *Immigration Act* (Canada). Twenty-nine individuals were covered under Minister’s permits in 2002-2003.

No legislative amendments to the Act or the Regulations in the 2002-2003 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 other insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arrival in Manitoba is entitled to benefits upon the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation (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 upon completion of their studies.

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

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

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

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

In 2002-2003, Manitoba Health made payments totalling approximately $16,701,176 for hospital services and $7,691,159 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 upon completion of their employment terms. Clergy serving as missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba upon completion of their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba upon completion of their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (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 their specialist stating that the patient requires a specific, medically necessary service. Physician services received in the United States are paid at no less than 100 percent of the equivalent Manitoba rate for similar services. Hospital services are paid at up to 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15-23).

Manitoba Health made payments totalling approximately $2,762,161 for hospital care provided in hospitals outside Canada in the 2002-2003 fiscal year. In addition, Manitoba Health made payments totalling approximately $607,066 for medical care.

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

4.4 Prior Approval Requirement

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

No legislative amendments to the Act or the Regulations in the 2002-2003 fiscal year had an affect 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 in relation to 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.

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, outpatients and day surgeries, which are also insured services.

Manitoba continues to experience a shortage of nurses in all geographic areas, with some improvement in the past year noted, especially in larger urban centres or areas near Winnipeg. Interest in nursing education continues to be high.

Manitoba also has a wide range of other health care professionals. Shortages in some of the technology fields such as radiation therapy, ultrasound technology, Magnetic Resonance Imaging (MRI) technology and lab technology are also an issue.

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

Manitoba has 16 Computerized Tomography (CT) Scanners – three (one for paediatric patients) at the Health Sciences Centre, two at St. Boniface General Hospital, one each at Victoria General Hospital, Dauphin Regional Health Centre, Thompson General Hospital, Brandon Regional Health Centre, Boundary Trails Health Centre, Misericordia Health Centre, Seven Oaks, Grace and Concordia Hospitals, and newly installed scanners in Steinbach and Selkirk. One of the scanners at the Health Sciences was replaced and one scanner was upgraded, both by 16-slice scanners. As well, ultrasound scanners are located in Winnipeg health facilities and rural and northern regions. Bone density testing is funded by Manitoba Health on two machines located in Winnipeg and Brandon.

In March 2003, CancerCare Manitoba completed the opening of their 205,000 square foot world-class facility for treatment, education and research with an on-site laboratory for the Manitoba Institute of Cell Biology. Eight students graduated in September 2002 from the Manitoba School of Radiation Technology, which now has classroom space in the new CancerCare facility. In June 2002, funding was provided for equipment to implement 3D Conformal Radiation Therapy.

Manitoba's conversion of the Pan Am Clinic into a non-profit facility under the public umbrella is an exciting innovation that shows how Medicare can and should adapt to the rapid changes in health care today. The Pan Am Clinic is a day surgery centre in Winnipeg that has established itself as a preferred medical environment offering cutting-edge treatments and state-of-the-art technology for muscular- skeletal medicine, including primary care, orthopaedics, rheumatology and other related services. Since the acquisition in 2001, the number of monthly cases at the Pan Am Clinic has steadily increased, from 199 cases in April 2002 to 304 cases in April 2003. Expansion plans were approved for orthopaedic and plastic surgery, expanded surgical recovery room space, physiotherapy and a third operating theatre to be used for Minimally Invasive Surgery.

Manitoba Health allocated funding to a Cardiac Critical Shortages Fund to send patients, if they so choose, out of province for cardiac surgery. No patients on the cardiac surgery wait list chose the option of being sent out of province.

Manitoba Health has established a Task Force with Regional Health Authority participation to address access and waiting time issues. The work is ongoing. Targeted funding was provided to Regional Health Authorities to address

specific capacity issues including funding to increase diagnostic procedures. Manitoba is a partner in the Western Canada Waiting List project. The Winnipeg Regional Health Authority is implementing and evaluating two of the tools developed through this project: the Children's Mental Health tool and the General Surgery tool.

In January 2003 the Department of Health released a new guide to assist Manitobans in accessing and understanding their health care system. The *Infohealth Guide* is broken down into three specific sections. They are:

- **At a Glance –** a quick reference to key phone numbers and emergency information;
- **Health Services** – information on the type of health care services provided within the province's health care system; and
- **Health Care Rights** – information on the rights, responsibilities and protections available through the health care system.

5.3 Access to Insured Physician and Dental-Surgical Services

In 2002-2003, Manitoba Health continued to implement initiatives to improve access to physicians in rural and northern areas of the province. In June 2002 a medical director was appointed to the Office of Rural and Northern Health, which will be located in Dauphin. The Office will provide infrastructure support for the Rural Physician Action Plan. This plan includes the promotion of medicine as a career to rural and northern students, expansion of training opportunities in these areas for undergraduates and postgraduates and restructuring rural and northern continuing education opportunities. Further increases in enrolment in medical school and residency positions are planned for 2004.

Manitoba continues to experience small increases in the number of new physicians registering with the licensing body. To encourage retention of Manitoba graduates, the Province continued to provide a financial assistance grant 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. The program was introduced in May 2001. There are plans to expand the program to include family doctors from outside Manitoba and family doctors who have left the province and want to return. The Province continues to support the Medical Licensure Program for International Medical Graduates, which was introduced in 2001. Starting in 2002, foreign-trained physicians are able to receive financial support to assist them in completing the process that will enable them to practice medicine in Manitoba. Annual costs of the program are approximately $1 million.

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

On June 2, 2002, Manitoba Health and the Manitoba Medical Association (MMA) entered into an Interest Arbitration Agreement (the "Agreement") with respect to both fee-for-service (FFS) and alternate funded physicians represented by the MMA. The specific highlights are:

- The Agreement provides a mechanism for determination of fee increases for all fee-for-service and alternate funded physicians represented by the MMA for the period October 1, 2002 to March 31, 2005.
- Either party may require that a new arbitration process be undertaken to determine fee increases subsequent to March 31, 2005.
- The Agreement establishes a Maternity/Parental Benefits Fund of $1 million annually.
- The Agreement establishes a Physician Retention fund of $5 million annually.
- The Agreement continues a Professional Liability Insurance fund of $5 million annually.

- The Agreement continues a Continuing Medical Education Fund in the amount of $1 million annually.
- There shall be no service withdrawals by medical practitioners for the duration of the Agreement.
- The MMA will administer the Professional Liability Insurance and the continuing Medical Education reimbursement funds for both fee-for-service and alternate funded physicians.
- The Arbitration Agreement provides for a separate arbitration mechanism with a sole arbitrator for 16 issues deemed outstanding from the previous agreement. In 2002-2003, the arbitrator rendered a decision with respect to five of the outstanding issues.

Under the main arbitration process outlined in the Agreement, a three-person Board has been constituted to issue one overall award for fee-for-service physician services. Upon receipt of the fee-for-service award, all alternate funding agreements are to receive an interim award of one-half the percentage increase granted to fee-for-service. Each party is then to select two alternate funding agreements for separate arbitration. Following the determination of the separate awards, the Board is to issue an overall award for the remaining alternate funding agreements. The arbitration process for the fee-for-service envelope commenced on February 26, 2003.

Insured services provided by physicians are remunerated through a combination of fee-for-service payments, alternative service arrangements, independent contracts, etc. In 2002-2003, Manitoba had no capitation arrangements in place. However, Manitoba and the MMA agreed on a maximum global expenditure for private laboratories over the duration of the Arbitration Agreement. For 2002-2003, the maximum global expenditure for private laboratories was set at $23 million.

The Payments for Insured Medical Services Regulation made under *The Health Services Act* governs fee- for-service payments to physicians. This Regulation is usually re-promulgated for each fiscal year.

Manitoba and the Manitoba Dental Association (MDA) entered into a Memorandum of Agreement effective April 1, 1998 to March 31, 2002. The Agreement, which has since expired, provided for an overall increase in funding of 13 percent over the four years. Discussions are proceeding between Manitoba and the MDA for a new agreement.

Insured services provided by certified oral and maxillofacial surgeons or licensed dentists are compensated on a fee-for-service basis for specified oral/dental/maxillofacial surgical procedures performed in hospital facilities only.

The Hospital Services Insurance and Administration Regulation (M.R. 48/93) made under *The Health Services Insurance Act* governs payments to dentists for insured dental services. The Regulation was amended in the 2001-2002 fiscal year to reflect payments in effect as of April 1, 2001.

No amendments to *The Health Services Insurance Act* during 2002-2003 had an impact on Physician/Dentist Compensation.

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.

The Regional Health Authorities have concluded the required agreements. The operating agreements between the Winnipeg Regional Health Authority and the health corporations operating facilities in Winnipeg will expire March 31, 2006. The operating agreements

enable the Authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities.

In addition to the Winnipeg Regional Health Authority, there are two other Regional Health Authorities that continue to have hospitals operated by health corporations in their health regions. In all other regions, the hospitals are operated by the Regional Health Authorities or the federal government. The agreements in place between the Authorities and the health corporations do not have expiry dates. The Authorities are empowered to determine the funding to be provided each year.

The allocation of resources by Regional Health Authorities for the provision of hospital services is approved by Manitoba Health through the approval of the Authorities' regional health plans, which the Authorities are required to submit for approval pursuant to section 24 of *The Regional Health Authorities Act*. Section 23 of the Act requires that Authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of *The Health Services Insurance Act*, payments from the Manitoba Health Services Insurance Plan for insured hospital services are to be paid to the Regional Health Authorities. In relation to those hospitals that are not owned and operated by an Authority, the Authority is required to pay each hospital in accordance with any agreement reached between the Authority and the hospital operator.

No legislative amendments to the Act or the Regulations in 2002-2003 had an affect 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 and Social Transfer in public documents.

7.0 Extended Health Care Services

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

Personal Care Home Services

The Personal Care Services Insurance and Administration Regulation under *The Health Services Insurance Act* authorizes the provision of services to personal care home residents. Both proprietary and non-proprietary homes are licensed by Manitoba Health. Residents of personal care homes also pay a residential charge. The total Manitoba Health operating expenditures for personal care services during fiscal year 2002-2003 amounted to $377,448,184, supporting a total of 9,636 licensed set-up personal care beds. In addition, there were estimated capital and equipment expenditures of $19,510,077.

Home Care Services

Manitoba Home Care is a province-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the local offices of the Regional Health Authorities and include a broad range of services based on a multidisciplinary assessment of individual needs. Services may be coordinated by a case coordinator or self-managed and may include personal care assistance, home support, health care, family relief, respite care, supplies and equipment, adult day programs and/or volunteer services.

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.

Adult Residential Care Services

Residential care facilities are community-based facilities that provide room and board, 24-hour on-site care and supervision and assistance with activities to ensure that the needs of individual residents are met. These facilities are classified by size: approved homes have up to three adults and licensed facilities have occupancies of four or more adults. The facilities are further differentiated between for-profit and not-for-profit facilities.

Residential care facilities are required to be licensed under *The Social Services Administration Act* and Manitoba Care Facilities Licensing Regulation (484/88 R) and are required to meet standards established by the Residential Care Licensing Branch of the Department of Family Services and Housing. The Regulations mandate the licensing of facilities for three adult disability categories (mentally ill, mentally disabled and infirm aged).

There are approximately 102 licensed and approved residential care facilities for individuals with mental illness in Manitoba, for a total of 520 bed spaces. There are also 57 mixed facilities, for a total of 235 bed spaces. There are 12 licensed and approved facilities for individuals with the infirmities of aging, for a total of 164 bed spaces. The majority of residential care facilities are located in Winnipeg and Brandon.

8.0 Additional Materials Submitted to Health Canada

- Manitoba Health Annual Report, 2002-2003.
- Manitoba Health Auditor's Report, 2002-2003.
- Supplementary Information for Legislative Review, 2002-2003.
- Consolidated Legislation and Regulations.
- Infohealth Guide to Health Services in Manitoba.
- Annual Statistics, 2002-2003.
- Manitoba 2003 – What Manitoba's Budget Means to You.
- Manitoba 2003 – Budget Speech.
- Manitoba 2003 – Budget Papers.
- Manitoba 2003 – The Manitoba Advantage.
- Manitoba 2003 – Manitoba's Action Strategy for Economic Growth.

Saskatchewan

Introduction

Saskatchewan is the birthplace of Medicare. Insured hospital services were first provided in Saskatchewan in 1947. Insured physician services followed in 1962, further reinforcing the principle that health services should be provided to individuals based on their health need, not on their ability to pay.

Today, in the face of continued debate over the future direction of health care in Canada, Saskatchewan remains committed to this principle. It is recognized, however, that within the boundaries of the publicly funded health care system, there is a need for continued evolution to a more sustainable system that ensures healthier people and healthier communities.

In this context, Saskatchewan was one of the first provinces in Canada to undertake an in-depth review of health care delivery. The recommendations of the Fyke Commission on Medicare formed the basis of several months of careful study and consultation. During these consultations, the Government heard from a wide range of health community partners, as well as residents from across the province. There was a clear message: Saskatchewan people believe strongly in the continuation of a public Medicare system, but recognize the need for change to maintain a strong, responsive system into the future.

As a result of this examination, the Government released *Saskatchewan. Healthy People. A Healthy Province: The Action Plan for Saskatchewan Health Care* in December 2001. This plan provides a long-term blueprint to improve the health of Saskatchewan people, while ensuring the best value for every health dollar.

In keeping with the Action Plan's strategic focus, Saskatchewan Health released, for the first time, a public performance plan. The 2002-2003 Performance Plan, released in August 2002, sets out the Department's vision for health care renewal, focusing on increasing access to quality care and improving accountability in the health care system. The Plan also outlines four key strategic goals in support of this vision:

- provide better access to quality health care;
- increase effective health promotion and disease prevention;
- improve health workplaces and address shortages of key health providers; and
- increase emphasis on efficiency and accountability in the health care system.

Saskatchewan Health's 2002-2003 Annual Report outlines the progress that is being made in achieving these goals. The Department took steps to improve the management of surgical waiting lists to ensure fair, timely access to surgery for Saskatchewan people. The Saskatchewan Surgical Care Network (SSCN), an advisory committee to the Saskatchewan Minister of Health, was introduced in March 2002. It is dedicated to creating a better surgical care system. Since then, significant progress has been made toward the full implementation of a province-wide surgical waitlist registry. A Web site provides information to the public on waiting times for certain procedures and on how the surgical care system works.
www.sasksurgery.ca

Other initiatives such as a 24-hour telephone advice line, introduced in August 2003, further support the Department's performance plan. Such initiatives are also a significant development in the Province's detailed strategy to provide better primary health care services.

To facilitate innovation and improvements to the quality of care, Saskatchewan Health established Canada's first independent Health Quality Council in November 2002. The Council provides objective, timely, evidence-based information and advice to government, regional health authorities, providers, professional and regulatory bodies and others for achieving the best possible health care within available resources. The council reviews care standards, the use of health-care technologies and prescription drugs, and strategies to improve health system quality and safety.

Saskatchewan Health's goal to increase the effectiveness of health promotion and disease

prevention resulted in the development of a strategy for summer 2003 to reduce the risk of West Nile Virus. Key actions included enhanced surveillance efforts including the hiring of a West Nile Virus coordinator and a public education campaign emphasizing personal protection measures to reduce the risk.

During 2002-2003, the Department built a strong foundation for moving forward with its Action Plan. Saskatchewan Health redesigned the system of health care governance by creating 12 new regional health authorities to replace the 32 former health districts. *The Regional Health Services Act* was proclaimed on August 1, 2002 with the new regional authority names taking effect on November 1, 2002. In spring 2003 each regional health authority received its first accountability document along with the 2003-2004 budget plan that set out clear targets and expectations for health services.

The new regional health authorities are working closely with the Department to ensure a coordinated, effective and accountable health system that offers a consistent quality and level of service across the province. Specifically, regional health authorities are now taking a lead role in assessing local health needs as well as planning and delivering health services to meet those needs.

Regional health authorities are key partners in the health system and provide a wide range of hospital, physician, public health, mental health, rehabilitation and addictions services. Other partners in the system include affiliated agencies, fee-for-service physicians, pharmacists and other health care providers. The provincial government is the major funder of Saskatchewan's health care system, providing approximately $2.3 billion in 2002-2003.

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 that 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 the provision and operation of 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 as the Minister considers necessary; and
- make grants or provide subsidies for the purpose of stimulating and developing public health research and the conducting of surveys and studies in the field of public health.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* provide authority for the Minister of Health to establish and administer a plan of medical care insurance for residents.

The Regional Health Services Act provides authority for the establishment of 12 regional health authorities, replacing the former 32 district health boards.

Sections 5 and 11 of *The Cancer Foundation Act* (1997) provide for the establishment of a Saskatchewan Cancer Agency and for it to coordinate a program for the diagnosis, prevention and treatment of cancer.

The mandates of the Department of Health, regional health authorities and the Saskatchewan Cancer Agency for 2002-2003 are outlined in *The Department of Health Act, The Regional Health Services Act* and *The Cancer Foundation Act*, as described above.

1.2 Reporting Relationship

The Department of Health is directly accountable to and regularly reports to the Minister of Health on the funding and

administration of funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual report of the medical care insurance plan to the Legislative Assembly.

The Regional Health Services Act prescribes that a regional health authority shall, within three months after the end of each fiscal year, submit to the Minister of Health:

- a report of 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. The Provincial Auditor may also conduct audits of regional health authority boards. The Provincial Auditor independently determines the scope and frequency of its audits based on accepted professional standards.

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.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The Regional Health Services Act was proclaimed 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* provides authority so that the Minister may 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 prescribes standards for the delivery of services in those facilities by regional health authorities and health care organizations, which have entered into service agreements with a regional health authority.

The Act sets out new accountability requirements for regional health authorities and health care organizations. These requirements include submission of annual operational and financial and health service plans for Ministerial approval (sections 50-51), establishment of community advisory networks (section 28) and the reporting of 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 bylaws (sections 42-44).

Funding for hospitals is included in the funding provided to regional health authorities.

As of March 31, 2003, 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.

The Hospital Standards Act and The Hospital Standards Regulations, 1980, established minimum standards for care and certain administrative requirements for hospitals.

With the passage of *The Regional Health Services Act*, Saskatchewan plans to incorporate those provisions relating to hospital organization and program standards under the new Act, thereby allowing for the repeal of *The Hospital Standards Act* and The Hospital Standards Regulations, 1980.

A comprehensive range of insured services is provided by hospitals, which may include:

- public ward accommodation;
- necessary nursing services;
- the use of operating room and case room facilities;
- required medical and surgical materials and appliances;
- x-ray, laboratory, radiological and other diagnostic procedures;
- radiotherapy facilities;
- anaesthetic agents and the use of anaesthesia equipment;
- physiotherapeutic procedures;
- all drugs, biological and related preparations administered in hospital; and
- services rendered by individuals who receive remuneration from the hospital.

The Action Plan for Saskatchewan Health Care establishes new hospital categories and outlines a standard array of services that should be available in each hospital. Hospitals will be 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, predicable 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 are always there when needed.

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, considering 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. Depending upon the specific service request, consultations could involve 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 2002, 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 and changes in payment levels for selected services.

Physicians may provide insured services in Saskatchewan if they are licensed by the College of Physicians and Surgeons of Saskatchewan and have agreed to accept payment from the Department of Health without extra billing for insured services.

As of March 31, 2003, there were 1,636 physicians licensed to practise in the province and eligible to participate in the medical care insurance plan. This increase over previous years is partly the result of including locum registrations previously excluded from the active physician counts.

Physicians 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 reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2003, 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 3,000 different insured physician services as of March 31, 2003.

Insured physician services are added to the Medical Services Plan through a process of formal discussion with the Saskatchewan Medical Association. The Executive Director of the Medical Services Branch manages the process of adding a new service. When a new insured physician service is covered by the Medical Services Plan, a regulatory amendment is made to the Physician Payment Schedule. A number of new services were added in April 2002.

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, 2003, 94 dental specialists were providing such services.

Amendments were made in January 2003, to The Saskatchewan Medical Insurance Branch Payment Schedule for Insured Services Provided by a Dentist. Those amendments provided for the addition of new insured services and 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, 2003.

Insured surgical-dental services are those that are medically necessary and must be carried out in a hospital. Such services include:

- oral surgery required in hospital as a result of trauma;
- treatment for infants with cleft palate;
- hospital-based dental care to support medical/surgical care (e.g., extractions when medically necessary); and
- surgical treatment for temporomandibular joint dysfunction.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with 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 and non-emergency diagnostic imaging services provided outside Saskatchewan without prior written approval;
- non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written approval;
- non-medically required elective physician services;
- surgical-dental services that are not medically necessary or are not required to be performed in a hospital; and
- services covered by the Saskatchewan Workers' Compensation Board.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with 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 determined 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 determined not medically necessary or not required to be carried out in a hospital. The process is based on discussion and consultation with the dental surgeons of the province and managed by the Executive Director of the Medical Services Branch.

Insured physician services could be de-insured if determined not medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

No health services were de-insured in 2002-2003.

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 all residents to register for provincial health coverage. There were no changes to this legislation during 2002-2003.

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 of establishing 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; federal inmates; refugee claimants; and Kosovar refugees who are covered under the Interim Federal Health Program;
- visitors to the province; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the Royal Canadian Mounted Police, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (includes those prisoners who have completed their sentences in the federal penitentiary and those prisoners who have been granted parole and are living in the community);
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required); and
- Kosovar refugees, on expiration of their coverage under the Interim Federal Health Program (immigration documentation is required).

3.2 Registration Requirements

The following 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 December 2005.)

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, 2002, was 1,024,827.

3.3 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of either 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 either an employment/student permit, Minister's permit or permanent resident, i.e., landed immigrant record.

As of June 30, 2002, there were 3,906 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 this legislation in 2002-2003.

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: up to 12 months (no documentation required); and
- vacation and travel: up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority for payment of in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province.

Section 10 of The Saskatchewan Medical Care Insurance Payment Regulations, 1994 provides for the payment of physician services to Saskatchewan beneficiaries temporarily residing outside the province.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services and all but Quebec for physician services. Rates paid are at the host province rates.

The reciprocal arrangement for physician services applies to every province except Quebec. Physician bills are submitted and Saskatchewan Health pays for insured services provided in Quebec at Saskatchewan rates. However, the physician fees will be paid at Quebec rates with prior approval.

Payments/reimbursement to Quebec physicians, for services to Saskatchewan residents, are made at Saskatchewan rates (Saskatchewan Physician Payment Schedule).

In 2002-2003, expenditures for insured physician services in other provinces were $16.95 million. Insured hospital services in other provinces were $30.59 million.

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* describes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on expiration of the approved period as follows:

- students: for the duration of studies at a recognized educational facility (written confirmation by a Registrar of full-time student status is required annually);
- employment of up to 24 months (written confirmation from the employer is required); and
- vacation and travel of up to 12 months.

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

In 2002-2003, $1,891,800 was paid for in-patient hospital services and $359,400 was spent on out- patient hospital services outside Canada. In 2002-2003, expenditures for insured physician services outside Canada were $1,129,300.

4.4 Prior Approval Requirement

Out-of-Province

Saskatchewan Health covers most hospital and medical care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health and problem gambling services; and
- cataract surgery services, bone densitometry (outside of hospitals), and non-urgent Magnetic Resonance Imaging (MRI), because Saskatchewan Health does not normally cover these services out-of-province.

Before the Department of Health funds non-urgent services for a Saskatchewan resident in another province or territory, prior approval from the Department must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of Saskatchewan Health. Requests for out-of-country cancer treatment must be approved by the Saskatchewan Cancer Agency. If approved, Saskatchewan Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.
- Saskatchewan Health does not normally cover elective (non-emergency) hospital, physician, optometric and chiropractic services; therefore, prior approval is required.

5.0 Accessibility

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services is not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in the provision of public services, which include insured health services, on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

5.2 Access to Insured Hospital Services

As of March 31, 2003, Saskatchewan had 3,129 staffed hospital beds in 66 acute care hospitals, including 2,544 acute care beds, 241 psychiatric beds and 344 other beds.

The Wascana Rehabilitation Centre had 43 rehabilitation beds and 205 extended care beds. Rehabilitation services are also provided in a Geriatric Rehabilitation Unit in one acute care hospital and in two special care facilities.

The Department does not collect information on acute care beds used for out-patient services.

Keeping and attracting key health providers such as nurses continues to be a top priority for Saskatchewan Health. Tracking the actual number of people who work within the health professions can be difficult, as people move and change jobs, hours of work or even careers.

One way to measure our health workforce is to count how many providers are registered in the province. The professional regulatory bodies in Saskatchewan do this every year. Much of this information is reported to the Canadian Institute for Health Information (CIHI), allowing comparisons with other provinces.

According to the three professional regulatory bodies for nursing in Saskatchewan, in 2002 there were 11,940 nurses in Saskatchewan, an overall increase from the 11,914 nurses

reported in 2001. The number of nurses and ratio of nurses to the provincial population has stabilized over the past five years. This is a positive trend. Other trends such as the aging of the nursing workforce indicate we need to continue efforts at retaining and recruiting nurses.

There are signs of progress that show nursing graduates are more enthusiastic about remaining in Saskatchewan. Over the past couple of years, our province has retained about 80 percent of graduates from our nursing education program.

The number of Registered Nurses (RN) per capita in Saskatchewan in 2002 (81.8 per 10,000 population) is higher than the Canadian average (73.4 per 10,000 population). This also represents a slight decrease from 1998 for Saskatchewan (82.4). There is also considerable variation in RN per population ratios across Canada, from a low of 65 per 10,000 in Ontario to a high of 117.6 in the NWT.

Listed below are some of the 2002-2003 initiatives implemented to improve the retention and recruitment of nurses.

- A nursing bursary program of $500,000 was provided to students training to be future Registered Nurses, Licensed Practical Nurses and Registered Psychiatric Nurses. The province introduced Primary Care Nurse Practitioner bursaries for individuals studying to become nurse practitioners in Saskatchewan.
- A northern nursing program for Aboriginal students delivered through the First Nations University of Canada was introduced and adds 40 training sets to the existing Nursing Education Program of Saskatchewan (NEPS).
- Access to NEPS has been enhanced through distance delivery with the entire first year of the program available by distance learning. The development of a Bachelor of Science in Nursing second-degree program is being explored.
- Over the past three years a total of $860,000 has been provided for projects related to quality workplaces, nursing workforce casualization and the retention of nursing graduates. The Quality Workplace Program pilot projects were evaluated and new sites in other locations in the province were added to the program.
- Saskatchewan Health funded a project to develop senior nurses who mentor nursing students receiving clinical experience. This involves a workshop for senior nurses, workload relief for the nurses while they are working with students and an appropriate recognition program.
- Saskatchewan Health provided funding to explore the challenges and opportunities for practical nurses to achieve job satisfaction and career advancement through career laddering.
- The Province hosted a daylong Saskatchewan Communication Network (SCN) workshop entitled “Creating High Quality Health Care Workplaces”. More than 600 people participated at 30 sites across the province.
- The Province provided $1.25 million for a co-ordinated approach to continuing education and development for health providers with the focus on clinical education, specialized training and leadership development.
- Saskatchewan Health’s “I Choose Saskatchewan” recruitment campaign appeared in a number of publications during the fiscal year.
- Regional health authorities implemented a number of retention and recruitment strategies for nurses.
- Provincial health human resource planning guidelines were developed and serve as a foundation for building future strategies and initiatives. Human resource performance expectations and indicators were developed and will form the basis of accountability frameworks between major third parties and the Province.
- Saskatchewan Health worked with Saskatchewan Government Relations and Aboriginal Affairs and a variety of nursing partners to expand the Saskatchewan Immigrant Nominee Program to include the nursing professions.
- A number of initiatives to support Aboriginal students in the health disciplines, including the Northern Access to Nursing Program and the nursing career pathways initiative continued.

Aside from nurses and physicians, there is a wide range of other health care professionals

who are also vital to the provision of quality care. Registration data for these professionals – including technologists, therapists and pharmacists – indicates the number of these professionals working in Saskatchewan has for the most part increased over the past decade.

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

- Magnetic Resonance Imaging (MRI) machines are located in Saskatoon (2) and Regina (1).
- Computed Tomography (CT) scanners are available in Saskatoon (3), Regina (3), Prince Albert (1) and Swift Current/Moose Jaw (1).
- Renal dialysis is provided at Saskatoon, Regina, Lloydminster, Prince Albert, Tisdale, Yorkton and Swift Current.
- Cancer treatment 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 2002-2003, approximately 4,300 new patients began treatment for cancer and about 50,000 cancer treatments were provided to both new and review patients.
- Twenty-one sites are involved in the Community Oncology Program that allows patients to receive chemotherapy and other supports closer to home, while maintaining a close link to expertise at the Cancer Centres in Regina and Saskatoon.
- Approximately 71 percent of surgery services are provided in Saskatoon and Regina, where there are specialized physicians and staff and the equipment to perform a full range of surgical services. An additional 23 percent 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 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 2002-2003 to improve access to insured hospital services.

- Access and use of specialized medical imaging services, including MRI, CT and bone mineral density testing has grown steadily in Saskatchewan during 2002-2003. In that year, approximately 13,000 MRI tests and approximately 72,000 CT tests were performed.
- Access to renal dialysis services continues to improve, with an anticipated opening in fall 2003 of the dialysis satellite at the Battlefords Union Hospital.
- On June 30, 2000, the 12-month Northern Telehealth Network (NTN) pilot project was completed. The NTN is a partnership between Saskatchewan Health and six health districts. An external evaluation concluded that the network improved access to services for patients and clients, particularly for child psychiatry and dermatology patients. The number of specialist clinics held in the North has remained stable, which means that the NTN has increased access to specialists without increasing their travel.
- The NTN has proven an effective tool for clinical consultation and continuing education in northern Saskatchewan. Saskatchewan Health continues to support the network and was successful in securing funding (approximately $1 million) from Health Canada under the Canadian Health Infostructure Partnership Program (CHIPP) for further development of the Telehealth program in the province. As of March 31, 2003, the telehealth network has been established at 12 sites in 10 communities.
- The Chronic Renal Insufficiency Clinics that were established in the Regina 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 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 has the highest

participation rate in Canada with 36,000 to 40,000 women served annually.

- The Cancer Agency is in the process of developing and implementing the cervical screening program. This program will consist of the following components:
  - a comprehensive information system;
  - recruitment and recall strategies;
  - results notification;
  - quality patient/client management; and,
  - quality assurance processes.

  While some components of the program are expected to be complete in 2003, the program is expected to be fully operational in 2004.

- The Provincial Stem Cell Transplant Program continues to grow. In 2001-2002, the Program was expanded to include allogenic transplantation (i.e., infusion of tissue-compatible stem cells from a related donor). The provision of this specialized service ensures that more cancer patients can be effectively treated closer to home, reducing the financial and emotional burden of travelling long distances to receive treatment.
- Saskatchewan Health continues to dedicate considerable time and resources to addressing waitlist issues.
- Saskatchewan Health continues to participate in the Western Canada Waiting List (WCWL) Project along with 19 partner organizations from the four western provinces. The Project works closely with physicians, the public, regional health authorities and governments to develop and test clinical assessment tools. These tools will help physicians to consistently prioritize patients waiting for total hip or knee replacement, cataract surgery, general surgery, children's mental health services and diagnostic MRI scans. Each tool has undergone pilot testing in a regional health authority in Western Canada, the primary purpose being to gain a better understanding of the validity and the potential for implementation of each tool.
- The importance and potential of the five assessment tools that have been developed through the WCWL partnership has been widely recognized. Their use by clinicians, health authorities and ministries is being actively considered in all western Canadian jurisdictions.
- Preliminary findings and recommendations from the report "Surgical Wait List Management; A Strategy for Saskatchewan" formed the basis of the waitlist strategy outlined in the Government's Health Action Plan released in December, 2001.
- The goal of the wait-list strategy outlined in the new Action Plan is to ensure that patients who are waiting for surgery in Saskatchewan receive the care they need within clinically appropriate time frames and in a fair and equitable manner.
- The Saskatchewan Surgical Care Network (SSCN), established in March 2002 to ensure that a variety of perspectives are applied to the important tasks of assessing and determining how to address surgical access issues across the province, has been actively overseeing the development of several surgical care system initiatives.
- In January 2003, the Saskatchewan surgical Web site was launched (**www.sasksurgery.ca**) and allows patients to obtain information on how long they may expect to wait for their particular procedure. Also announced were surgical care coordinators for Regina/Qu'Appelle and Saskatoon regional health authorities. A surgical care coordinator provides a means of communication between the region, patients and their referring physician. Other health regions have identified key surgical contacts for their communities.
- In 2002-2003, work proceeded toward the development of a province-wide surgical patient registry information system. A pilot of this registry was initiated in January 2003 in Five Hills Health Region. By fall 2003, this registry will track all patients needing surgery in the province and will produce reports with accurate data that will be used by physicians, health regions and Saskatchewan Health for decision making.
- A new Patient Assessment Process is being finalized and will be implemented province-wide to improve consistency and fairness for all surgical patients in Saskatchewan.
- In 2002-2003, the provincial government continued to provide funds to the Province's four largest health regions from the $13 million surgical wait-list fund that was initiated in August 1999, to address waitlist

issues and reduce waiting times for insured services. These funds are used to: purchase additional capital equipment; increase available operating room time; fund staff recruitment, retention and training initiatives; and implement coordination and utilization management initiatives.

5.3 Access to Insured Physician and Dental-Surgical Services

As of March 31, 2003, there were 1,636 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 936 (57.2 percent) were family practitioners and 700 (42.8 percent) were specialists. This shift to more specialists in the last two years is the result of provincial review and certification of foreign trained specialists and their inclusion in the category previously occupied by only Canadian certified specialists.

As of March 31, 2003, there were approximately 346 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety-four provided services insured under the Medical Services Plan.

A number of new or continuing initiatives were underway in 2002-2003 to enhance access to insured physician services and reduce waiting times.

- A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.
- Effective July 1, 2001, a specialist emergency room coverage program was established to compensate specialist physicians who made themselves available to provide emergency coverage to acute care facilities.
- A Re-entry Training Program provides two grants annually to rural family physicians wishing to enter specialty training, and requires a return service commitment.
- New Specialist Recruitment and Retention Funding provides funding for new initiatives in addition to the existing funding of the Regina and Saskatoon regional health authorities.
- A Physician Recruitment Coordinator is assisting rural regions and physicians in recruiting physicians.
- Rural physicians are supported through an integrated Emergency Room Coverage and Weekend Relief Program that compensates physicians providing emergency room coverage in rural areas, and assists those communities with fewer than three physicians to gain access to other physicians to provide weekend relief.
- The Rural Practice Establishment Grant Program makes grants of $18,000 to Canadian-trained or landed immigrant physicians who establish new practices in rural Saskatchewan for a minimum of 18 months.
- The Medical Resident Bursary Program provides bursaries of $18,000 to three family medicine residents to assist them with medical educational expenses in return for a rural service commitment.
- The Undergraduate Medical Student Bursary Program provides an annual grant of $25,000 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 Continuing Medical Education Program provides funds to rural physicians for certification and re-certification of skills in emergency care and risk management. Approved physicians are required to provide service in rural Saskatchewan after completing an educational program.
- The Resident Weekend Relief Program matches second-year family medicine residents with physicians in larger rural communities who are seeking weekend relief.
- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.
- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based

services through the Alternate Payments and Primary Health Services Program.

- The Northern Medical Services Program is a tripartite endeavour of Saskatchewan Health, Health Canada and the University of Saskatchewan to assist in stabilizing the supply of physicians in northern Saskatchewan.
- The Rural Extended Leave Program supports physicians in rural practice who want to upgrade their skills and knowledge in areas such as anaesthesia, obstetrics and surgery by reimbursing educational costs and foregone practice income for up to six weeks.
- The Rural Travel Assistance Program provides travel assistance to rural physicians participating in educational activities.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

5.4 Physician Compensation

The process for negotiating compensation agreements for insured services with physicians and dentists is prescribed by 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 commence discussion on a new agreement;
- each party shall appoint no more than six representatives to the Committee;
- the objective of the Committee is to prepare an agreement respecting insured services that is satisfactory to both parties;
- in the case that a satisfactory agreement cannot be reached, the matter may be referred to the Medical Compensation Review Board, consisting of an appointee by either party who in turn select a third member; and
- the Board has the authority to make a decision binding on the parties.

In December, 2000, a new three-year agreement (retroactive to April 1, 2000) was successfully negotiated with the Saskatchewan Medical Association. It provides an increase in the Physician Payment Schedule of three percent in each year of the contract. Similar increases were applied to non fee-for-service physicians. Increased funding was also provided for new items and modernization of the payment schedule.

Section 6 of The Saskatchewan Medical Care Insurance Payment Regulations (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.

5.5 Payments to Hospitals

In 2002-2003 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 the provision of specialized hospital programs (e.g., renal dialysis, specialized medical imaging services, specialized respiratory services), or for the provision of 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 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 the provision of services in any area of Saskatchewan if it is in the public interest to do so.

Designated funds to address surgical waitlist issues were provided to the four largest health regions in 2002-2003. Each region was asked to outline a maximum expenditure on capital equipment and a plan for allocating equipment,

with the remainder of the allocated funds to be spent on operational initiatives to increase surgical capacity and throughput. Regions were required to report all expenditures and changes in service volumes resulting from the additional funding.

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 and Social Transfer in the Department of Health 2002-03 Annual Report, the 2002-2003 Annual Budget and related budget documents, its 2002-2003 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 Web-site, news releases, issue papers, in speeches and remarks made at various conferences, meetings and public policy forums. Federal assistance was also recognized in The Action Plan progress reports released in both the spring and fall of 2002.

7.0 Extended Health Care Services

As of March 31, 2003, 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 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 for immunization of 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 a recently announced option of the Home Care Program. This option provides funding directly to people so they can arrange and manage their own supportive services. The Home Care Program is 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. Mental health services are governed by *The Mental Health Services Act.*
- Regional health authorities offer podiatry services. Services include 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 include hearing testing, assessments for at-risk infants, and the selling, fitting and maintenance of hearing aids. *The Hearing Aid Act* and Regulations and *The Regional Health Services Act* govern these programs.
- Rehabilitation therapies, including occupational and physical therapies and speech and language pathology, are offered by the regional health authorities and help individuals of all ages to improve their functional independence. 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 provide a continuum of support and living assistance to individuals with long-term mental illnesses. These programs are governed by *The Residential Services Act.*
- 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 is currently governed by *The Non-profit Corporations Act* (1995) and *The Co-operatives Act* (1996).

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. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure of detoxification services.
- 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. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure for in-patient services.
- 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. The Adult and Youth Group Homes Regulations of *The Housing and Special-care Homes Act* govern licensure for long-term residential services.

8.0 Additional Materials Submitted to Health Canada

- *Saskatchewan Health Annual Report, 2002-2003* (which includes the 2003-04 Performance Plan).
- *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care*.
- *It's For Your Benefit: A Guide to Health Coverage in Saskatchewan.*

Alberta

Introduction

Alberta's commitment to public health care: understanding your public health care insurance plan

Alberta has a commitment to building a better publicly-funded health care system for Albertans. The province provides medically necessary services in a public system that follows the principles of the *Canada Health Act:* publicly administered, comprehensiveness, universality, portability and accessibility. Medically necessary services are hospital, physician and specific services provided by oral surgeons and other dental professionals.

Alberta also provides full and partial coverage for health care services not required by the *Canada Health Act,* including:

- home care and long-term care;
- mental health services;
- dental and eyeglass benefits for recipients of the Alberta Widow's Pension and their eligible dependents;
- palliative care;
- immunization programs for children;
- allied health services such as optometry (for residents under 19 and over 64 years) and chiropractic and podiatry services; and
- drug benefits through Alberta Blue Cross.

Alberta Health and Wellness Vision:

"Citizens of a healthy Alberta achieve optimal health and wellness."

The slogan "Healthy Albertans in a healthy Alberta" reflects this vision.

The Government of Alberta wants Albertans to:

- realize their full health potential in a safe environment with appropriate income, housing, nutrition and education; and
- play a valued role in family, work and their community.

Alberta Health and Wellness contributes to that effort by ensuring Albertans have equitable access to affordable, effective and appropriate health and wellness services, when they need them.

The vision also requires individuals to take responsibility for their own health.

Alberta Health and Wellness Mission

"To maintain and improve the health of Albertans by leading and working collaboratively with citizens and stakeholders."

Two core business lines support this mission:

1. Deliver quality health services to Albertans.
2. Encourage and support Albertans to lead healthy lives.

Progress on health reform in 2002-2003

Alberta waitlist registry

Pilot testing of the Alberta waitlist registry has begun. By fall 2003, the registry will put waitlists for selected procedures on the Internet to help Albertans and their physicians plan where they can go for surgical and diagnostic procedures.

Pharmaceutical Information Network

Two Pharmaceutical Information Network pilot projects were successfully conducted in Westlock and Leduc. The projects demonstrated that use of electronic medication information results in more effective decisions about drug prescriptions for patients.

Provincial Personal Health Identifier

The Provincial Personal Health Identifier (PPHI) identifies each person who receives health services in Alberta. The identifier is unique to each person and remains the same over the person's lifetime. The PPHI can be used to collect demographic information and is a key foundation in the development of Alberta's electronic health record system.

Rural health strategy

An MLA appointed committee has been reviewing standards for assessing emergency and acute care services, primary health care services, health workforce needs and the use of technology in rural communities.

Collaboration and innovation

The Alberta government accepted 49 of the 50 recommendations of the Committee on Innovation and Collaboration report to make Alberta's regional health authorities more collaborative, innovative and accountable. New multi-year performance agreements will be established that will require regional health authorities to improve collaboration and innovation, develop new models of care, create centres of specialization and contract with a blend of providers to offer a range of services.

Accessible, quality care

The Ministry and its partners explored ways to make the best use of health care professionals and improve access to health care:

- a comprehensive workforce plan is being developed to attract and retain health professionals;
- a $8.25 million allocation to new alternative funding plans will allow more than 190 academic physicians to spend more time teaching students, conducting research and caring for patients; and
- more than 75 foreign-trained health professionals have been given permanent resident status through the Provincial Nominee Program, a program that expedites the immigration process for foreign professionals.

Protection, promotion and prevention

Actions to help Albertans live healthy lives and avoid injury and disease were a critical focus this year.

Healthy U campaign

A public information and education campaign was launched to encourage Albertans to lead healthier lifestyles. The Healthy U campaign included television and radio advertisements, a newspaper supplement, and a website that directs visitors to reliable health information.

Ten-year health targets and strategies

Targets to lower the rate of chronic disease such as heart disease, cancer, and chronic obstructive pulmonary disease, have been established. Strategies to reach the targets by 2012 have been identified.

Alberta diabetes strategy

A new strategy was developed to provide financial assistance for low-income Albertans, improve screening for diabetes and address complications for Aboriginal people living off reserve. This plan also proposes prevention initiatives and new approaches for the care and management of diabetes.

Two new vaccines

Two new vaccines were added to Alberta's routine immunization program for children, starting at age two months. These vaccines protect children from meningitis, serious blood infections and pneumonia at a cost of $20 million annually.

Tobacco reduction strategy

The Alberta Alcohol and Drug Abuse Commission (AADAC) launched an information campaign to reduce tobacco use in Alberta. The To Tell the Truth campaign included television, radio advertisements and a magazine that carried facts about the dangers of tobacco. A toll-free Smoker's Help Line was established to help Albertans quit smoking.

The *Prevention of Youth Tobacco Use Act* was proclaimed to make it illegal for anyone under the age of 18 to use or possess tobacco in a public place.

Accountability to Albertans

The Canadian Institute for Health Information confirmed that Albertans receive high quality care in its Health Care in Canada 2002 report. Alberta performed better than the Canadian average in several areas, including per-person health spending, joint replacement surgery and heart attack survival rates.

Alberta's Report on Comparable Health Indicators finds Albertans experience lower rates of in-hospital mortality rates for heart attacks and strokes, lower potential years of life lost for lung cancer, colorectal cancer, heart attack and stroke, and lower hospital re-admission rates for heart attacks.

The Annual Health Survey asks Albertans to rate how well their health care system is performing each year. Copies of the annual survey and other publications on health care system measures can be accessed at:
www.health.gov.ab.ca/reading/publications.html

Health Services Utilization and Outcomes Commission

A survey conducted by the Health Services Utilization and Outcomes Commission found the majority of Albertans give good marks to the quality of their health care system. Albertans also said improvement needs to be made in emergency services, getting access to specialists, receiving satisfaction in how complaints are addressed and managing patient safety issues.

The commission is studying practice patterns of family physicians and the use of drugs in the health care system.

1.0 Public Administration

What is the Alberta Health Care Insurance Plan?

Since 1969, the Alberta Health Care Insurance Plan, as defined by the *Alberta Health Care Insurance Act,* has provided Albertans with medically necessary hospital services, and medically necessary services provided by physicians, oral surgeons and other dental professionals.

Alberta's health legislation and regulations can be accessed at the following internet address:
www.health.gov.ab.ca/system/minister/legislation.html

Who administers and reports on the plan?

The Alberta Health Care Insurance Plan is operated through the Department of Health and Wellness. The plan is operated on a non-profit basis and is administered by the Minister of Health and Wellness.

Each September, the department issues an annual report that documents the ministry's activities and consolidated financial statements for the previous fiscal year. The annual report provides information about the actions, key achievements and results for all key performance measures included in the 2002-2003 Business Plan.

The Alberta Health and Wellness annual report can be accessed at:
www.health.gov.ab.ca/public/document/AR02_03/

The department also issues an annual statistical supplement report on data related to the Alberta Health Care Insurance Plan. The Statistical Supplement report can be accessed at:
www.health.gov.ab.ca/reading/publications.html#4

Who ensures that reports are accurate?

The Auditor General of Alberta audits the records and financial statements of the Ministry of Health and Wellness. In addition, each health authority must provide its own audited financial statements to be included in the Ministry's annual report.

How much is spent on the plan each year?

In 2002-2003, the Alberta Health Care Insurance Plan issued a total of $1,225,626,637 in fee-for-service payments to Alberta physicians and a total of $61,714,534[1] to Alberta allied health practitioners (dental surgeons, dentists, chiropractors, optometrists, podiatrists) for basic health services.

1 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

2.0 Comprehensiveness

What Alberta legislation covers hospital services in the province?

The *Hospitals Act*, the Hospitalization Benefits Regulation (AR244/90), the *Health Care Protection Act* and Health Care Protection Regulation define how insured services are provided by hospitals or designated surgical facilities in Alberta.

Alberta Health Care Insurance Plan Statistics

Physicians, Practitioners and Residents

In the 2002-2003 fiscal year, there were 5,206 physicians and 1,777 allied health practitioners who were registered with and received payment from the Alberta Health Care Insurance Plan. There were 3,124,487 residents registered with the Alberta Health Care Insurance Plan.[2]

Facilities

There are 214 health care facilities in Alberta, excluding psychiatric hospitals and nursing homes:

There are 100 **Acute Care Facilities** that offer health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation

There are 110 **Continuing Care Centres** that offer health services to residents who require treatment for long-term or chronic illnesses, diseases or infirmities.

Rehabilitative Facilities offer health care services for persons requiring professional assistance to restore physical skills and functionality following an illness or injury. These services are offered at the Glenrose Rehabilitative Centre.

Community Care Facilities There are three community care facilites in Alberta: La Crete Health Centre; Paddle Prairie Community Health Centre; and Rainbow Lake Community Health Centre

There are two other types of "non-hospital" facilities:

- **Non-hospital surgical facilities** Facilities that offer health care services involving medical operative procedures that do not require an overnight stay in the facility for post-operative recovery or observation – including private cataract, abortion, dental and ophthalmology clinics. According to the College of Physicians and Surgeons of Alberta, there are currently 53 non-hospital day surgical facilities accredited under the college bylaws.
- **Non-hospital diagnostic facilities** Non-hospital diagnostic facilities offer health care services for procedures that do not require an overnight stay and detect and determine various diseases or health conditions. A total of 157 non-hospital diagnostic facilities received fee-for-service payments from the Alberta Health Care Insurance Plan in 2002-2003.

What Alberta legislation covers these types of facilities?

The *Health Care Protection Act* defines rules for the operation of surgical facilities and protection of the publicly funded and administered health care system. Under section 7 of this Act, surgical facilities are allowed to provide insured surgical services when they are accredited, have an agreement with a health authority and the facility is designated by the Minister.

Under section 11, the Minister may designate a surgical facility to provide specified insured surgical services where the Minister has approved a proposed agreement with a health authority, and the Minister is satisfied that the surgical facility either is, or will be, accredited to provide those surgical services.

Section 8(3) states that the Minister "shall not approve an agreement" unless:

- the insured surgical services are consistent with the principles of the *Canada Health Act*;
- there is a current and will likely be a future need for surgical services in the geographical area to be served;

2 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

- the proposed surgical services will not have a negative impact on the province's public health system;
- it is expected the public will benefit from the insured surgical services being provided;
- the 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 conflict of interest and ethical requirements within the *Medical Profession Act* and bylaws.

How are Albertans protected by the *Health Care Protection Act*?

Under this Act:

- operation of private hospitals is prohibited (section 1);
- operation of non-hospital surgical facilities is prohibited unless they are approved (section 2);
- "queue jumping" is prohibited (section 3);
- non-hospital surgical facilities cannot charge facility fees to patients who receive insured surgical services (facility fees are payable by health authorities) (section 4);
- no person can charge or collect payment for enhanced medical goods or services above the actual cost to provide them (section 5); and
- no person can charge or collect payment for enhanced medical goods or services unless the nature of the goods or services offered and the charges for them are fully explained.

How is a hospital approved in Alberta?

Acute care hospitals and auxiliary hospitals must receive department and ministerial approval. A new hospital must undergo a regional needs assessment, have a program and service plan developed and conduct a hospital functional programming study.

How is a hospital service insured in Alberta?

Section 25(1)(h) of the *Health Care Protection Act* gives Cabinet the authority to determine whether a particular good or service is a standard or an enhanced good or service. The Health Care Protection Regulation defines major surgical services, minor surgical procedures, and standard and enhanced medical goods and services. An amendment to the regulation must be made to add or remove an insured service.

What Alberta legislation covers physician services?

Insured physician services are paid for 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 physician services under the Alberta Health Care Insurance Plan.

Before being registered with the department, a practitioner must complete the appropriate registration forms and include a copy of his/her licence issued by the appropriate governing body or association, such as the College of Physicians and Surgeons of Alberta or the Alberta Dental Association and College.

As of March 31, 2003, there were 5,206 physicians in Alberta who were registered with and received payment from the Alberta Health Care Insurance Plan of which 2,841 were general practitioners and 2,365 were specialists.[3]

Can physicians opt out of the plan?

Yes, 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, 2003, there were no opted-out medical practitioners in the province.

3 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

Are surgical-dental services insured?

The province insures a number of medically necessary oral surgical procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits. A dentist or dental surgeon may perform a small number of these procedures, but the majority of the procedures can be billed to the Alberta Health Care Insurance Plan only when performed by an oral and maxillofacial surgeon.

Total payments to oral surgeons and dentists for insured surgical-dental services in 2002-2003 were $2,394,458.[4]

There were 234 oral surgeons and dentists registered with the Alberta Health Care Insurance Plan who billed the plan for insured dental services as of March 31, 2003.[5]

Can dentists and oral surgeons opt out of the plan?

Under section 7 of the *Alberta Health Care Insurance Act,* dentists and oral surgeons may opt out of the Alberta Health Care Insurance Plan. As of March 31, 2003, there were no opted-out dentists or oral surgeons in Alberta.

What medical benefits are insured?

The Medical Benefits Regulation defines which medical services are insured. These services are documented in the Schedule of Medical Benefits, which is prepared and published by the department and approved by the Minister.

A complete list of medical benefits can be accessed at:
www.health.gov.ab.ca/professionals/somb.htm

How are changes to the list made?

Insured physician services and any changes to the Schedule of Medical Benefits are discussed between the department and the Alberta Medical Association (AMA). All changes to the Schedule of Medical Benefits require ministerial approval after joint negotiations between the department and the AMA have concluded.

What is not insured?

Section 4(1) of the Hospitalization Benefits Regulation provides a list of uninsured hospital services. Uninsured services include drugs, services and products that have been deemed medically unnecessary and services provided by a facility outside of Canada, unless prior approval of the Minister is obtained.

The Minister of Health and Wellness determines what services the Alberta Health Care Insurance Plan covers. The department reviews scientific literature, consults expert advice and assesses policy, funding and training in considering medical products, services or devices for insured coverage.

Section 21 of the Alberta Health Care Insurance Regulation defines what services are not considered insured services.

Can Albertans be billed for any services?

Physicians may bill a patient for services that are not medically required and not included in the Schedule of Medical Benefits. The department does not regulate physicians' billings for uninsured services. The College of Physicians and Surgeons of Alberta has developed and enforces a policy on this issue entitled Charging for Uninsured Services, and the AMA provides the Guide to Direct Billing for Uninsured Services to physicians.

There were no medical services de-insured or de-listed in 2002-2003.

3.0 Universality

Who is eligible for coverage in Alberta?

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

4 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

5 Ibid.

province his or her home and is ordinarily present in Alberta. The term "resident" does not include a tourist, transient or visitor to Alberta.

There were 3,124,487 residents of Alberta registered with the Alberta Health Care Insurance Plan as of March 31, 2003.[6]

Who is not eligible for coverage in Alberta?

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan are:

- members of the Canadian Forces;
- members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank; and
- persons serving a term in a federal penitentiary. (However, family members are eligible for coverage.)

Are people who have moved to Alberta from other countries covered?

People from outside Canada who move to Alberta to establish permanent residence are eligible for coverage if they are landed immigrants, returning landed immigrants or returning Canadian citizens. Temporary residents arriving from outside Canada, who may be deemed residents, include persons on Visitor Records, Student or Employment Authorizations and Minister's Permits. As of March 2003, there were 17,107 people covered under these conditions.

How do people new to Alberta apply for health coverage?

All new Alberta residents are required to register themselves and their eligible dependents with the Alberta Health Care Insurance Plan. New residents to Alberta should apply for coverage within three months of arrival. Family members are registered on the same account for billing purposes and to ensure that benefits, such as non-group Blue Cross, can be provided to all members of the family unit.

Who is required to pay premiums for health care in Alberta?

All Alberta residents, except dependents and individuals excluded from registration, are required to pay premiums. Exceptions include individuals enrolled in special groups (such as Alberta Widows' Pension or Support for Independence), or people entitled to full premium assistance.

Two programs assist lower-income, non-senior Albertans with the cost of their premiums: the Premium Subsidy Program and the Waiver of Premiums Program.

Seniors are required to pay premiums at the same rates as non-seniors, although seniors may be eligible for premium assistance as determined through the Alberta Seniors Benefit Program.

Money raised through premiums in 2002-2003

Alberta spent $6.8 billion on health care costs in 2002-2003. Premium payments raised $937 million which covered only 14 percent of the total.

Can Albertans be denied coverage if they are unable to pay their premiums?

No. Although Albertans are required to pay premiums, no resident is denied coverage due to an inability to pay.

4.0 Portability

Eligibility: Coverage when you move to Alberta

Are out-of-province residents insured when they move to Alberta?

Persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their

6 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

arrival, provided they register within three months of arrival.

Are people from outside of Canada insured when they move 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, provided their Canada entry documents are valid for at least 12 months.

Portability: Coverage when you move out of Alberta or out of Canada

Is there coverage for Albertans living temporarily in another province?

The Alberta Health Care Insurance Plan provides the following coverage:

- Visit/Vacation – up to 24 months coverage.
- Work/Business/Missionary Work – up to 48 months.
- Post Secondary Education – no limit. Covered until studies are completed.

Extension requests for longer than 24 months will be reviewed on a case-by-case basis.

Individuals who are routinely absent from Alberta every year will need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage.

If individuals will not be present in Alberta for the required 183 days, they may be considered residents of Alberta if they satisfy Alberta Health and Wellness that Alberta is their permanent and principle place of residence.

More information on coverage during temporary absences outside of Canada or Alberta is accessible at:
www.health.gov.ab.ca/coverage/ahcip/travel.html

Is there coverage for people receiving medical attention in another province?

Alberta participates in the Hospital Reciprocal Agreement with other provinces and territories, which allows for the processing of hospital costs provided by the host province.

Alberta also participates in the Medical Reciprocal Billing Agreement with provinces and territories (except Quebec), which allows for the processing of medical costs provided by practitioners in the host province. Payments are paid at the host province or territorial rates.

Is there coverage for people living temporarily outside Canada?

The Alberta Health Care Insurance Plan provides coverage for the first six consecutive months of absence outside Canada. Residents who wish to maintain coverage for a longer period may request an extension of coverage for a maximum of 24 consecutive months from the month of departure.

Extension requests for longer than 24 months will be reviewed on a case-by-case basis and will be responded to the same as for Albertans living temporarily in another province.

The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day, (not including day of discharge). The maximum hospital out-patient per visit rate is $50 (Canadian), with a limit of one visit per day. The only exception is haemodialysis, which is paid at a maximum of

Out-of-province payments in 2002-2003 within Canada

	Number of Services	Total Paid
In-patient and out-patient insured hospital services provided to Alberta residents	72,250	$23,707,079
Insured physician services provided to Alberta residents	559,503	$13,880,981

These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003. Is approval needed to receive services outside Alberta?

$220 per visit, with a limit of one visit per day. Physician and allied health practitioner services are paid according to Alberta rates.

Is approval needed to receive services outside Alberta?

Prior approval is not required for elective services received outside Alberta, except for the treatment of alcohol and substance abuse, eating disorders and similar addictive or behavioural disorders. Approval by the Minister must be received before these services can be covered.

Out-of-country payments in 2002-2003

	Number of Services	Total Paid
In- and out-patient insured hospital services provided to Alberta residents	7,437	$546,853
Insured physician services provided to Alberta residents	21,289	$976,232

These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

5.0 Accessibility

Who has access to insured health services?

All Alberta residents have access to insured health services in Alberta.

How is Alberta increasing access to insured hospital services in Alberta?

The 2002-2003 budget included:

- an increase of 7.3 percent or $468 million, with total Alberta Health and Wellness spending in 2002-2003 of $6.837 billion;
- an increase of $247 million or 6.9 per cent to regional health authorities and provincial boards;
- an increase of approximately $21 million for province-wide services for key life-saving procedures primarily done in Edmonton and Calgary; and
- an increase of $177 million for physician compensation, as part of the agreement negotiated with the Alberta Medical Association.

How is Alberta increasing access to insured physician and dental-surgical services in Alberta?

The Alberta International Medical Graduate (AIMG) Program and the Alberta Rural Family Medicine Network (ARFMN) continued to have funding extended during this period. There are currently 17 residents training in the AIMG Program. The ARFMN Program has a total of 40 family medicine residents. As well, $920,000 was provided to the University of Alberta to support the continuance of the School of Dentistry.

What other initiatives aimed at increasing access are underway?

In response to the Premier's Advisory Council on Health report, the Alberta government has committed to the following:

- launch a website posting information on wait times for selected procedures;
- establish a centralized booking system for selected procedures to allow patients to find a surgeon and facility that matches their needs;
- increase the use of care groups, which involve a range of health professionals and new approaches to care for people with chronic diseases; and
- work with physicians and health authorities to identify appropriate access standards for selected health services.

Number of practitioners who were registered with and received payment from the Alberta Health Care Insurance Plan as of March 31, 2003

Health Occupation	Registered/ Licensed to Practise
Opticians	31
Podiatrists	50
Denturists	102
Optometrists	340
Oral Surgeons/Dentists	453
Chiropractors	801
Physicians	5,206
total	6,983

These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

How are physicians paid?

Most physicians in Alberta are paid on a fee-for-service basis for providing insured services. The department and the Alberta Medical Association are working with health authorities, facilities and physicians to develop a number of new alternate payment plan projects as alternatives to fee-for-service payment.

These alternate payment plans and alternate funding plans were expanded in 2002-2003 with approximately 225 physicians involved in such arrangements. A number of other plans, involving approximately 1,000 primary care specialist and academic physicians, are in development.

Who determines what physicians are paid?

Alberta Health and Wellness (AHW) negotiates payment agreements with the Alberta Medical Association (AMA), the professional association representing physicians and surgeons in Alberta. Negotiations are currently underway to establish a new agreement between AHW and the AMA. Regional health authorities (RHAs) are represented in these negotiations for the first time. AHW, RHAs and the AMA will sign this new agreement.

In 2002-2003, total fee-for-service payments to physicians for insured physician services were $1,225,626,637 (for general practitioners and specialists).[7]

What role do regional health authorities play?

The *Regional Health Authorities Act* defines the roles and responsibilities for regional health authorities in delivering hospital and health services.

Alberta Health and Wellness uses a population-based funding formula to fund regional health authorities. The formula calculates the total population, age, gender and socio-economic composition of the region, as well as the services provided to residents, to determine how much funding is provided to each region.

In 2002-2003, $3.9 billion in population-based funding was provided to the regional health authorities.

Edmonton and Calgary health authorities also receive funding to provide specialized tertiary services (province-wide services) to all Albertans. Province-wide services received $418 million in 2002-2003, an increase of approximately six per cent over the previous year.

6.0 Recognition Given to Federal Transfers

The Alberta Government has publicly acknowledged the federal contributions provided through the Canada Health and Social Transfer in publications released during 2002-2003.

7 These figures will be considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2002-2003.

8.0 Additional Materials Submitted to Health Canada

- Schedule of Medical Benefits, April 1, 2003.
- Schedule of Oral and Maxillofacial Surgery Benefits, August 1, 2001.
- Reports of the Auditor General of Alberta for 2002/2003.
- Alberta Ministry of Health and Wellness Annual Report, 2002/2003.
- Ministry of Health and Wellness Three-Year Business Plan, 2003-2006.
- Alberta Budget, 2002/2003.
- Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan, Statistical Supplement 2003/2003.

These publications are available from the Alberta Health and Wellness website at:
www.health.gov.ab.ca/reading/publications.html

Office consolidations of all health care insurance legislation, together with all relevant regulations:

- *Alberta Health Care Insurance Act*
- *Alberta Health Care Insurance Regulation*
- *Government Accountability Act*
- *Health Care Protection Act*
- *Health Care Protection Regulation*
- *Health Insurance Premiums Act*
- *Health Insurance Premiums Regulation*
- *Hospitalization Benefits Regulation*
- *Hospitals Act*
- *Hospital Foundation Regulation*
- *Medical Benefits Regulation*
- *Medical Profession Act*
- *Nursing Homes Act*
- *Nursing Homes General Regulation*
- *Regional Health Authorities Act*
- *Regional Health Authorities Regulation.*

All Alberta Statutes and Regulations are available online at
http://qpsource. gov.ab.ca

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British Columbia

Introduction

British Columbia has a progressive and integrated health care system. The British Columbia health system includes insured services under the *Canada Health Act* as well as services funded wholly or partially by the Government of British Columbia and services regulated by, not funded by, the government. It is based on regional delivery and self-regulating professions providing quality, accessible and affordable health care. Health authorities are responsible for the delivery and management of health services in each community of British Columbia. As of March 31, 2003, there were five regional health authorities plus a Provincial Health Services Authority.

Health care is a top priority for the Government and people of British Columbia.

Activities for 2002-2003

The 2002-2003 fiscal year marked the second year of activity directed to meeting government's goal of creating a patient-centred public health care system that provides accessible, high-quality services, improves health and wellness, and is sustainable over the long term.

Building on the work started in 2001-2002 to consolidate health authorities, clarify roles and responsibilities, and establish clear accountability for outcomes, the ministries worked this year to strengthen the current health system, while making it more adaptable to changing needs. Over the past decade, health spending increased from about 33 percent to 41 percent of the provincial budget, and in 2002-2003, health spending increased by 12 percent to $10.4 billion. Increases of this magnitude are not sustainable.

Under the structure established in June 2001, the Ministry of Health Services provides funding, strategic direction and leadership to support the delivery of health care, preventive health and health promotion services in British Columbia. The Ministry of Health Planning supports the development of long-term planning necessary to sustain British Columbia's public health care system in the years ahead.

Five regional health authorities are responsible for managing and delivering a range of health services, including acute and hospital care, home and community care, mental health, addictions, and public health services. These five regional health authorities encompass 15 health services delivery areas, which were established to reflect natural patient referral patterns. In addition to the regional health authorities, the Provincial Health Services Authority coordinates and delivers highly specialized services that cannot be offered in all regions, and facilitates coordination of provincial initiatives. Health authorities receive three-year budgets, which assists in planning, and have greater accountability through performance agreements that define expectations and performance deliverables for three fiscal years. The performance agreements also set out the major change requirements in areas of service such as emergency care, surgical services, home and community care, public and preventive health, and mental health. A new population-needs-based funding formula was developed in 2001-2002 and implemented in 2002-2003.

Service redesign efforts this year focused on shifting the mix of services and care providers to ensure patient care is delivered at the most appropriate level and setting. These efforts will help create an integrated network of services that will allow patients to get the care they need and to move seamlessly between settings and providers. To facilitate this, in April 2002, BC's new health authorities released health service redesign plans outlining their strategies to begin creating a seamless high-quality and sustainable network of care for patients in their communities. Acute care access standards developed by the Ministry of Health Planning were used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services.

A number of measures were undertaken in 2002-2003 to improve access for insured

hospital services. To assist the health authorities to ensure appropriate utilization and maintenance of hospital facilities and equipment to meet the needs of patients and providers, the Ministry of Health Service's three-year capital spending plan for 2002/03 included:

- $100 million for converting existing facilities to more appropriate uses consistent with the new regional priorities;
- $138 million to implement the Mental Health Plan (e.g. Tertiary Mental Health Facilities in Kamloops); and
- $115 million per year to maintain and improve facilities, and to purchase equipment.

A wide range of capital projects was funded to provide new and improved health care facilities.

In December 2002, $21.5 million was made available to educate, recruit and retain nurses, including $10.7 million from the Ministry of Advanced Education. These dollars fund several initiatives, including new nursing education seats, grants for 192 nurses to take upgrading or refresher courses to return to the nursing profession, and specialty or continuing education opportunities for 3,000 nurses. Also this year, health science education seats were increased for allied health workers such as medical imaging technologists, medical laboratory technologists and respiratory therapists. As well, new education spaces were provided for midwifery and resident care attendants.

In February 2003, a $58.5 million benefits and incentives package was rolled out to attract doctors to rural communities and improve access for patients living there.

Planning was undertaken to implement the commitment, announced in March 2002, of $134 million to expand medical school facilities at the University of British Columbia and establish satellite medical programs at the University of Northern British Columbia and the University of Victoria. This will almost double the number of medical school places by 2005.

The November 2002 release of *The Picture of Health: How We Are Modernizing British Columbia's Health Care System* provided the public and health care community with a detailed description of the direction British Columbia's health care system will be moving over the coming years. In 2002-2003, the Ministry of Health Planning concentrated on working with health care providers, plus diverse health experts and academics, patients and interest groups, and decision-makers at all levels, to determine the best paths to follow to achieve that direction. In February 2003, in further support for evidence-based health care, $8 million was provided to the Michael Smith Foundation for Health Research to conduct research for improving the effectiveness of health care reforms.

Information on health and health care in British Columbia is available from the following website:

www.gov.bc.ca/healthservices

www.gov.bc.ca/healthplanning

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

On January 1, 1949, the British Columbia provincial government commenced making payments to hospitals for treatment provided to qualified residents under the authority of the *Hospital Insurance Act*. Hospital services are funded, on a non-profit basis, through the Performance Management and Improvement Division of the Ministry of Health Services. This program is responsible to the provincial government for the ongoing funding of the province's public hospitals, delivered via funding and transfer agreements with the six health authorities, under the terms of the *Hospital Act*, the *Hospital Insurance Act* (section 9), and the *Hospital District Act* (section 20). This entails expenditures and commitment controls for the operation of hospitals, provision of funds for hospital construction and equipment and payment of out-of-province hospital costs for qualified British Columbia residents.

Section 9 of the *Hospital Insurance Act* previously required that the Minister pay hospitals directly to cover the costs of publicly insured hospital services. Section 9 was amended in 2003 (Bill 33, 2003, the *Health Services Statutes Amendment Act, 2003*) to reflect the fact that hospitals are no longer

funded directly by government. This amendment came into force September 22, 2003. Funding of insured hospital services is now provided to hospitals through the funding of health authorities.

The Medical Services Plan of British Columbia is administered and operated on a non-profit basis by the Medical Services Commission. The Medical Services Commission is responsible to the Minister of Health Services and facilitates, in the manner provided for under the *Medicare Protection Act* (1996), reasonable access to insured benefits under British Columbia's Medical Services Plan by beneficiaries (residents). The day-to-day administration is carried out by the employees of the Medical Services Plan of the Ministry of Health Services. Section 3 of the *Medicare Protection Act* establishes both the Medical Services Plan and the Medical Services Commission.

The Commission's powers (set out under section 5 of the *Medicare Protection Act*) include determining benefits, registering beneficiaries, enrolling practitioners, processing and paying practitioners' bills for benefits rendered, registering diagnostic facilities, establishing advisory committees, authorizing research and surveys related to the provision of benefits, auditing claims for payment and patterns of practice or billings submitted and hearing appeals from practitioners and beneficiaries.

There were no amendments to the *Medicare Protection Act* or the Medical and Health Care Services Regulation made under the *Medicare Protection Act* in 2002-2003 that changed the name of the plan or its public authority.

1.2 Reporting Relationship

Health authorities are required to report health information data respecting hospitals in their jurisdictions to the Ministry of Health Services in accordance with provincial policy. The Performance Management and Improvement Division reports to government through the *Ministry of Health Services Annual Report*.

The Medical Services Commission reports annually to the Minister of Health Services in a separate Financial Statement. The 2002-2003 Financial Statement was tabled in October 2003.

In their annual performance reports, the Ministries of Health Planning and of Health Services provide extensive information on the performance of British Columbia's publicly-funded health care system. Tracking and reporting this information is consistent with the Ministries' increasingly strategic approach and responsibilities for performance planning and reporting, under the Budget Transparency and Accountability Act, which was passed in 2000.

1.3 Audit of Accounts

The Performance Management and Improvement Division and the Medical Services Commission are subject to audit of their accounts and financial transactions through three types of auditor. Internally, the Ministry of Health Services Finance and Decision Support Unit reviews Ministry operations.

The Office of the Comptroller General's Internal Audit and Advisory Services is the provincial government's internal auditor and the Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the findings. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry of Health. The Ministry's Senior Financial Officer determines the scope and timing of reviews conducted by the Finance and Decision Support Unit.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Insurance Act* establishes public insurance coverage for general hospital services. Eligibility is defined by the Regulations, which include both a residency requirement and a waiting period. Insured hospital services are provided in facilities specified in section 1 of the *Hospital Insurance Act*. In 2002-2003 there were 92 acute care hospitals, three rehabilitation hospitals, 18 free-

standing extended care hospitals and 25 diagnostic and treatment and other health centres.

Insured hospital services are provided as recommended by the attending physician or midwife. These services, and the conditions under which they are provided, are listed in the Hospital Insurance Act Regulations, Division 5. Insured in-patient services provided by hospitals are:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister;
- clinically approved drugs, biologicals and medical supplies, when administered in a general hospital specified in the *Hospital Insurance Act*;
- routine surgical supplies;
- use of operating room and case room facilities;
- anaesthetic equipment and supplies;
- use of radiotherapy, physiotherapy and occupational therapy facilities, where available; and
- other services approved by the Minister that are rendered by persons who receive remuneration from the hospital.

Beneficiaries not requiring in-patient hospital care may receive emergency treatment for injuries or illness and operating room or emergency room services for surgical day care and minor surgery, including the application and removal of casts.

Listed hospital out-patient benefits include:

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

Insured hospital services are provided at no charge to beneficiaries. Incremental charges for preferred medical/surgical supplies are made on the basis of a patient's request. The patient is not required to pay the incremental charge if the preferred service is deemed medically necessary by the attending physician.

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

In 2002-2003, no new services were added to the list of insured hospital services covered by the *Hospital Insurance Act*. General hospital services are set out in sections 5 and 8 of the *Hospital Insurance Act*. The hospital services listed in the Regulations are both comprehensive and generic. Changes to listed items can be made through a regulatory amendment which must be approved by Cabinet.

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, it does not require routine review and updating.

2.2 Insured Physician Services

Insured physician services are provided under the authority of the *Medicare Protection Act* (1996). Section 13 of the *Medicare Protection Act* (MPA) provides that practitioners (including medical practitioners and health care practitioners, such as dentists) 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.

The Medical Services Plan (MSP) provides for medically required services of medical practitioners. Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA and 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.

To practise in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with the MSP. There were 7,892 physicians enrolled and billing fee-for-service in fiscal year 2002-2003. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) arrangements under alternative payments. Most physicians paid by alternative mechanisms also practise on a fee-for-service basis.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission. Enrolled physicians may cancel their enrolment by giving 30 days' written notice to the Commission. Services provided by un-enrolled physicians are not benefits and patients are responsible for the full cost of the service. There was one previously enrolled physician who had de-enrolled as of March 31, 2003.

Enrolled physicians can elect to be paid directly by beneficiaries by giving written notice to Commission. The Commission will specify the effective date between 30 and 45 days following receipt of the notice. In this case, beneficiaries may apply to the MSP for reimbursement of the fee for insured services rendered. Only six physicians had opted out as of March 2003.

The *Medicare Protection Act* was amended in April 2002 (*Health Services Statutes Amendment Act, 2002*) with respect to insured physician services. The amendments: repeal section 13.1 to eliminate mandatory de-enrollment of physicians from billing the MSP at age 75; amend section 37 to provide for surcharge and interest charges against physicians who receive money from the Commission for services they did not provide; and amend section 37 to allow the Commission to order interest on inappropriate billings retroactive to the billing period. The amendments were brought into force on July 4, 2002.

Under the Master Agreement between the Commission and the British Columbia Medical Association (BCMA), additions, deletions, fee changes or other modifications to the Commission Payment Schedule are made by the Commission, upon advice from the BCMA. Physicians who wish to have modifications to the Schedule considered submit their proposals to the BCMA Tariff Committee through the appropriate section. On recommendation of the BCMA Tariff Committee, interim listings may be designated by the Commission for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

Several new fee items were added in 2002-2003, as follows:

- abdominal aortic aneurism repair using endovascular stent graft – Vascular surgery component;
- telephone advice to a Community Health Representative in First Nations Communities;
- cortical or deep brain localization with SSEP or simulation in an awake patient;
- craniotomy and insertion of subdural grid electrodes with or without additional strip electrodes – unilateral;
- re-opening of craniotomy for removal of subdural grid electrodes – unilateral;
- craniotomy and microsurgical hemispherotomy for epilepsy;
- stereotactic localization during neurosurgery in association with craniotomy – extra;
- clinical immunology and allergy consultation;
- paediatric clinical immunology and allergy consultation;
- repeat or limited clinical immunology and allergy consultation;
- Clinical Immunology and Allergy – continuing care by consultant (directive care, subsequent office visit, subsequent hospital visit, emergency visit when specially called);
- microelectrode recording (MER) – electrophysiological (EP) mapping of the basal ganglia and thalamus, intra-operatively – extra;
- consultation for complex behavioural, developmental or psychiatric condition in a child;
- 34 new laboratory fee items;

- HIV/Aids Primary Care Management, advice about a patient in Community Care, hospital visit – first routine visit of the day laboratory tests for several psychiatric and anti-epileptic drugs;
- diagnostic vaginoscopy under GA;
- variocele and/or uterine artery embolization; and
- tropinin (laboratory test).

A number of new clinical practice guidelines were also approved by the Commission:

- detection and treatment of helicobacter pylori infection in adult patients;
- investigation and management of iron deficiency;
- clinical management of chronic Hepatitis C;
- clinical management of chronic Hepatitis B;
- diabetes care;
- otitis media with effusion; and
- acute otitis media.

2.3 Insured Surgical-Dental Services

The Medical Services Plan provides for specified dental or oral surgery when it is medically or dentally necessary for it to be performed in hospital by a dental or oral surgeon. Surgical-dental services are covered by the Medical Services Plan when hospitalization is medically required for the safe and proper performance of the surgery and the procedure is listed in the Dental Payment Schedule. The *Medicare Protection Act* defines patient eligibility and provider criteria. Additions and/or changes to the list of insured services are managed by the Medical Services Plan on the advice of the Dental Liaison Committee, which has equal representation from the Dental Association and the Ministry of Health Services. Additions and changes must be approved by the Medical Services Commission. Included as insured surgical-dental procedures are those related to the remedying of 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 dental 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 249 dentists enrolled and billing fee-for-service in 2002-2003. None have de-enrolled and none have opted out of the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial Pharmacare program. Other procedures not insured under the *Hospital Insurance Act* are:

- diagnostic out-patient services not associated with emergency services;
- the services of medical personnel not employed by the hospital;
- treatment for which the Workers' Compensation Board, the Department of Veterans Affairs or any other agency is responsible;
- services solely for the alteration of appearance; and
- reversal of sterilization procedures.

Uninsured hospital services also include:

- preferred accommodation at the patient's request;
- televisions, telephones and private nursing services;
- preferred medical/surgical supplies;
- dental care that could be provided in a dental office including prosthetic and orthodontic services; and
- preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan 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 surgery.

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 beneficiaries for services that would be benefits if performed by a practitioner. Section 17 of the Act prohibits persons from charging a beneficiary for a benefit or for "materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit." The Ministry of Health Services responds to complaints made by patients and is prepared to take appropriate actions to correct situations identified to the Ministry.

In September 2002, the Ministry of Health Services issued a Policy Communiqué to all health authorities on Hospital-Based Revenue Generation. Among the categories of services covered by this policy is use of hospital facilities to provide services covered by third party insurers, such as the Workers' Compensation Board. The policy specifies that health authorities' primary obligation is to provide insured health services to beneficiaries, and that revenue generating practices must not occur at the expense of providing appropriate and timely service to beneficiaries. It also reinforces that health authorities must follow the requirements of the *Canada Health Act*, as well as relevant provincial legislation. Health authorities are required to report new initiatives of this type within their annual Health Service Plans, and the Ministry of Health Services monitors compliance with the policy within the overall performance monitoring plan and service design plans.

The Medical Services Commission determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the Commission. Consultation may take place through a sub-committee of the Commission and usually includes a review by the British Columbia Medical Association's Tariff Committee.

3.0 Universality

3.1 Eligibility

Provincial policy on eligibility for hospital services is set out in Chapter 2 of the Ministry of Health Service's Acute Care Policy Manual.

Section 7 of the *Medicare Protection Act* defines the eligibility and enrolment 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 in order 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, and is physically present in British Columbia at least six months in a calendar year. The definition of resident includes a person who is deemed under section 2 of the Medical and Health Care Services Regulations to be a resident but does not include a tourist or visitor to British Columbia.

All residents, excluding those eligible for compensation from another source, are entitled to hospital and medical care insurance coverage. The Medical Services Plan provides first-day coverage to discharged members of the Royal Canadian Mounted Police and the Canadian Forces, and to released inmates of federal penitentiaries. However, if discharged outside British Columbia, they must wait the prescribed period.

3.2 Registration Requirements

As of April 1, 1998, residents must be enrolled in the Medical Services Plan to receive insured hospital and physician services. Those who are eligible for coverage are required to enrol. Once enrolled, there is no expiration date for coverage. New residents are advised to make application immediately upon arrival in the

Province. Each person who enrols with the Medical Services Plan is issued a CareCard. Renewal of cancelled enrolment can usually take place over the telephone, by calling the Medical Services Plan.

Beneficiaries may cover their dependants, provided the dependants are residents of the province. Dependants include the account holder's spouse (either married to or living and cohabiting in a marriage-like relationship), any unmarried child or legal ward under the age of 19 supported by the beneficiary, or a child under the age of 25 and in full-time attendance at a school or university.

The number of residents registered with the Medical Services Plan as of March 31, 2003, was 4.11 million. Enrolment in the Medical Services Plan is mandatory. Only those adults who formally opt out of all provincial health care programs are exempt. As of March 31, 2003, 231 people had opted out.

3.3 Other Categories of Individual

Refugee claimants are not generally eligible. Individuals who are approved for refugee status and who are, therefore entitled to reside in Canada on a permanent basis, are eligible. Under specific circumstances, special consideration is given to these individuals regarding the effective date of benefits. Holders of Minister's Permits are eligible for benefits where deemed to be residents under the Medical and Health Care Services Regulation. A waiting period applies.

3.4 Premiums

Enrolment in the Medical Services Plan is mandatory, and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Effective May 1, 2002, monthly premiums for the Medical Services Plan were $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 been resident in Canada and a Canadian citizen or holder of permanent resident (landed immigrant) status.

There are no additional premiums for insured hospital services. However, there is a daily charge for extended-care hospital services for patients over the age of 19. The client rate, representing the cost of accommodation and meals, is established once a year. As of March 31, 2003, the maximum non-subsidized rate was $50 a day. Residents with limited means are eligible for assistance, on a sliding scale. In certain circumstances there is a provision to waive a portion of the fee. Client rates of less than $50 per day are reviewed quarterly and patients are advised one month before any changes are made.

4.0 Portability

Persons moving permanently to another part of Canada are entitled to coverage to the end of the second month following the month of departure. Such persons may be extended coverage, not to exceed three months, for a reasonable period of travel.

Persons moving permanently outside Canada are entitled to coverage to the end of the month of departure.

4.1 Minimum Waiting Period

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

Coverage is available to landed immigrants who have completed the waiting period. Also after the waiting period, coverage is available to persons from outside Canada who are in the Province on work permits or student visas, provided the permits or visas are valid for at least six months, and have been issued at the time of admission to Canada.

4.2 Coverage During Temporary Absences In Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulations define portability provisions for persons temporarily absent from British Columbia in Canada with regard to insured services. In 2002-2003, there were no amendments to the Medical and Health Care Services Regulation, made under the *Medicare Protection Act*, 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 among the Provinces concerning hospital insurance matters, and to make arrangements under which a qualified person may move his or her home from one province or territory to the other without ceasing to be entitled to benefits.

Individuals who leave the province temporarily on extended vacations or for temporary employment may be covered for up to 12 months. Approval is limited to once in five years for such absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada for at least six months in a calendar year and continue to maintain their homes in British Columbia. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to inter-provincial and inter-territorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, on presentation of a valid Medical Services Plan Card (CareCard). British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, charges are paid at the standard ward rate actually charged by the hospital. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

As Quebec does not participate in reciprocal billing agreements, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. Reimbursement may be made either to the physician providing the service, or directly to the beneficiary who received the service, whichever submits the claim.

The Financial Administration section of the Acute Care Policy Manual sets out the specific details of the current interprovincial or territorial reciprocal billing agreement for insured hospital services. Each provincial hospital insurance plan will process hospital in- and out-patient accounts on behalf of the residents of the other provinces and territories, with the exception of Quebec, which is not a signatory to the Agreement. The Agreement covers benefits rendered within provincial or territorial boundaries and makes provision for the periodic settling of accounts between provinces and territories.

In addition, there is a BC-Yukon Accord which covers several aspects of health services, including provision of air ambulance services, abortion services and physician services. There are no other special bi-lateral agreements in place between the Province of British Columbia or Health Authorities and adjacent jurisdictions respecting the servicing of border communities

4.3 Coverage During Temporary Absences Outside Canada

The Hospital Insurance Act Regulations, division 4 and sections 3, 4, and 5 of the Medical and Health Care Services Regulations define portability of insured hospital and physician services during temporary absences outside Canada. In 2002-2003, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

A qualified person leaving British Columbia to attend university, college or other educational institutions recognized by the Medical Services Commission, on a full-time basis, retains eligibility during the absence for study until the last day of the month in which the person ceased full-time attendance at that educational institution, or if studying outside Canada, the last day of the sixtieth month since the date of departure from British Columbia.

A qualified person who is absent from British Columbia for vacation or work for more than six months is deemed a resident for the purpose of determining beneficiary status for up to the initial 12 consecutive months of absence, if this person obtains prior approval from the Medical Services Commission, does not establish residency outside British Columbia and has not been granted approval for a similar absence during the preceding 60 months.

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

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

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements. Some treatments may require the approval of Performance Management and Improvement Division (e.g., treatment for anorexia). All non-emergency procedures performed outside of Canada require approval from the Commission prior to the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

British Columbia believes that all residents have reasonable access to hospital and medical care services. Beneficiaries, as defined in section 1 of the *Medicare Protection Act* and the Ministry of Health Services' Acute Care Policy Manual, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, Part 4, prohibits extra-billing by enrolled practitioners.

5.2 Access to Insured Hospital Services

In 2002-2003, there were 7,093 occupied acute care beds in 92 acute care facilities, and 150 rehabilitation beds in acute care or rehabilitation hospitals. In addition, there were 25 diagnostic and treatment centres and six Red Cross Outpost hospitals.

The Province also provides access to care services for extended care patients. In 2002-2003, there were 18 free-standing extended care facilities, and a total of 7,421 extended care beds.

The number of practising Registered Nurses as of December 2002 was 29,775. British Columbia hospitals also employ Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). In 2002 there were 2,161 RPNs and 4,957 LPNs. In 2002-2003, a further $21.5 million was allocated to nursing strategies, for a total of $42.5 million over two years. British Columbia's nursing strategies are identified, developed and implemented by the Ministry of Health Planning with input from nurses and other stakeholders. They are intended to improve the recruitment, retention, education and workplace needs of British Columbia nurses and nursing students. The strategies in 2002-2003 included more education seats (1,266 new nursing spaces created since 2001); initiatives to encourage British Columbia nurses who are not working in their profession to return to the health system; new opportunities for nurses to upgrade their skills; and Aboriginal nursing strategies.

Telehealth continues to provide improved access to services in British Columbia. March 31, 2003 marked the conclusion of the federal funding period through the Canada Health Infostructure Partnerships Program (CHIPP), and the regional Health Authorities now support the equipment and infrastructure deployed during CHIPP. Services established through the different projects continue to be delivered, and new applications are being implemented on an ongoing basis. Pediatric echocardiograms and ultrasounds are transmitted live from remote locations in the province to specialists at British Columbia Children's Hospital, providing timely access to care for patients in their own communities. Videoconferencing allows for clinical consultations in the areas of oncology, maternal fetal medicine, genetic counseling, psychiatry, child rehabilitation and development, pediatrics, trauma management, nutrition – these are some examples of the types of services which have been and continue to be provided via telehealth.

The Ministry of Health Planning has prepared acute care access standards that are being used by health authorities in the redesign of hospital services. The standards specify the maximum travel time for accessing emergency services, in-patient services and core specialty services. They also ensure that the majority of British Columbians, in all regions, have reasonable access to these services. Within the Ministry of Health Services Service Plan 2002/2003 – 2004/2005, performance measures were included regarding waiting times for key services (radiotherapy and chemotherapy). For 2002-2003, the target for chemotherapy was met, but the target for radiotherapy was not achieved, although significant and steady improvement over 2000-2001 levels was noted.

In May 2002, the British Columbia government established a new capital asset management framework, which articulates the Province's minimum standards for capital asset management. The framework encourages agencies to prepare capital asset management plans and to review all options for addressing infrastructure needs. The Ministry of Health Services is working with health authorities to implement the new framework. In this respect, an implementation plan has recently been completed which includes the prioritization of key elements for which Ministry policy and/or tools to support best practices in capital asset management are required.

To support the health authorities and the Ministry of Health Services in preparing capital asset management plans, a health care facility inventory and assessment project started in 2002-2003.

Since the restructuring of health authorities and the introduction of service plans and performance agreements in 2001-2002, health authorities have the ability and incentive to ensure appropriate utilization and maintenance of hospital facilities and equipment to meet the needs of patients and providers.

To assist the health authorities with this, the Ministry of Health Service's three-year capital spending plan for 2002-2003 included:

- $100 million for converting existing facilities to more appropriate uses consistent with the new regional priorities. At March 31, 2003, $25.47 million had been approved from this allocation;
- $138 million to implement the Mental Health Plan (e.g. Tertiary Mental Health Facilities in Kamloops). At March 31, 2003, $21.13 million had been approved from this allocation; and
- $115 million per year to maintain and improve facilities, and to purchase equipment.

A number of capital construction projects completed in 2002-2003 provided new and improved health care facilities for British Columbians. The major projects completed included:

- The $2.45 million, operating room upgrade at the Richmond General Hospital completed in May 2002.
- The $31.1 million Mount Saint Mary Hospital, in Victoria, opened in March 2003. This new state of the art facility is a 200-bed, five-story residential care facility for persons with complex care needs. The facility is unique in that it is designed as a community, with 16 houses of 12 to 13 rooms, including rooms typically found in a home. The common area, which offers various services, is designed to create the atmosphere of a village street.
- The $1.5 million upgrade to the pathology laboratory at the Children's and Women's Health Centre of BC completed in October 2002.

- Construction was completed in January 2002 on the $6.3 million phase one redevelopment at Fort St. John General Hospital.
- In April 2002, construction was completed on the $1.5 million upgrading of the acute care tower at Langley Memorial Hospital.
- The $9 million Rotary Manor 44-bed long term care complex opened in December 2002.
- The $1.13 million, 10-bed expansion to the Iris House was completed in March 2003. The specialized mental health facility on the grounds of Prince George Regional Hospital will help house and care for people with serious or persistent mental illness, providing assessment, treatment and rehabilitation.

The BC HealthGuide Program, started in 2001, has a comprehensive approach to self-care unique in Canada, and is based on information delivered in a variety of formats:

- BC HealthGuide Handbook - delivered free to every household in BC, it contains tips for prevention and early identification of illnesses, when to see a doctor, self-care "home treatment" tips, and information on managing chronic diseases.
- BC First Nations Health Handbook was developed in partnership with the BC First Nations Chiefs' Health Committee – the handbook provides specific information on health services available to aboriginal communities. The BC First Nations Health Handbook was distributed to aboriginal communities in January 2003. The handbook provides aboriginal communities with tools and information necessary to help improve their health.
- BC HealthGuide OnLine - expands on the information in the Handbook with more than 35,000 medically reviewed pages covering 2,500 detailed health topics on symptoms and conditions. The website, www.bchealthguide.org is updated quarterly.
- BC NurseLine - toll-free 24 hour a day, 7 days a week nursing triage and health education by telephone. Registered nurses are specially trained to use medically approved protocols for acute and chronic health symptoms and conditions. The Line gives people the information they need, when they need it, where they need it, and includes services for people who are deaf and hearing impaired as well as translation services in over 130 different languages - improving access for all British Columbians. In 2002-2003, the BC NurseLine received over 170,000 calls.
- BC Health Files – a series of over 146 one-page, easy-to-understand fact sheets about a wide range of public and environmental health and safety issues. The fact sheets are available in the province's 120+ health units and departments and certain other offices (Government Employee Health Services, Native Health Centres, physicians offices/clinics and nursing stations).

5.3 Access to Insured Physician and Dental-Surgical Services

There were 4,471 general practitioners, 3,421 specialists and 249 dentists who provided insured fee-for-service physician and dental-surgical services in 2002-2003.

The Ministry of Health Services implemented several new programs under the new 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. The Rural Retention Program provides eligible rural physicians (approximately 1,200) with fee premiums and is now available for visiting physicians and locums. Through the Northern and Isolation Travel Assistance Outreach Program, funding was provided for an estimated 1,355 visits by family doctors and specialists to rural communities. The Northern and Rural Locum Program assisted physicians practising in approximately 50 small communities to secure subsidized continuing medical education and vacation relief. A one-year interim Rural Specialist Locum Program provides locum support for core specialists in 16 rural communities while physician recruitment efforts are underway. The Rural Education Action Plan supported the training of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practising physicians. The Rural Loan Forgiveness Program decreases BC student loans by 20 percent for each year of rural practice for physicians, nurses, midwives and pharmacists.

Several additional measures were taken in 2002-2003 to improve access to physician

services. In November 2002, British Columbia received $74 million in a federal funding commitment over four years to develop sustainable improvements to Primary Health Care and increase patient access to comprehensive, high-quality services in doctors' offices and community clinics — the usual first points of contact with the health care system.

In February 2003, a $58.5 million benefits and incentives package was rolled out to attract doctors to rural communities and improve access for patients living there.

Planning was undertaken to implement the commitment, announced in March 2002, of $134 million to expand medical school facilities at the University of British Columbia and establish satellite medical programs at the University of Northern British Columbia and the University of Victoria. This will almost double the number of medical school places by 2005.

5.4 Physician Compensation

The Province of British Columbia negotiates with the British Columbia Medical Association to establish the conditions, benefits and overall compensation for both fee-for-service physicians and physicians paid under alternative payment mechanisms, including salaried physicians.

The Government of British Columbia and the British Columbia Medical Association signed a Memorandum of Understanding (MOU) on March 26, 2002, to provide for retroactive fee increases for 2001-2002, as well as a process for resolving outstanding issues. The three-year agreement provided for an increase of $392 million per year in physician compensation plus utilization increases. In addition, a dispute resolution mechanism was put in place that provides for conciliation and binding arbitration. The resulting Working and Subsidiary Agreements signed in November of 2002 provided retroactive payments equivalent to 6.2 percent for the period April 1 to October 31, 2001 and 11.6 percent for the period November 1, 2001 to March 31, 2002. The MOU increased the overall specialist on-call program by $80 million thus provided for payments up to $125 millions per year. The Working Agreement ends March 31 2004 and the MOU terminates March 31, 2005 while the Second Master Agreement is in place until March 31 2006. Negotiations for renewal of the Working Agreement began in October 2003.

During 2002-2003, the Medical Services Plan's (MSP) payments to physicians in the Province totalled approximately $1.904 billion. The MSP paid approximately approximately $17.1 million in reciprocal payments to other provinces or territories for medical services provided outside the province.

Section 13 of the *Medicare Protection Act* provides that practitioners (including medical practitioners and health care practitioners, such as dentists) who are enrolled under the Act and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule. The Association of Dental Surgeons of BC and the Ministry recently completed a revision of the dental fee schedule, to ensure that insured services remain within the Available Amount however a renewed agreement remains outstanding. Section 13.1 of the Act which required mandatory de-enrolment of physicians from billing the Medical Services Plan at age 75, was repealed in 2002 under the *Health Services Statutes Amendment Act, 2002*. That amendment came into force on July 4, 2002.

Payment for medical services delivered in the Province is made through the MSP to individual physicians, based on billings submitted. The patient is not normally involved in the payment system. Ninety-eight percent of claims are submitted electronically through the Teleplan System, while the remaining two percent are submitted on claim cards by low-volume physicians and other health care practitioners.

The Medical Services Commission also funds comprehensive programs of health care services through contracted physician arrangements. The Ministry of Health Services' Alternative Payments Program (APP) provides program-specific funding to British Columbia's six health authorities and the Nisga'a, which in turn, contract with physicians for their services or time through service contracts or sessional payments. A number of provincial agreements, negotiated as subsidiaries to the Master and Working agreements between the Government of British Columbia and British Columbian Medical Association, set the terms and conditions of physician compensation when delivering government-funded services, including those funded by the APP.

Approximately 2305 physicians are supported through APP funding arrangements.

5.5 Payments to Hospitals

Section 9 of the *Hospital Insurance Act* used to require that the Minister pay hospitals directly to cover the costs of publicly insured hospital services. Effective December 12, 2001, as part of its health care restructuring initiative to increase efficiencies and accountabilities for health authorities, Government restructured British Columbia's regional health authorities by amalgamating 52 health authorities into five regional health authorities. Section 9 of the *Hospital Insurance Act* was amended in 2003 (the *Health Services Statutes Amendment Act, 2003*) to reflect the fact that hospitals are no longer funded directly by government. Funding of insured hospital services is now provided to hospitals through the funding of health authorities.

In 2002-2003, the total funding provided to Health Authorities was $6.1 billion, including funds for hospital, continuing care, public and preventive health, and adult mental health programs. Payments to out-of-province hospitals within Canada for insured services (both in- and out-patient) provided to British Columbia residents totalled $51.4 million, while payment to hospitals outside the country totalled $2.8 million in 2002-2003.

6.0 Recognition

Funding provided by the federal government through the Canada Health and Social Transfer has been recognized and reported by the Government of British Columbia through various government websites and provincial government documents. For the fiscal year 2002-2003, these documents included the following:

- Public Accounts 2001/02 (Tabled July 11, 2002);
- Public Accounts 2002/03 (Tabled June 27, 2003);
- Budget and Fiscal Plan, 2003/04 to 2005/06 (Tabled February 18, 2003);
- Estimates, Fiscal Year Ending March 31, 2004 (Tabled February 18, 2003).

7.0 Extended Health Care Services (EHCS)

The Performance and Management Improvement Division of the Ministry of Health Services funds and provides a comprehensive range of community-based supportive care services to assist people whose ability to function independently is affected by long term health-related problems or who have acute care needs that can be met at home. Services include case management; in-home support services (home support, community home care nursing, physiotherapy, occupational therapy, nutrition counselling, social worker services and meals programs); assisted living; residential care services (family care homes, group homes and residential care facilities); community palliative care; residential hospice; and special support services (adult day centres, respite care and assessment and treatment centres). Services are delivered at the community level through the health authorities.

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

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

Home support services provide assistance with activities of daily living and personal care. Adult day centres offer a centre-based program of health, social and recreational activities.

Assisted living services provide a housing arrangement that consists of a private housing unit with a lockable door, hospitality services and personal care services.

A Palliative Care Benefits Program was implemented in 2001 to provide home-based palliative care clients with medication for pain and symptom relief and medical supplies and equipment, at no charge.

8.0 Additional Materials Submitted to Health Canada

Annual Reports

- Ministry of Health Planning 2002/03 Annual Service Plan Report:
  www.bcbudget.gov.bc.ca/annualreports/hp/hp.pdf
- Ministry of Health Services 2002/03 Annual Service Plan Report
  www.bcbudget.gov.bc.ca/annualreports/hs/hs.pdf

Audit Reports

- A Review of Performance Agreements Between the Ministry of Health Services and the Health Authorities, Office of the Auditor General of British Columbia, 2003/04 Report 1 - May 2003
  www.bcauditor.com/PUBS/2003-04/Report1/Health/May2003.pdf

  (This report was issued in 2003-04, but reviews the performance agreements for 2002/03 to 2004/05)

Financial Reports

- 2002/03 Public Accounts, Ministry of Finance
  www.fin.gov.bc.ca/ocg/pa/02_03/PA_2003_all.pdf
- Medical Services Commission Financial Statement 2003
  www.healthservices.gov.bc.ca/msp/financial_statement.html
- Budget Papers: British Columbia Budget 2003
  www.bcbudget.gov.bc.ca/
- Ministry of Health Services Service Plan 2003/04 - 2005/06
  www.bcbudget.gov.bc.ca/sp2003/hs/hs.pdf
- Ministry of Health Planning Service Plan 2003/04 – 2005/06
  www.bcbudget.gov.bc.ca/sp2003/hp/hp.pdf

Legislation

- All Statutes and Regulations referred to in the BC submission are posted alphabetically by Statute title
  www.qp.gov.bc.ca/statreg/

Other Documents

- Medical Services Commission Payment Schedule
  www.healthservices.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html
- MSC for BC Residents (on-line information regarding eligibility, enrolment, and benefits)
  www.healthservices.gov.bc.ca/msp/infoben/index.html
- The Picture of Health: How we are modernizing British Columbia's health care system (December 2002)
  www.healthplanning.gov.bc.ca/cpa/publications/picture_of_health.pdf

Yukon

Introduction

The health care insurance plans operated by the Government of the Yukon Territory are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The Yukon Health Care Insurance Plan is administered by the Director, as appointed by the Executive Council Member (Minister). The Yukon Hospital Insurance Services Plan 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 the delivery of all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services. There were 30,558 eligible persons registered with the Yukon health care plan on March 31, 2003.

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:

- telehealth continues to expand and link patients and health care providers;
- primary care initiatives are underway that will broaden and strengthen service delivery and modernize and improve system capabilities;
- an increasing number of continuing care beds;
- a new medical imaging program;
- increased numbers of family physicians;
- increased numbers of specialists; and
- stabilized numbers of registered nurses.

The 2002-2003 budget increased health care expenditures over the 2001-2002 forecast as follows:

- Insured Health Services increased by $950,000.
- Yukon Hospital Services increased by $558,000.
- Continuing Care increased by $4,416,000.
- Community Nursing and Emergency Medical Services increased by $229,000.
- Community Health Programs increased by $102,000.

Some of the major challenges facing the advancement of insured health care service delivery in the Territory are:

- effective linkages and co-ordination of existing services and service providers;
- recruitment and retention of qualified health care professionals;
- increasing costs related to service delivery, for example pharmaceuticals, facilities, public demand and labour;
- increasing costs to maintain and administer insured health services and extended benefit programs;
- 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*, adopted April 1, 1972, sets out the legislative framework for the payment of insured physician services to eligible Yukon residents. The *Hospital Insurance Services Act*, adopted April 9, 1960, sets out the legislative framework for payment to hospitals, i.e., amounts in respect of the cost of insured services provided by hospitals to insured persons.

Subject to the *Health Care Insurance Plan Act*, (section 5) and Regulations, the mandate and function of the Director, Insured Health 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 the Yukon's right of subrogation under this Act to the rights of insured persons;
- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required under this Act and the form such information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports and accounts; and
- perform such other functions and discharge such other duties as are assigned by the Executive Council Member under this Act.

There were no amendments made to the legislation in 2002-2003.

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 the Yukon with hospitals in or outside the Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for purposes of this Act;
- conduct surveys and research 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.

There were no amendments made to the legislation in 2002-2003.

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.

The Statement of Revenue and Expenditures for the health care insurance programs of the Health Services Branch is tabled annually in the fall session of the Legislature. The report, to be

tabled December 2003, covers the fiscal years 1997-1998 to 2002-2003.

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 the 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 the 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, 2003.

With regard to 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

Adopted on April 9, 1960, the *Hospital Insurance Services Act*, sections 3, 4, 5 and 9 and sections 2, 4, 5, 9 and 11 of the Hospital Insurance Services Regulations, establish authority to provide insured hospital services. There were no amendments made to the legislation in 2002-2003.

In 2002-2003, insured hospital services to both in- and out-patients were delivered in 15 facilities throughout the Territory. These facilities include one general hospital, one cottage hospital[1] and 12 Health Centres.[2] Visiting nursing services are provided from one satellite health station.[3]

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 establish and maintain a quality assurance program. Currently, the Yukon Hospital Corporation is operated under a full 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:

"(i) accommodation and meals at the standard or public ward level,

1 This facility provides 24-hour emergency treatment, short-term admissions and respite care.

2 Community Nurse Practitioners, in the absence of a physician, provide daily clinics for medical treatment, community health programs and 24-hour emergency services.

3 Community Nurse Practitioners provide itinerant services on a regularly scheduled basis.

(ii) necessary nursing service,

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

(iv) drugs, biologicals and related preparations as provided in Schedule B of the Regulations, when administered in the hospital,

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

(vi) routine surgical supplies,

(vii) use of radiotherapy facilities where available,

(viii) use of physiotherapy facilities where available,

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

Section 2(f) of the same Regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely:

"(i) necessary nursing service,

(ii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury,

(iii) drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital,

(iv) use of operating room and anaesthetic facilities, including necessary equipment and supplies,

(v) routine surgical supplies,

(vi) services rendered by persons who receive remuneration therefor from the hospital,

(vii) use of radiotherapy facilities where available,

(viii) 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 new Yukon Computed Tomography Scan Program was implemented at the Whitehorse General Hospital in fall 2002. The Government provided $1.5 million toward the purchase of a computed tomography scanner and picture archiving system. The program has been very successful and provides Yukon residents with local access to a standard diagnostic service.

These measures will help reduce the Territory's reliance on out-of-territory services.

No services were discontinued in 2002-2003.

2.2 Insured Physician Services

Adopted on April 1, 1972, sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 4, 7,10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to the legislation in 2002-2003.

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 as of March 31, 2003, was 59.

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 2002-2003, 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.

From April 1, 2002 to March 31, 2003, the following services were added to the list of insured physician services covered by the Yukon Health Care Insurance Plan:

- complicated pre-anesthetic check;
- laparscopic excision of endometriosis; and
- management of prolonged third-stage labour.

The process used to add a new fee to the relative Value Guide to Fees[4] is administered through a committee structure. This process requires physicians to submit requests in writing to the 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.

4 Physician's fee guide manual

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of the Territory must be licensed pursuant to the *Dental Professions Act* and are given billing numbers for the purpose of billing the Yukon Health Care Insurance Plan for the provision of insured dental services. In 2002-2003, four oral surgeons, two dental surgeons and two orthodontists billed the Plan for insured dental services provided to Yukon residents.

Dentists are able to opt out of the health care plan in the same manner as physicians. In 2002-2003, 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;
- medico-legal 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 Workers' 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, tray fees 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 2002-2003.

- **Hospital services** – an amendment by Order-In-Council to section 2 (e)(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2003, no insured in-patient or out-patient hospital services, as provided for in the Regulations, have been de-insured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- **Dental-surgical services** – an amendment by Order-In-Council to Schedule B of the Regulations Respecting Health Care Insurance Services is required. A service could be de-insured if determined not medically necessary or if it 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 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". No changes affecting eligibility were made to the legislation in 2002-2003.

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;
- 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 landed immigrant; 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, 2003, there were 30,534 residents registered with the Yukon Health Care Insurance Plan.

3.3 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals as follows:

Category	Coverage
Returning Canadians	No waiting period is applied.
Landed Immigrants	No waiting period is applied.
Minister's Permit	No waiting period is applied if authorized.
Convention Refugees	No waiting period is applied if holding Employment Authorization.[1]
Foreign Workers	No waiting period is applied if holding Employment Authorization.[1]
Clergy	No waiting period is applied if holding Employment Authorization.[1]

1 Employment Authorization must be in excess of 12 months

The estimated number of new individuals receiving coverage in the Yukon during 2002-2003 under the following conditions is:

Category	Number of Individuals
Returning Canadians	27
Landed Immigrants	36
Minister's Permit	1
Convention Refugees	0

The estimated number of individuals receiving coverage in the Yukon as of March 31, 2003, under the following conditions is:

Category	Number of Individuals
Foreign Workers	33
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

Persons moving to the Yukon from another province or territory are entitled to coverage pursuant to section 4(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations. The Regulation states that "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory."

4.2 Coverage During Temporary Absences In Canada

The provisions relating to portability of health care insurance during temporary absences 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. No amendments to the legislation were made in 2002-2003.

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." 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 the cancellation of 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, Insured Health and Hearing Services.

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.

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 for the fiscal year 2002-2003.

In-patient Services	Out-patient Services
$5,861,530	$1,037,692

Note: Figures are by date of service and subject to adjustment.

In 2002-2003 payments to out-of-territory physicians totaled $1,799,019. This figure includes out-of-Canada costs and is by payment date.[5]

5 Out-of-country costs are reported under lines 22 and 23 in the Yukon section of Annex A – Provincial and Territorial Health Care Insurance Plan Statistics.

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 the legislation in 2002-2003.

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”.

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 the cancellation of 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, 2003, was $1,165. This rate dropped to $1,100 per day effective August 1, 2003. These rates are established through Order-in-Council and are derived as follows:

- Standard Ward Rate = (total operating expenses - non-related in-patient costs - related newborn costs - associated out-patient costs) / (total patient days - patient days for other services, ex. non- Canadians).

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation. The out-patient rate is currently $110 and is established through Order-in-Council and derived by the Inter-provincial Health Insurance Agreements Coordinating Committee (IHIACC).

The following amounts were paid in 2002-2003 for elective and emergency services provided to eligible Yukon residents outside Canada:

In-patient Services	Out-patient Services
$9,339	$2,451

Note: Figures are by service date and 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 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 the two acute care facilities.

In 2002-2003, the following staffed beds in facilities providing insured hospital services were available as of March 31, 2003:

Facility	Number of Beds
Whitehorse General Hospital	49[a]
Watson Lake Cottage Hospital	12

(For additional information on the number and type of hospital beds in the Yukon see the related Statistical Annex, items 3 and 4.)

a Eight additional acute-care beds can be made available at the Whitehorse General Hospital, should future occupancy trends indicate a need.

Decisions on the number of acute care beds in a facility are made by the Whitehorse General Hospital and Community Nursing and are based on utilization patterns and staffing compliments. Based on the population of the Yukon, the current number of hospital beds is considered sufficient.

The Yukon has no rehabilitative beds. Patients are referred out-of-territory for these services – usually to Vancouver or Edmonton.

The estimated number of full-time equivalent (FTEs) nurses and other health care professionals working in facilities providing insured hospital services in the Yukon as of March 31, 2003, is:

Profession	Whitehorse General Hospital # of FTE's	Watson Lake Cottage # of FTE's
Registered Nurses	72	8
Licensed Practical	8	n/a
Nurse Pract.	0	n/a
Social Worker	1	n/a
Pharmacist	2	n/a
Physiotherapist	4.4	n/a
Occup. Therapist	1	n/a
Psychologist	1	n/a
Medical Lab/X-ray	21	n/a
Dietician	3.5	n/a
Public Health	n/a	2
Home Care	n/a	1

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:

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 the Yukon recruit and retain nurses in both the long and short term.
  - competitive salaries
  - recruitment and retention bonuses
  - participation at job fairs
  - training and educational opportunities
  - relief positions

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
- Travel bonus/$2,000 after one year
- Northern Living Allowance/Up to $5,400

Facilities

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. Emergency Department services are provided on rotation by local physicians.

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/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.

Watson Lake Cottage Hospital: A second acute care facility is located in Watson Lake. Medical services include emergency trauma, maternity, minor orthopaedics, cellulitis, failure

to thrive and respite care. Diagnostic services include x-ray, laboratory and electrocardiogram. This is a 12-bed facility and there is no waitlist for admission.

The only other facility in the Yukon to provide in-patient services is located in Dawson City and is limited to 48-hour care. Out-patient and 24-hour emergency services are provided by the remaining 12 Community Health Centres. One or more Community Nurse Practitioners and auxiliaries staff Health Centres.

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 to Community Nurse Practitioners and improves local access to cardiac care.
- Officials from the Department attend nursing recruitment fairs across Canada. Information on working in the Territory was provided 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 the initiation, elimination, expansion or reduction of programs or services.
- Telehealth continued to provide real-time video to support access and delivery of services between outlying rural communities with Whitehorse, and Whitehorse with outside centres in British Columbia or Alberta. Funding was provided through the Canada Health Infostructure Partnerships Program (CHIPP) to October 31, 2003.

  Telehealth sessions have occurred regularly between Whitehorse and rural Yukon as well as between Whitehorse and British Columbia. These sessions have been 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 Dental-Surgical 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, 2003 (see Statistical Annex item #30):

Practise	Number of Practitioners
General Practitioners/ Family Practitioners	53
Specialists	6
Dentists	8

Outside 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. Outside 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:

Specialty	Number of Specialists
Ophthalmology	1
Oncology	3
Orthopaedics	3
Internal Medicine	1
Otolaryngology	2
Neurology	1
Rheumatology	1
Dermatology	1
Dental Surgery[1]	3
Infectious Disease[1]	1
Psychiatry[1]	3

1 Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Visiting Specialist clinics are held between one and eight times per year depending on demand and availability of specialists. As of March 31, 2003, the waitlist for non-emergency specialist services was estimated at:

Specialist service	Waitlist
Ophthalmology	0-3 months
Orthopaedics	1-22 months
Otolaryngology	1-12 months
Neurology	3-5 months
Rheumatology	3-5 months
Dental Surgery[1]	2-3 months

1 Services not provided through the Visiting Specialist as administered by the Whitehorse General Hospital.

Note: There is no waitlist for visiting services not included in the above listing. Patients are seen on the next scheduled visit (i.e., Oncology, Internal Medicine, Dermatology, Infectious Disease and Psychiatry).

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 to increase the number of resident and locum physicians in the Territory, including:

- **Resident Support Program:** assists with travel, accommodation and vehicle expenses for residents in a family practice program and for medical students in the Yukon.
- **Locum Support Program:** assists with travel and accommodation expenses for physicians providing locum services to resident physicians.
- **Physician Relocation Fund:** assists with relocation costs for family practice physicians recruited to the Yukon. A return-in-service commitment is required.
- **Office Start-Up Fund:** assist physicians relocating to the Yukon in an area designated by the Joint Management Committee as requiring additional physician resources.
- **Education Support Program:** supports Yukon physicians who leave the Territory for specialized training. A return-in-service commitment is required.
- **Rural Training Fund:** supports rural physicians to maintain emergency skills through specialized course work.

Amendments were made to the *Medical Professions Act* in 2002-2003 to provide for the

issuance of special licenses in response to a demonstrated need. The candidate must have already been offered a position in the Territory subject to special licensing and the Minister of Health and Social Services must state in writing that a demonstrated need exists within an area of practice.

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 has been 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 fee negotiations were concluded on March 26, 2002. The resulting Memorandum of Understanding is effective from April 1, 2002 through March 31, 2004. The MOU establishes the terms and conditions for payment of the following:

- Fee-for-service physicians;
- Alternative payment physicians;
- Continuing Medical Education;
- Medical Practice Insurance; and
- Benefit Programs.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations. No amendments were made to the legislation in 2002-2003.

The fee-for-service system is used to reimburse the majority of physicians and dentists providing insured services to residents. In 2002-2003, two full-time resident rural physicians and two resident specialists were compensated on a contractual basis. Three physicians providing visiting clinics in outlying communities were paid a flat sessional rate for services.

5.5 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital) through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O and M) and capital funding levels are negotiated and adjusted based on operational requirements and utilization projections from prior years. The current one-year contribution agreement is in effect to March 31, 2003.

In addition to the established O and 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 the legislation in 2002-2003.

6.0 Recognition Given to Federal Transfers

The Government of the Yukon has acknowledged the federal contributions provided through the Canada Health and Social Transfer (CHST) in its 2002-2003 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. These documents are available to Health Canada as part of the Additional Materials section.

7.0 Extended Health Care Services

Residential Care Services

Continuing Care Health Services are available to eligible Yukon residents. In 2002-2003, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services:

- personal care;
- extended care services;
- nursing home intermediate care;
- special care;
- respite;
- day program; and
- meals on wheels.

A new continuing care facility was opened in summer 2002 with 72 beds staffed and in operation. Twenty-four additional beds can be made available should future occupancy trends indicate a need.

In total there were 113 continuing care or extended care beds in the Territory in 2002-2003.

No other major changes were made in the administration of these services in 2002-2003.

Home Care Services

The Yukon Home Care Program provides assessment and treatment, personal support, social support, respite services and palliative care. In Whitehorse, services are provided by home support workers, nurses, social workers and therapists. In rural communities, auxiliary home support workers assist clients with personal care and respite services. Services are available Monday through Friday. In Whitehorse, additional services such as planned weekend and evening support may be provided to 9:00 pm during end-stage palliative care. Twenty-four hour care is not provided.

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.

The above services are not provided for in legislation.

In addition to the services described above, the following are also available to eligible Yukon residents 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 Travel for Medical Treatment 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 Mental Health Act 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.
- ***The Ambulance Services Program*** is responsible for the emergency stabilization and transportation of sick and injured persons from an accident scene to the

nearest health care facility capable of providing the required level of care. This is a non-legislated program.

- ***Hearing Services*** provides services designed to help people of all ages with a variety of hearing disorders, through the provision of routine and diagnostic hearing evaluations and community outreach. This is a non-legislated program.
- ***Dental Services*** provides a comprehensive diagnostic, prevent and restorative dental service to children from pre-school to grade eight in Whitehorse and Dawson City. All other Yukon communities receive services for pre-school to grade 12. This is a non-legislated program.

8.0 Additional Materials Submitted to Health Canada

- Listing of uninsured hospital, physician and surgical-dental services
- *Health Care Insurance Plan Act* and Regulations (office consolidation of Act)
- *Hospital Insurance Services Act* and Regulations (office consolidation of Act)
- *Medical Professions Act* and Regulations
- *Hospital Act* and Regulations
- *Mental Health Act* and Regulations
- *Dental Professions Act* and Regulations
- Statement of Revenue and Expenditures: Health Care Insurance Programs (1997-1998 to 2002-2003)
- Yukon Public Accounts – Excerpt of the Auditor General's Report, 2002-2003
- Yukon Public Accounts – Excerpt of consolidated Financial Statements, 2002-2003
- Yukon Budget, 2002-2003
- Program Brochures:
  - *Health Care Outside the Yukon*;
  - *Medical Treatment Travel*;
  - *Hospital Services and Health Care in the Yukon*;
  - *Seniors Health Benefits*;
  - *Chronic Disease and Disability Benefits*; and
  - *Children's Drug and Optical Program*

Northwest Territories

Introduction

The Northwest Territories (NWT) Department of Health and Social Services, together with seven Health and Social Services Authorities (HSSAs), plan, manage and deliver a full spectrum of community and facility-based services for health care and social services. Community health programs include daily sick clinics, public health clinics, home care, school health programs and educational programs. Visiting physicians and specialists routinely visit the communities. Services also include early intervention and support to families and children, mental health, and addictions.

Boards of trustees for each HSSA provide NWT residents with the opportunity to shape priorities and service delivery for their communities. Nurses are the largest group of health care practitioners in the NWT.

Changing Demographics

As of April 1, 2003, there were an estimated 41,719 people in the Northwest Territories, of which half were Aboriginal people.[1] The NWT continues to have a relatively young population and a high birth rate. According to 2002 population estimates, approximately 26 percent of the NWT population is under 15 years of age, compared with 18.5 percent in the overall Canadian population.[2] This population profile supports the continued need to invest in services that target children, youth and young families.

Although the territorial population is comparatively young, it is nonetheless aging. It is expected that in less than 20 years, the number of seniors 65 years of age and older will rise from approximately 1,700 to about 4,600, representing an increase of 170 percent. In contrast, it is expected that the population under 20 years of age will increase by approximately 11 percent over the same period.[3] The demand for health resources among seniors is approximately eight times that of the population under 65.[4] This relates to higher rates of cancer, circulatory diseases, nervous system and sense organ diseases, injuries and respiratory diseases. This growing number of aging residents has a significant impact on services for the elderly such as home and long-term care.

Changing Economic Conditions

Changes in the economic situation in the North continue to have an impact on the health and well-being of residents. Increased employment opportunities, especially in the areas of mining and oil and gas exploration, are having a positive impact on the economy. With this comes increased disposable income, which can result in improved nutrition, safety and security for families. However, the changes in economic conditions have also led to increases in social problems such as abuse of alcohol and gambling.

Studies have shown that the unemployed have a reduced life expectancy and suffer more health problems than the employed. In the NWT's smaller communities, low household income levels and reduced employment opportunities combined with overcrowded housing conditions create stress and unhealthy living conditions. There is also a continued urbanization process occurring, specifically the migration of individuals and families from smaller communities to regional centres, including Yellowknife, in search of employment.

Incidence of Preventable Illness, Injury and Death

Compared with the rest of Canada, the incidence of preventable illness, injury and death continue to be high in the Northwest Territories (*1999 Health Status Report*). Adverse outcomes such as family violence, Fetal Alcohol

1 Statistics Canada, Quarterly Population Estimates and Statistics Canada, 2001 Census.

2 Statistics Canada, CANSIM II, Table 051-0001, June 2003.

3 NWT Bureau of Statistics, Custom Population Projections, 2000.

4 Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01* (August 2001).

Spectrum Disorder and many forms of cancer are linked to poor lifestyle choices made by individuals regarding diet, degree of physical activity or the use of alcohol, tobacco and drugs. Injuries and deaths associated with injuries are often the result of risky behaviour. The underlying causes of many acute and long-term care needs are linked to poverty, low educational achievements, unemployment and low self-esteem, all of which can lead to poor coping skills.

Even though there is a downward trend in the rest of Canada, tobacco use continues to be a serious public health concern in the NWT. Smoking rates in the NWT are among the highest in Canada. The implications for health care costs and human costs in terms of death and disability are significant and rising.

Increases in Health Care and Social Services Costs

Many factors continued to affect the demand for resources. These factors include, but are not limited to, demographics, recruitment and retention of health professionals, compensation packages, new technologies, pharmaceuticals and medical practices, increased incidence of chronic and new diseases and public expectations. Increasing costs continue to place pressure on the system.

Maintaining a Sustainable System

In February 2002, the Minister of Health and Social Services released the *Health and Social Services System Action Plan 2002-2005.* The *Action Plan* is based on reports and evaluations conducted over the past eight years and builds on the principles and vision of the Department's 1998 strategic plan, *Shaping Our Future.* The *Action Plan* outlines 45 action items, with specific commitments, timelines and deliverables.

Public status reports have been issued every six months. As of March 2003 (fiscal year-end), 18 of the 45 action items were completed. The specific deliverables and timelines for improvements are in the following areas:

- services to people;
- support to staff;
- system-wide management;
- support to trustees; and
- system-wide accountability.

Information Technology

Considering the relatively small population distributed over a large and isolated area, the NWT is using new information technologies as a means to improve communications between communities. However, these are the same factors that make it costly and difficult to provide and maintain technological solutions in the NWT.

Data quality and integrity continue to be a challenge in the NWT. It has become increasingly important that new integrated information systems created for the Department and the HSSA's be developed recognizing issues related to client privacy. Vendors are responding to these challenges by improving the access and security facilities in new applications and infrastructures. The NWT is moving forward to harness these new opportunities as quickly as its financial resources permit.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The name of the plan in the NWT is The Northwest Territories Health Care Plan, which includes the Medical Care Plan and the Hospital Insurance Plan. The public authority responsible for the administration of the Medical Care Plan is the Director of Medical Insurance as appointed under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan either through Boards of Management established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act (HIHSSA)* or pursuant to section18 of the same Act, which allows the Minister to approve a contract for the management of health and social services facilities.

Legislation that enables the Plan in the Northwest Territories includes the *Medical Care Act* (revised 1988) and the *Hospital Insurance*

and Health and Social Services Administration Act (revised 2002). In October 2002, minor amendments were made to both the *Medical Care Act* and the *Hospital Insurance and Health and Social Services Administration Act* to clarify subrogation provisions. In January 2001, sections of the *Medical Care Act* Regulations pertaining to fee schedules were amended to reflect the negotiated contract between the NWT Medical Association and the Department of Health and Social Services. Contract negotiations, which began in October 2002, will result in amendments to the fee schedule in 2003.

The powers of the Minister are outlined in section15 of the *Hospital Insurance and Health and Social Services Administration Act* and the Minister's mandate is further described in the Establishment Policy for the Department of Health and Social Services.

1.2 Reporting Relationship

In the Northwest Territories, the Minister of Health and Social Services appoints a Director of Medical Insurance. The Director is responsible for the administration of the *Medical Care Act* and the regulations. The Director must report to the Minister each fiscal year respecting the operation of the Medical Care Plan.

The Minister also appoints members to a Board of Management for each facility located throughout the Northwest Territories. Boards of Management are established under section 10 of the *Hospital Insurance and Health and Social Services Administration Act* or under the *Societies Act*. The Boards are established with the authority to manage, control and operate health and service facilities and, subject to the *Financial Administration Act* (revised 2002), exercise any powers necessary and incidental to these duties. The Boards' chairpersons hold office during the pleasure of the Minister, while the remaining members typically hold office for a term of three years, to a maximum of three consecutive terms.

Pursuant to the *Financial Administration Act*, an annual audit of accounts is done at each Board of Management. The Minister has regular meetings with chairpersons of the Boards of Management. 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 Auditor General of Canada (AGC) has the mandate to audit the payments made under the Medical Care Plan. As part of the Public Accounts Audit, the AGC also audits the Hospital Insurance Plan.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and the Regulations. During 2002-2003, four hospitals and 28 health centres delivered insured hospital services to both in- and out-patients.

The Northwest Territories provides a full range of insured hospital services. Boards of Management have the authority to provide services above those considered medically necessary, although those services are not covered by the insurance plans. NWT 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 provide 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 Hospital Insurance Regulations states that "out-patient insured services" means the following services and supplies are given to out-patients:

- laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of 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 the hospital;
- use of operating room and anaesthetic facilities including necessary equipment and supplies;
- routine surgical supplies;
- services rendered by persons who receive remuneration for those services from the hospital;
- use of radiotherapy facilities; and
- use of physiotherapy facilities.

The Minister may add insured hospital services to the Regulations. As such, on the Minister's recommendation, the Commissioner may make Regulations prescribing the in- and out-patient services that insured persons are eligible for and entitled to. The Minister also determines if any public consultation will occur prior to making changes to the list of insured services.

Where insured services are not available in the Northwest Territories, NWT residents can receive them from hospitals in other jurisdictions. These services must be medically necessary and can include hospital-to-hospital transfer as well as referral from physicians. The NWT provides medical travel assistance, a supplementary health benefit program outlined in the Medical Travel Policy, which ensures that NWT residents can have access to medically required services.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide for insured physician services. Only medical doctors, as medical practitioners, are allowed to deliver insured physician services in the NWT. The physician must be licensed to practice in the NWT.

A wide range of medically necessary services are provided in the NWT. No limitation will be 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.

Following negotiations between the NWT Medical Association and the Director of Medical Insurance, additional medical services may be considered for inclusion to the fee schedule Regulation. It is the responsibility of the Director of Medical Insurance to manage the process of adding or deleting a medical service and to determine if public consultations are appropriate before changes are made to the approved schedules. However, it is the Minister who makes the determination to add or delete insured hospital services to the Regulations. On the recommendation of the Minister, the Commissioner may approve Regulations as follows:

- "establishing a Medical Care Plan for providing to insured persons insured services by medical practitioners that will in

all respects qualify and enable the Territories to receive payments of contributions from the Government of Canada under the *Canada Health Act*;

- "prescribing rates of fees and charges that may be paid in respect of insured services rendered by medical practitioners whether in or outside the Territories, 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 oral surgeons may submit claims for billing. During the reporting period, there was no oral surgeon in the NWT. As a result, the NWT used the Province of Alberta 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 health care insurance plan of the NWT, include:

- medical-legal services;
- third-party examinations;
- services not medically required;
- group immunization;
- *in-vitro* fertilization;
- services provided by a doctor to his or her own family;
- 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 approvals of uninsured medical goods or services provided in conjunction with an insured health service must adhere to the procedure in place. The procedure includes seeking advice from the Medical Advisor. The Medical Advisor is appointed to provide medical expertise to the Director of Medical Insurance. This approach does not compromise reasonable access to insured services for NWT residents.

The NWT *Medical Care Act* includes Medical Care Regulations as well as a Physician Fee schedule. This Act also provides for the authority to negotiate changes or deletions to the Physician Fee Schedule. The process was described in section 2.2 of this report.

3.0 Universality

3.1 Eligibility

The *Medical Care Act* is the legislation that defines the eligibility of Northwest Territories residents to the NWT Health Care Insurance Plan.

The Northwest Territories uses the Interprovincial Agreement on Eligibility and Portability in conjunction with the Northwest Territories Health Care Plan Registration Guidelines to define eligibility. No changes to eligibility have been implemented in 2002-2003.

Ineligible individuals for Northwest Territories health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police, federal inmates and residents who have not completed the minimum waiting period.

3.2 Registration Requirements

Registration requirements include a completed application form and supporting documentation as applicable, e.g. visas and immigration papers. The applicant must be prepared to provide proof of residency if requested. Registration should optimally occur prior to the actual eligibility date of the client. Health care cards are renewed every two years. There is a direct link between registration and eligibility for coverage. Claims are not paid for clients who do not have valid registration.

As of August 18, 2003, there were 39,714 individuals registered with the Northwest Territories Health Care Plan. The registered number is from the NWT Department of Health and Social Services health care plan registration database. At any point in time, it is possible for more people to be registered than actually live in the NWT. For example, people do not always immediately inform the Department when they have moved out of the NWT.

No formal provisions are in place for clients to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they hold valid visas for a period of 12 months or more.

4.0 Portability

4.1 Minimum Waiting Period

There are waiting periods imposed on insured persons moving to the Northwest Territories. 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 Northwest Territories Health Care Plan Registration Guidelines define the portability of health insurance during temporary absences within Canada.

Coverage is provided to students who are temporarily out of the Northwest Territories for full-time attendance in a post-secondary institution, and for up to one year for individuals who are temporarily absent from the Northwest Territories for work, vacation, secondments, etc. Once an individual has completed a Temporary Absence form and been approved by the Department of Health and Social Services as being temporarily absent from the Northwest Territories, the full cost of insured services is paid for all services received in other jurisdictions.

The Northwest Territories participates in both the Hospital Reciprocal Billing Agreements and the Medical Reciprocal Billing Agreements with other jurisdictions.

4.3 Coverage During Temporary Absences Outside Canada

The Northwest Territories Health Care Plan Registration Guidelines set the criteria to define coverage for absences outside Canada.

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 will be required to cover their own costs and seek reimbursement upon their return to the NWT. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

Individuals may be granted coverage for up to a year if they are outside the country, with prior approval. During the reporting period, no one was granted authorization to continue with their NWT Health care coverage while remaining outside Canada for up to one year. In the

eligibility rules, NWT residents may continue their coverage 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. Because there was no one covered by this clause, no payments were required. The rates are the same as those contained in the Fee Schedule for physicians and the hospital out- or in-patient rate.

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 Supplementary Health Benefit Program ensures that economic barriers are reduced for all Northwest Territories residents. As per section 14 of the *Medical Care Act*, extra-billing is not allowed.

5.2 Access to Insured Hospital Services

Beds were accessible during the reporting period. If bed shortage was 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 operations. However, through the use of medical travel arrangements, access to services was maintained throughout 2002-2003.

Facilities in the NWT do offer a range of medical, surgical, rehabilitative and diagnostic services. The NWT medical travel program ensures that residents may have access to necessary services not available in NWT facilities.

In order to improve access to insured hospital services, the NWT continued its expansion of the telehealth program in 2002-2003. A number of steps were taken to ensure that installation of equipment and the upgrading of the three existing WestNet sites (Inuvik, Fort Smith and Yellowknife) and the addition of four communities (Deline, Fort Simpson, Hay River and Holman) were completed. In addition, four sites were equipped in 2002-2003 to support telecare to three communities (Fort Resolution, Lutse'ke and Yellowknife).

In December 2002, the Government of the NWT announced an investment of an additional $8.3 million in human resources for the health and social services system. The new resources were dedicated to the creation of 42 new positions for nurses, physicians, nurse practitioners and midwives as well as training and mentorship programs for current health professionals. This investment builds on a Recruitment and Retention Plan for NWT Allied Health Professionals, Nurses and Social Workers (released in November 2002) to enhance professional development and educational opportunities, as well as employee supports.

5.3 Access to Insured Physician and Surgical-Dental Services

All residents of the Northwest Territories have access to all facilities operated by the Government of the Northwest Territories.

The medical travel program provides access to physicians for residents and the telehealth program has provided an expansion of specialist services to residents in isolated communities.

5.4 Physician Compensation

The *Medical Care Act* and the Medical Care Regulations are used in the Northwest Territories to govern payments to physicians. To compensate physicians, the NWT uses two models: fee-for-service and employee contracts. The majority of family physicians are employed through a contractual arrangement with the Northwest Territories, the remaining provide services through a fee-for-service arrangement.

Physician compensation is determined for physician contracts and fee-for-service scheduled through negotiations between the Northwest Territories Medical Association and

the Department of Health and Social Services. The Director of Medical Insurance and his or her designates negotiate on behalf of the Department. The Northwest Territories Medical Association chooses a negotiation team from within their membership. The NWT Fee Schedule, General Practitioner contract and the specialists contract for the Stanton Territorial Heath Authority are set to expire March 31, 2004.

5.5 Payments to Hospitals

Payments made to hospitals are based on contribution agreements between the Boards of Management and the Department of Health and Social Services. Amounts allocated in the agreements are based upon the resources available in the total government budget and level of services provided by the hospital.

Payments to facilities providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act.* No amendments were implemented in 2002-2003 to provisions involving payments to facilities. A global budget is used to fund hospitals in the Northwest Territories.

6.0 Recognition Given to Federal Transfers

Federal funding received through the Canada Health and Social Transfer has been recognized and reported by the Government of the Northwest Territories through press releases and various other documents. For fiscal year 2002-2003, these documents included:

- 2002-2003 Budget Address;
- 2002-2003 Main Estimates;
- 2001-2002 Public Accounts; and
- 2002-2005 Business Plan for the Department of Finance

The Estimates noted above represent the financial plan of the Government and is presented each year by the Government to the Legislative Assembly.

7.0 Extended Health Care Services

7.1 Nursing Home Intermediate Care and Adult Residential 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 *Hospital Insurance and Health and Social Services Administration Act* and the Hospital 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 territorial-wide program established to provide effective, reliable and responsive community health care services to support independent living; to develop appropriate care options to support continued community living; and to facilitate admission to institutional care when community living is no longer a viable alternative. Home care services are delivered through the Regional Health and Social Services Authorities and include a broad range of services based on a multi-disciplinary assessment of individual needs. The Home Care Program is currently offered by six of the Health and Social Services Authorities: Yellowknife; Hay River; Fort Smith; Inuvik; Deh Cho; and Dogrib.

8.0 Additional Materials Supplied to Health Canada

The NWT health and social services system has been extensively reviewed over the past ten years. This includes the Legislative Assembly's Special Committee on Health and Social Services (1993), the Med-Emerg Review (1997) and the Minister's Forum on health and Social Services. During the reporting period, the Minister of Health and Social Services took into account these reviews in the actions identified in the *NWT Health and Social Services System Action Plan.* Copies of the Action Plan, six month status reports and other materials produced by the NWT Department of Health and Social Services can be found at:
www.hlthss.gov.nt.ca

In addition, NWT legislation, regulations and other documents, such as the Main Estimates, can be found at:
www.gov.nt.ca

As well, NWT health legislation and regulations can be found on the Department of Health and Social Services Web site at:
www.hlthss.gov.nt.ca

Other documents, such as the Business Plans, Main Estimates and Public Accounts, can be found on the financial Management Board Secretariat Web site at:
www.gov.nt.ca/FMBS/

Nunavut

Introduction

Nunavut was formed as a Territory on April 1,1999. The Territory covers one-fifth of Canada's total landmass. There are twenty-six communities situated across three time zones. The Territory is divided into three regions: the Baffin, which consists of 13 communities; the Kivalliq, which consists of eight communities; and the Kitikmeot, which consists of five communities. According to recent statistics, the population of Nunavut is 29,384. Approximately 40 percent of the population is under the age of 25. Inuit make up the majority at about 85 percent of the residents. There is a small French-speaking population of about four to six percent residing on Baffin Island, predominantly in the capital city of Iqaluit. Nunavut has a highly transient workforce, in particular skilled labourers and other 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 *Nunavut Act* (1999). Over the coming years, the Department of Health and Social Services plans to review all existing legislation to ensure its relevancy and appropriateness for the Government of Nunavut as set out in the objectives of the Bathurst Mandate. The Bathurst Mandate outlines the Government's agenda to achieve healthy communities, simplicity and unity, self-reliance and continuous learning. The incorporation of traditional Inuit values, known as Inuit Qaujimajatuqangit, in program policy development, service design and delivery, is an expectation placed on all departments.

The delivery of health services in Nunavut is based on a primary health care model. There is a local health centre in each of the 25 communities across Nunavut, as well as one regional hospital in Iqaluit. The primary health care providers are nurses with expanded scopes, with the exception of 14.5 full-time family physicians; eight in the Baffin region; 4.5 in the Kivalliq region; two in the Kitikmeot region. Nunavut relies heavily on the Northern Medical Unit of the University of Manitoba, Ottawa Health Services Network Inc. and Stanton Regional Hospital in Yellowknife for the majority of its physician and specialist services.

The management and delivery of health services in Nunavut were integrated into the overall operations of the Department on March 31, 2000, when the former boards (Baffin, Kitikmeot and 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, which 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 2002-2003 was $166,133,000, including approximately $15 million allocated for capital. Only the Department of Education has a higher budget.

In 2002-2003, Nunavut upgraded its five existing telehealth sites and added an additional 10 telehealth communities to its network with funds from the Canadian Health Infostructure Partnership Program. The Department of Health and Social Services will soon learn if it will receive an additional $2.7 million from the Primary Health Care Transition Fund. This would allow for the addition of seven communities to the telehealth network, bringing the total to 22 communities. These communities receive a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education.

Nunavut has many unique needs and challenges with respect to the health and well-being of its residents. Approximately one-fifth of the Department's budget is spent on medical travel. Due to the very low population density in this vast territory and limited health infrastructure (equipment and health human resources), access to a range of hospital and specialist services often requires that residents be sent out of the Territory. A new regional hospital in Iqaluit and new regional health facilities in Rankin Inlet and Cambridge Bay, that will be built over the next three years, will enable Nunavut to build internal capacity and

enhance the range of services that can be provided within the Territory. There continue to be high rates of respiratory diseases such as tuberculosis. Nunavut continues to be challenged by the acute shortage of nurses, despite aggressive national and international recruitment and retention activities. Recruitment and retention of other health care professionals such as social workers, physicians and physiotherapists is also a challenge.

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, importance of traditional foods, etc.

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 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 for the fiscal year 2002-2003.

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. In November 2002, the Auditor General released the audit report for 2000-2001 entitled *2002 Annual Report to the Nunavut Legislative Assembly*.

2.0 Comprehensiveness

2.1 Insured Hospital Services

Insured Hospital Services are provided in Nunavut under the authority of the *Hospital and Social Services Administration Act and Regulations,* sections 2 to 4. No amendments were made to legislation or Regulations in 2002-2003.

In 2002-2003, insured hospital services were delivered in 26 facilities throughout Nunavut, including a general hospital located in Iqaluit and 25 community health centres. The Baffin Regional Hospital in Iqaluit is the only acute care facility in Nunavut providing a range of in- and out-patient hospital services as defined by the *Canada Health Act*. Community health centres provide public health, out-patient services, emergency room services and some overnight services (observations). There are also a limited number of birthing beds at the

Rankin Inlet Birthing Centre. Public health services are provided at a Public Health Clinic 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, 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 2002-2003 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 legislation or Regulations in 2002-2003.

Medical doctors are the only medical practitioners permitted to deliver insured physician services in Nunavut. The physician must be in good standing with a College of Physicians and Surgeons and be licensed to practise in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. There are a total of 14.5 full- time family physicians in Nunavut (eight in the Baffin region; 4.5 in the Kivalliq region; 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, 2003, Nunavut had 176 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 2002-2003, no physicians provided written notice of this election.

Insured physician services means 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.

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 additions or deletions were added in 2002-2003.

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 the purpose of billing the Plan for the provision of insured dental services. In 2002-2003, three 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.

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 2002-2003.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided for under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act,* are excluded.

Services provided by physicians that are not insured include:

- yearly physicals;
- cosmetic surgery;
- services that are considered experimental;
- prescription drugs;
- physical examinations done at the request of a third party;
- optometric services;
- dental services other than specific procedures related to jaw injury or disease;
- the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and
- physiotherapy, speech therapy and psychology services, received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include:

- hospital charges above the standard ward rate for private or semi-private accommodation;
- services that are not medically required, such as cosmetic surgery;
- services that are considered experimental;
- ambulance charges (except inter-hospital transfers);
- dental services, other than specific procedures related to jaw injury or disease; and
- alcohol and drug rehabilitation, unless has prior approval.

The Baffin Regional Hospital charges $2,180.25 per diem for services provided for non-Canadian resident stays.

When residents are sent out of the Territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see 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 for Inuit and First Nations.

3.0 Universality

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under section 3(1)(2)(3) of the *Medical Care Act*. The Department also adheres to the Inter-Provincial/Territorial Agreement on Eligibility and Portability as well as internal guidelines. No amendments were made to the legislation or Regulations in 2002-2003.

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 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/Territorial 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. Nunavut will be going to a staggered renewal process once a new health claims system is put into place next fiscal year. 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, 2003, 28,039 residents were registered with the Nunavut Health Care Plan. Nunavut's population statistics as published by Statistics Canada include a number of "temporary residents" who are not eligible for coverage under the Territory's health plan. There are no formal provisions for Nunavut residents to opt out of the health care insurance plan.

3.3 Other Categories of Individual

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessment is done on an individual basis. This is consistent with section 15 of the NWT's Guidelines for Health Care Plan Registration, which were 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 2002-2003 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure coverage continues. 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 receipt of 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. Agreements are in place with other provinces and territories (Ontario, Manitoba, Alberta and the Northwest Territories).

The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the Territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Coordinating Committee on Reciprocal Billing. A special agreement exists between the Northwest Territories and Nunavut Territory which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (Western Arctic).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents 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 $22,547,986.26 in the fiscal year 2002-2003.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $1,396 per diem and $110 for out-patient care. No changes were made to these rates in 2002-2003.

In 2002-2003, Nunavut paid a total of $586.75 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 the one acute care hospital facility in Nunavut. The hospital has 25 beds available for acute, rehabilitative, palliative and chronic care services. The hospital has a staff of 101, including seven physicians, one surgeon and 37 nurses. 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, intensive care services, respiratory services, cardiovascular care, maternity, palliative care, gastrointestinal bleeds and hypertension treatment. 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 (Manitoba), Winnipeg, Edmonton and Yellowknife to provide insured services to referred patients.

Outside the Baffin Regional Hospital, out-patient and 24-hour emergency services are provided by all 25 health centres located in the communities.

Although nursing and other health professionals were not at the desired levels of staffing, all basic services were provided in 2002-2003. Nunavut is seeking to increase resources in all areas.

The use of telehealth services has been a significant step in improving access to hospital, medical and other health and social services in Nunavut. To date, telehealth facilities are active in 15 communities with a goal of expanding to seven more communities in 2003-2004. 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 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, linking 15 communities, allows for the delivery of a broad range of services: specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education. In 2002-2003, Nunavut had 176 physicians registered, of which 170 had an annual license and six had limited a license (less than one year).

The following specialist services were provided under the visiting specialists program: ophthalmology, orthopaedics, internal medicine, otolaryngology, neurology, rheumatology, dermatology, paediatrics, obstetrics, physiotherapy, occupational therapy, psychiatry and dental surgery. Visiting specialist clinics are held depending on demand and availability of specialists.

5.4 Physician Compensation

There is one fee-for-service physician residing in Nunavut. Because fee-for-service physicians pay the expenses of running a practice in an isolated community, they are paid a rate 20

percent greater than the amounts set out in the schedule (per the *Medical Care Act,* section 4). The fees are negotiated between the Department of Health and Social Services and the physician, and are based on the NWT standards. The remaining physicians are on contract at a per-diem rate or are on salary. Visiting specialists are paid on a per diem-basis under the terms of their contracts.

5.5 Payments to Hospitals

Funding for the Baffin Regional Hospital and the 25 community health centres 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 will be given this year when the Director of Medical Care presents the 2002-2003 annual report to the Minister.

7.0 Extended Health 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. Services include basic housekeeping support, meal preparation and assistance with daily living.

Intermediate care is available at St. Theresa's Home in Chesterfield Inlet. The facility provides 24-hour care and is fully staffed with professional and para-professional personnel. Nursing services are 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 Iqaluit and Arviat's Elders Homes. These facilities provide the highest level of long-term care in Nunavut; that is, extensive chronic care services up to the point of acute care (levels 4 and 5) services. Acute care cases are transferred to the closest hospital.

8.0 Additional Materials Submitted to Health Canada

2002 Annual Report to the Nunavut Legislative Assembly
http://www.oag-bvg.gc.ca/domino/reports.nsf/html/01nunavut_ehtml/$file/02english.pdf

Budget Address 2003-2004
http://www.gov.nu.ca/baeng.pdf

Department of Health and Social Services Main Estimates 2003-2004
http://www.gov.nu.ca/Nunavut/English/budget/2003/hss.pdf

Department of Health and Social Services Capital Estimates 2003-2004
http://www.gov.nu.ca/Nunavut/English/budget/2003/capital/hss.pdf

Department of Health and Social Services Business Plan 2003-2004
http://www.gov.nu.ca/Nunavut/English/budget/2003/bp/hss.pdf

Public Accounts 2000-2001
http://www.gov.nu.ca/Nunavut/English/research/gpa.pdf

Annex A – Provincial and Territorial Health Care Insurance Plan Statistics

Introduction

The purpose of this Annex is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the Act.

The Annex contains statistical data on the cost and utilization of insured hospital, physician and surgical- dental services for each province and territory for the five consecutive fiscal years ending on March 31 of 1998-1999, 1999-2000, 2000-2001, 2001-2002 and 2002-2003.

The information has been provided by provincial and territorial officials. In order to ensure consistency in reporting, Health Canada provided provincial/territorial governments with a user's guide outlining what and how to provide the information. The user's guide was prepared in consultation with representatives in each provincial and territorial government.

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

Figures presented in the statistical annex are provided to Health Canada by provincial and territorial government authorities on a cooperative basis. Provincial and territorial governments are responsible for the quality and completeness of the data they provide. The *Ministère de la Santé et des Services sociaux du Québec* and the Alberta Department of Health and Wellness have chosen not to present Health Canada with statistics for this annex. Numbers appearing in the 2002-2003 column of the Alberta section of this annex were culled by Health Canada from the narrative description of Alberta's health care insurance plan description in chapter 3.

For a discussion of the associated programs on which the data in these tables are based, please refer to Chapter 3 – Provincial and Territorial Health Care Insurance Plans in 2002-2003.

Organization of the Information

Information in the tables on the following pages is organized into provincial and territorial sections of this annex and grouped according to the eight subcategories described below. In some cases data were not yet available and estimates were provided. In other cases, the requested statistics did not apply to the particular province or territory or were not available.

Registered Persons

Registered persons are the number of residents registered with the health care insurance plans of each province or territory. These estimates can be assessed with respect to the universality criterion of the *Canada Health Act* to assist Canadians, governments and stakeholders in reviewing the extent to which residents of provinces and territories have registered for coverage or chosen to opt out of their jurisdiction's health care insurance plan.

Insured Hospital Services within Own Province or Territory

Statistics on the provision of insured hospital services within each jurisdiction to residents of the jurisdiction and to visitors from other provinces or territories are provided in fields 2 through 13.

Details include numbers of facilities by type of care provided; number of beds; number of separations (i.e. persons released or discharged from health facilities); average length of stay; total payments in the province/territory per category of care; average cost per visit by type of care; and the number of, and payments to, private for-profit health care facilities.

These statistics are collected and presented to provide insights and understanding on how each provincial and territorial health insurance plan meets the requirements of the accessibility criterion of the *Canada Health Act* as it applies to insured hospital services.

Insured Hospital Services Provided to Residents in Another Province or Territory

This subsection 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. The information reported includes the total number of claims paid for insured hospital services in other provinces or territories, total payments made, and the average payment level.

These statistics can assist the federal Minister of Health in assessing provincial and territorial compliance with the in-country portability provisions in section 11(b)(i) of the *Canada Health Act* as they apply to insured hospital services.

Insured Hospital Services Provided Outside Canada

Hospital services provided out-of-country represent a person's hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are of the same type as hospital services provided out-of-province or out-of-territory.

These statistics can assist Canadians and the federal Minister of Health assess provincial and territorial compliance with the out-of-country portability provisions in section 11(b)(ii) of the *Canada Health Act* as they relate to insured hospital services.

Insured Surgical-Dental Services within Own Province or Territory

The information in this subsection describes insured surgical-dental services provided in each province and territory. This includes the number of participating professionals (dentists, dental surgeons, and oral surgeons); the number of services provided; total payments made in the fiscal year; and the average payment per service.

These statistics relate principally to the assessment of a province's or territory's compliance with the accessibility criterion of the *Canada Health Act* as it applies to insured surgical-dental services.

Insured Physician Services within Own Province or Territory

Statistics in this subsection relate to the provision of insured physician services to residents in each province or territory as well as to visitors from other regions of Canada.

Details include the number of physicians participating in the provincial or territorial health insurance plan; the number of physicians opted-out or not participating in the plan; the number of insured services provided; the total payments made to physicians by category of physician and by category of service; and the average payment level per insured physician service.

These statistics relate principally to the assessment of a province's or territory's compliance with the accessibility criterion of the *Canada Health Act* as it applies to insured physician services.

Insured Physician Services provided to Residents in Another Province or Territory

This subsection reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents. Statistics include the number of services paid, total payments made, and the average payment level per service.

These statistics can assist the federal Minister of Health in assessing provincial and territorial compliance with the in-country portability provisions in section 11(b)(i) of the *Canada Health Act* as they apply to insured physician services.

Insured Physician Services Provided Outside Canada

Physician services provided out-of-country represent a person's medical costs incurred while travelling outside of Canada that are paid for by their home province or territory. Statistics reported in this subsection are the same as for physician services provided out-of-province or out-of-territory.

These statistics can assist Canadians and the federal Minister of Health assess provincial and territorial compliance with the out-of-country portability provisions in section 11(b)(ii) of the *Canada Health Act* as they relate to insured physician services.

Newfoundland and Labrador

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	622,744	618,118 [1]	616,944 [2]	565,000 [3]	560,644 [4]

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	33	33	32	32	32
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	33	33	32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	1,814	1,807	not available	not available	not available
b. chronic care	0	0	0	0	0
c. rehabilitative care	62	57	not available	not available	not available
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total staffed beds	1,876	1,864	1,643	1,670	1,677
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	1,814	1,807	not available	not available	not available
b. chronic care	0	0	0	0	0
c. rehabilitative care	62	57	not available	not available	not available
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total approved bed complement	1,876	1,864	1,643	1,670	1,677

[1] Data are as of March 1, 2000.

[2] Data are as of April 11, 2001.

[3] Data as of April 30, 2002.

[4] Data as of April 15, 2003.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	68,729	66,828	not available	not available	not available
b. chronic care	0	0	0	0	0
c. rehabilitative care	227	272	not available	not available	not available
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care	0	0	0	0	0
f. alternative level of care	0	0	0	0	not available
g. newborns	0	0	0	0	not available
h. other	0	0	0	0	not available
i. total separations	68,956	67,100	not available	not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	7.50	7.40	not available	not available	not available
b. chronic care	0.00	0.00	0.00	0.00	0.00
c. rehabilitative care	not available	not available	not available	not available	not available
d. newborns	0.00	0.00	0.00	0.00	0.00
e. other	0.00	0.00	0.00	0.00	0.00
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	457,065,782	509,018,766	537,428,824	619,884,087	672,874,609 [5]
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total payments to facilities providing insured hospital services	457,065,782	509,018,766	537,428,824	619,884,087	672,874,609 [5]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	690.00	690.00	705.00	725.00	850.00 [6]
b. chronic care	0.00	0.00	0.00	0.00	0.00
c. rehabilitative care	0.00	0.00	0.00	0.00	0.00
d. other	0.00	0.00	0.00	0.00	0.00

[5] 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.

[6] New methodology for 2002-2003.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		1	1	1	1	1
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		212,990	387,030	270,750	338,200	286,425
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		212,990	387,030	270,750	338,200	286,425

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	1,826	1,549	1,699	1,681	1,588
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	28,739	25,546	24,929	26,155	26,464
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	12,037,091	10,144,354	10,608,368	10,312,515	10,817,595
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	3,316,482	3,138,582	3,047,375	3,213,978	3,488,186
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	6,592.00	6,549.00	6,244.00	6,135.00	6,812.00
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	115.00	123.00	122.00	123.00	132.00

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	42	73	111	62	61
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	363	260	287	258	278
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	503,043	198,072	1,102,540	123,692	269,963
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	56,614	15,626	36,260	22,567	18,432
24. Average payment for out-of-country, in-patient insured hospital services.	($)	4,997.00	2,713.00	9,933.00	1,995.00	4,426.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)	156.00	60.00	126.00	87.00	66.00

Insured Surgical-Dental Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan. (#)	30	35	35	26	33
27. Number of insured surgical-dental services provided by participating dentists. (#)	10,000	9,000	11,000	10,000	11,000
28. Total payments to dentists for insured surgical-dental services. ($)	374,000	354,000	389,000	409,000	419,000
29. Average payment per service for insured surgical-dental services. ($)	38.34	38.73	35.06	39.82	37.76

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician: [7] (#)					
a. general practitioners	not available	432 [8]	437 [8]	448 [8]	478 [8]
b. specialists	not available	480 [8]	485 [8]	504 [8]	500 [8]
c. other	not available	not applicable	not applicable	not applicable	not applicable
d. total	not available	912 [8]	922 [8]	952 [8]	978 [8]
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	0	0	0	0	0
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	0	0	0	0	0

[7] Excludes inactive physicians.

[8] Total Salaried and Fee-for-service.

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	2,471,000	2,489,000	2,340,000	2,263,000	2,147,000
b. specialists	2,440,000	2,443,000	2,318,000	2,218,000	2,206,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	4,911,000	4,932,000	4,657,000	4,481,000	4,353,000
34. Number of insured physician services provided, by category of service: [9] (#)					
a. medical	3,107,000	3,104,000	2,878,000	2,728,000	2,607,000
b. surgical	487,000	468,000	433,000	398,000	379,000
c. diagnostic	1,317,000	1,361,000	1,346,000	1,345,000	367,000
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	4,911,000	4,932,000	4,657,000	4,481,000	4,353,000
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	41,521,000	42,429,000	43,251,000	42,751,000	50,961,000
b. specialists	71,640,000	72,780,000	73,239,000	75,177,000	78,157,000
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	113,161,000	115,209,000	116,490,000	117,928,000	129,118,000
36. Total payments to physicians for insured physician services, by category of service: [9] ($)					
a. medical	not available	72,500	71,987	not available	not available
b. surgical	not available	10,923	10,834	not available	not available
c. diagnostic	not available	31,786	33,670	not available	not available
d. other	not available	not applicable	not applicable	not applicable	not available
e. total	113,161,000	115,209,000	116,490,000	117,928,000	not available
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	16.80	17.05	18.49	18.89	23.74
b. specialists	29.36	29.79	31.60	33.90	35.43
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	23.04	23.36	25.01	26.32	29.66
38. Average payment per service for insured physician services, by category of service: [9] ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not applicable	not applicable	not applicable	not available	not available
e. all services	23.04	23.36	25.01	26.30	not available

[9] Fee-for-Service.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	171,000	161,000	173,000	143,000	143,000
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	4,241,000	4,327,000	4,562,000	4,082,000	4,231,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	24.77	28.41	26.35	28.56	29.57

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	4,000	4,000	6,000	4,000	3,000
43. Total payments for out-of-country insured physician services.	($)	65,000	107,000	424,000	67,000	172,000
44. Average payment per service for out-of-country insured physician services.	($)	17.25	19.61	70.16	16.37	54.30

Prince Edward Island

Registered Persons						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	130,004	134,006	138,205	140,001	141,031

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		7	7	7	7	7
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities		7	7	7	7	7
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		470	470	470	479	474
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		566	566	566	575	575
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		470	470	470	479	474
b. chronic care		57	57	57	57	57
c. rehabilitative care		20	20	20	20	20
d. out-patient diagnostic care		19	19	19	19	19
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		566	566	566	575	575

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	18,644	17,796	18,280	16,409	16,335
b. chronic care	not available	not available	not available	not available	not available [1]
c. rehabilitative care	377	360	329	336	387
d. out-patient diagnostic care	not available	not available	not available	not available	not available [1]
e. surgical day care (out-patient)	6,250	6,186	not available	not available	not available [1]
f. alternative level of care	not available	not available	267	274	not available
g. newborns	not available	not available	1,363	1,356	1,362
h. other	not applicable	not applicable	not applicable	not applicable	not applicable
i. total separations	25,271	24,342	20,239	18,375	18,084
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	7.90	8.40	8.20	8.10	7.90
b. chronic care	not available	not available	not available	not available	not available [1]
c. rehabilitative care	19.00	18.00	20.00	13.00	13.80
d. newborns	not available	not available	not available	4.00	not available
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	101,600,000	104,000,000	106,774,200	109,128,000	115,697,000
b. chronic care	not applicable	not applicable	not applicable	900	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services	101,600,000	104,000,000	106,774,200	109,128,900	115,697,000
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	689.81	695.72	not available	not available	not available
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable

[1] Regional Health Authorities do not provide this information to the Prince Edward Island Department of Health and Social Services, therefore data are not available.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not available	not available	not available	not available	not available [2]
e. surgical day care (out-patient)		not available	not available	not available	not available	not available [2]
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available [2]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable

[2] Payments to facilities are not separated by in-patient and out-patient services.

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [3]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (In Canada).	(#)	2,279	1,812	1,903	2,220	2,059
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (In Canada).	(#)	16,457	14,428	14,839	17,572	16,790
16. Total payments for out-of-province/territory, in-patient, insured hospital services (In Canada).	($)	12,300,000	10,600,000	10,127,380	9,417,000	11,713,751
17. Total payments for out-of-province/territory, out-patient, insured hospital services (In Canada).	($)	2,600,000	2,300,000	2,380,567	2,930,100	2,879,064
18. Average payment for out-of-province/territory, in-patient insured hospital services (In Canada).	($)	5,397.00	5,850.00	5,322.00	4,242.00	5,689.00
19. Average payment for out-of-province/territory, out-patient insured hospital services (In Canada).	($)	158.00	160.00	160.00	167.00	171.00

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [3]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	27	21	30	26	23
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	102	106	112	85	152
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	50,100	53,800	54,180	123,127	79,577
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	11,700	21,700	43,494	13,702	25,954
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,856.00	2,561.00	1,806.00	4,736.00	3,459.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)	115.00	205.00	388.00	161.00	171.00

[3] Preliminary data as of November 2003. Figures are subject to change when additional hospital service claims, for 2002-2003, are received by PEI.

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	2	2	2	2	2
27. Number of insured surgical-dental services provided by participating dentists.	(#)	400	176	145	176	312
28. Total payments to dentists for insured surgical-dental services.	($)	52,700	37,600	53,100	60,989	88,443
29. Average payment per service for insured surgical-dental services.	($)	132.00	214.00	366.00	347.00	283.00

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		98	99	101	101	97
b. specialists		72	74	75	75	92
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		170	173	176	176	189
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists		not applicable	not applicable	not applicable	not applicable	not applicable
c. other		not applicable	not applicable	not applicable	not applicable	not applicable
d. total		not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	869,320	848,816	861,112	816,197	716,597
b. specialists	422,483	415,130	409,917	358,600	362,619
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,291,803	1,263,946	1,271,029	1,174,797	1,079,216
34. Number of insured physician services provided, by category of service: (#)					
a. medical	158,836	154,930	152,796	107,683	96,152
b. surgical	146,186	144,947	143,940	140,020	150,036
c. diagnostic	117,461	115,253	113,181	110,897	116,431
d. other	869,320	848,816	861,112	816,197 [4]	716,597 [4]
e. total	1,291,803	1,263,946	1,271,029	1,174,797	1,079,216
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	15,000,000	15,700,000	15,800,000	16,588,900	16,537,250
b. specialists	16,200,000	17,100,000	17,200,000	15,559,600	16,446,970
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	31,200,000	32,800,000	33,000,000	32,148,500	32,984,220
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	6,200,000	6,600,000	6,500,000	5,061,000	4,892,997
b. surgical	8,300,000	8,800,000	8,900,000	8,703,600	9,509,720
c. diagnostic	1,700,000	1,700,000	1,800,000	1,795,000	2,044,253
d. other	not applicable	not applicable	15,800,000	16,588,900 [4]	16,537,250 [4]
e. total	31,200,000	32,800,000	33,000,000	32,148,500	32,984,220
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	17.00	18.00	18.00	20.00	23.00
b. specialists	38.00	41.00	42.00	43.00	45.00
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	24.00	26.00	26.00	27.00	31.00
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	39.00	43.00	43.00	47.00	51.00
b. surgical	57.00	61.00	62.00	62.00	63.00
c. diagnostic	15.00	15.00	15.00	16.00	18.00
d. other	not applicable	not applicable	not applicable	20.00	23.00
e. all services	24.00	26.00	26.00	27.00	31.00

[4] Includes general practitioners.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (In Canada).	(#)	56,192	56,084	46,832	67,435	48,369
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	3,090,000	3,080,000	3,370,102	3,871,900	3,778,171
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	55.00	55.00	72.00	57.00	78.00

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	807	666	728	677	521
43. Total payments for out-of-country insured physician services.	($)	25,495	38,274	57,365	33,995	30,076
44. Average payment per service for out-of-country insured physician services.	($)	31.00	57.00	79.00	50.00	58.00

Nova Scotia

Registered Persons						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	937,587	944,487	947,963	953,385	955,475

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		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. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
g. total facilities		35	35	35	35	35
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		3,221 [1]	3,117 [1]	3,089 [1]	2,982 [1]	2,938 [1]
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total staffed beds		3,221	3,117	3,089	2,982	2,938
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. other		not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement		not applicable	not applicable	not applicable	not applicable	not applicable

[1] Includes rehabilitative care.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**
5. Number of separations from all facilities providing insured hospital services, by type of care: **(#)**					
a. acute care	106,954	104,509	98,209	93,878	90,865
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	846	778	792	827	855 [2]
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	89,046	93,700	96,832	96,797	97,559
f. alternative level of care	1,690	2,002	2,064	2,161	2,077
g. newborns	9,675	9,607	9,038	8,893	8,656
h. other	133	135	150	155	201
i. total separations	208,344	210,731	207,085	202,711	200,213
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: **(# of days)**					
a. acute care	7.93	8.29	8.61	8.50	8.27
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	42.00	43.30	47.20	42.90	39.07
d. newborns	3.68	3.69	3.80	3.70	4.07
e. other	125.00	159.41	147.08	111.90	76.20
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [3] **($)**					
a. acute care	795,946,000	812,776,800	877,019,426	926,797,569	1,021,934,504
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services	795,946,000	812,776,800	877,019,426	926,797,569	1,021,934,504
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: **($)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. other	not applicable	not applicable	not applicable	not applicable	not applicable

[2] Type 4 level of care.

[3] $'s are paid to acute care facilities/DHAs only.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not applicable
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		1	1	1	1	1
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		1	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		154	120	109	81	83
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		19,572	15,677	14,627	10,926	11,714
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	2,395	2,382	2,520	2,050	2,300
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	29,927	30,086	32,859	30,749	34,425
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	10,395,116	10,499,281	9,961,995	8,536,691	12,685,659
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	3,770,060	3,772,315	4,171,365	4,009,667	4,447,816
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,340.34	4,407.75	3,953.17	4,115.45	5,515.50
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	125.98	125.38	126.94	130.39	129.20

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	not available	not available	not available	not available	not available
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	not applicable	not applicable	not applicable	not applicable	not applicable
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	859,642	1,053,577	735,834	1,000,023	938,092
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	not applicable	not applicable	not applicable	not applicable	not applicable
24. Average payment for out-of-country, in-patient insured hospital services.	($)	not available	not available	not available	not available	not available
25. Average payment for out-of-country, out-patient insured hospital services.	($)	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	54	55	39	35	36
27. Number of insured surgical-dental services provided by participating dentists.	(#)	16,909	17,525	6,853	4,497	5,188
28. Total payments to dentists for insured surgical-dental services.	($)	1,726,646	1,467,485	998,692	884,506	939,004
29. Average payment per service for insured surgical-dental services.	($)	102.11	83.74	144.27	196.69	181.00

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available	829	920	865	875
b. specialists		not available	1,095	1,067	1,128	1,142
c. other		0	0	0	10	9
d. total		1,853	1,924	1,987	2,003	2,026
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available	not available	not available	not available	not available
b. specialists		not available	not available	not available	not available	not available
c. other		not available	not available	not available	not available	not available
d. total		not available	not available	not available	not available	not available
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	4,334,359	4,619,083	4,498,232	4,521,991	4,563,449
b. specialists	1,794,146	1,606,842	1,645,535	1,650,685	1,677,973
c. other	0	0	3,951	2,999	2,512
d. total	6,128,505	6,225,925	6,147,718	6,175,675	6,243,934
34. Number of insured physician services provided, by category of service: [4] (#)					
a. medical	5,809,644	5,908,054	5,457,153	5,462,682	6,458,299
b. surgical	320,861	317,871	985,321	1,009,997	1,096,509
c. diagnostic	1,544,529	1,514,011	1,121,296	1,124,792	1,144,383
d. other	0	0	291,352	308,326	324,081
e. total	7,675,034	7,739,936	6,147,718	7,905,797	9,023,272
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: [5] ($)					
a. general practitioners	91,620,190	104,587,110	102,332,556	102,555,964	113,507,874
b. specialists	118,656,216	112,250,617	117,891,477	118,414,434	127,688,914
c. other	0	0	175,890	162,779	165,984
d. total	210,276,406	216,837,727	220,399,923	221,133,176	241,362,772
36. Total payments to physicians for insured physician services, by category of service: [4,5] ($)					
a. medical	not available	not available	239,036,017	244,049,190	270,161,897
b. surgical	not available	not available	77,328,861	80,867,051	91,426,158
c. diagnostic	not available	not available	25,385,064	26,262,276	28,530,589
d. other	not available	not available	7,287,248	8,015,345	8,210,021
e. total	317,320,281	350,091,235	349,037,190	359,193,862	398,328,665
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	21.14	22.64	22.75	22.68	24.87
b. specialists	66.14	69.86	71.64	71.74	76.10
c. other	0.00	0.00	44.52	54.28	66.08
d. all physicians	34.31	34.83	35.85	35.81	38.66
38. Average payment per service for insured physician services, by category of service: [4] ($)					
a. medical	not available	not available	29.40	29.18	41.83
b. surgical	not available	not available	68.53	68.49	83.38
c. diagnostic	not available	not available	57.21	58.97	24.93
d. other	not available	not available	47.78	53.58	25.33
e. all services	41.34	45.23	35.85	35.81	44.14

[4] Fee- for- service + alternate funded programs.

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

Insured Physician Services Provided to Residents in Another Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada). **(#)**	not available	not available	180,299	179,833	187,390
40. Total payments for out-of-province/territory insured physician services (in Canada). **($)**	not available	not available	4,766,189	5,078,794	5,562,125
41. Average payment per service for out-of-province/territory insured physician services (in Canada). **($)**	not available	not available	26.43	28.24	29.68

Insured Physician Services Provided Outside Canada					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services. **(#)**	not available	not available	2,541	2,421	2,748
43. Total payments for out-of-country insured physician services. **($)**	not available	not available	98,461	109,484	121,780
44. Average payment per service for out-of-country insured physician services. **($)**	not available	not available	38.75	45.22	44.32

New Brunswick

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	735,510	739,336	738,598	737,299	738,774

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	31	31	31	31	not available
b. chronic care	0	0	0	0	not available
c. rehabilitative care	1	1	1	1	not available
d. out-patient diagnostic care	0	0	0	0	not available
e. surgical day care (out-patient)	0	0	0	0	not available
f. other	0	0	0	0	not available
g. total facilities	32	32	32	32	not available
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
f. total staffed beds	not available	not available	not available	not available	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,036	3,036	3,036	3,036	3,049 [1]
b. chronic care	397	397	397	397	397
c. rehabilitative care	20	20	20	20	20
d. out-patient diagnostic care	0	0	0	0	0
e. other	0	0	0	0	0
f. total approved bed complement	3,453	3,453	3,453	3,453	4,035

[1] Includes acute non-teritary, oncology tertiary, cardiac surgery tertiary and neurosurgery tertiary beds.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	109,542	108,353	102,465	102,465	98,461 [2]
b. chronic care	2,398	2,281	1,887	1,887	not available
c. rehabilitative care	411	444	465	465	not available
d. out-patient diagnostic care	0	0	0	0	not available
e. surgical day care (out-patient)	42,962	46,287	46,345	46,345	not available
f. alternative level of care	307	308	342	342	not available
Nu newborns	7,939	7,778	7,455	7,455	not available
h. other	0	0	0	0	not available
i. total separations	163,559	165,451	158,959	158,959	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	6.80	6.80	7.10	7.10	8.50 [2]
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	47.30	41.30	41.20	41.20	not available
d. newborns	not available	not available	not available	not available	not available
e. other	not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services	679,000,000 [3]	722,600,000 [3]	768,400,000 [3]	839,100,000 [3]	893,400,000 [3]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

[2] Includes: acute, rehab, extended, tertiary services (except psych.). Excludes: newborns, stillborns, alcohol and drug, hostel, DVA, and contract beds. Source: New Brunswick Annual Report 2002-2003.

[3] Gross hospital facility expenditures as shown in the New Brunswick Annual Report 2002-2003.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	not applicable
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not applicable
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available	not available	not available	not available	not available
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	3,768 pts / 24,915 days	3,900 pts / 25,655 days	4,130 pts / 26,572 days	3,796 pts / 23,342 days	4,168 pts / 23,949 days
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	36,081	32,796	35,834	36,687	40,145
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	21,863,730	22,473,974	21,561,907	19,110,500	23,477,103
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	4,374,860	4,235,429	4,702,219	5,261,500	5,387,946
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	877.53	876.01	811.45	818.72	1,005.79
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	121.25	129.14	131.22	143.42	134.21

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	145 pts / 661 days	212 pts / 1,691 days	166 pts / 1,096 days	148 pts / 1,447days	180 pts / 843 days
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	395	524	639	1,003	1,000
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	150,403	487,760	458,759	440,088	420,659
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	85,443	105,783	180,712	133,360	244,217
24. Average payment for out-of-country, in-patient insured hospital services.	($)	227.54	288.44	418.58	304.14	290.71
25. Average payment for out-of-country, out-patient insured hospital services.	($)	216.31	201.88	282.80	132.96	244.22

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	17	12	16	12	16
27. Number of insured surgical-dental services provided by participating dentists.	(#)	790	751	1,004	1,010	1,283
28. Total payments to dentists for insured surgical-dental services.	($)	132,577	136,491	189,777	186,944	208,946
29. Average payment per service for insured surgical-dental services.	($)	167.82	181.75	189.02	185.09	162.86

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		619	629	645	689	675
b. specialists		709	721	710	799	731
c. other		not available	not available	not available	not available	not available
d. total		1,328	1,350	1,355	1,488	1,406
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	3,692,566	3,721,782	3,668,781	3,611,747	3,731,076
b. specialists	2,551,663	2,612,744	2,590,346	2,523,217	2,624,893
c. other	not available	not available	not available	not available	not available
d. total	6,244,229	6,334,526	6,259,127	6,134,964	6,355,969
34. Number of insured physician services provided, by category of service: [1] (#)					
a. medical	729,803	739,911	728,947	699,991	749,181
b. surgical	828,626	852,725	839,980	826,342	887,993
c. diagnostic	993,234 [2]	1,020,108 [2]	1,021,419 [2]	996,884 [2]	987,719 [2]
d. other	3,692,566	3,721,782	3,668,781	3,611,747	3,731,076
e. total	6,244,229	6,334,526	6,259,127	6,134,964	6,355,969
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	77,851,628	77,958,130	78,139,070	85,584,720	100,812,443
b. specialists	104,752,866	111,554,173	111,224,207	119,386,452	135,546,463
c. other	not available	not available	not available	not available	not available
d. total	182,604,494	189,512,303	189,363,277	204,971,172	236,358,906
36. Total payments to physicians for insured physician services, by category of service: [1] ($)					
a. medical	40,384,442	41,795,791	41,068,744	43,525,046	50,457,210
b. surgical	46,871,179	48,732,272	47,840,045	52,103,502	60,579,805
c. diagnostic	17,497,245 [2]	21,026,109 [2]	22,315,418 [2]	23,757,904 [2]	24,509,448 [2]
d. other	77,851,628 [3]	77,958,130 [3]	78,139,070 [3]	85,584,720 [3]	100,812,443 [3]
e. total	182,604,494	189,512,302	189,363,277	204,971,172	236,358,906
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	21.08	20.95	21.30	23.70	27.02
b. specialists	41.05	42.70	42.94	47.32	51.64
c. other	not available	not available	not available	not available	not available
d. all physicians	29.24	29.92	30.25	33.41	37.19
38. Average payment per service for insured physician services, by category of service: [1] ($)					
a. medical	55.34	56.49	56.34	62.18	67.35
b. surgical	56.56	57.15	56.95	63.05	68.22
c. diagnostic	17.62 [2]	20.61 [2]	21.85 [2]	23.83 [2]	24.81 [2]
d. other	21.08 [3]	20.95 [3]	21.30 [3]	23.70 [3]	27.02 [3]
e. all services	29.24	29.92	30.25	33.41	37.19

1 Fee-for-service payments only.

2 Radiology only.

3 Includes general practitioners.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	140,375	137,950	141,014	161,415	178,569
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	5,684,969	6,050,729	6,280,048	7,721,995	9,302,980
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	40.37	40.50	43.86	47.84	52.10

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	3,835	4,554	4,202	4,360	5,018
43. Total payments for out-of-country insured physician services.	($)	223,066	356,128	362,994	482,915	395,061
44. Average payment per service for out-of-country insured physician services.	($)	50.39	58.17	78.20	110.76	78.73

Ontario

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	11,300,000	11,400,000	11,700,000	11,800,000	12,100,000

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	157	154	150	139	139
b. chronic care	22	12	12	11	11
c. rehabilitative care	5	4	4	4	4
d. out-patient diagnostic care	not available [1]	not available [1]	not available [1]	not available [1]	not available [1]
e. surgical day care (out-patient)	not available [2]	not available [2]	not available [2]	not available [2]	not available [2]
f. other	4	3	3	3	3
g. total facilities	not available [3]	not available [3]	not available [3]	not available [3]	not available [3]
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	23,872	24,254	25,008	24,233 [4]	24,436 [4]
b. chronic care	7,787	7,505	7,455	7,389	6,896
c. rehabilitative care	1,822	1,975	2,137	2,270	2,349
d. out-patient diagnostic care	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
e. other	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
f. total staffed beds	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
b. chronic care	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
c. rehabilitative care	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
d. out-patient diagnostic care	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
e. other	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
f. total approved bed complement	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]

1 Ontario does not have facilities in these categories. These types of facilities are privately owned and any insured services provided are covered by the province.

2 Day surgery only reports cases and the stretchers are not reported whereas acute, chronic and rehabilitative units report beds and have separations.

3 Total is not available as data on day surgery stretchers/beds is not available.

4 Acute staffed beds include Provincial Psychiatric Hospitals and data are from Daily Census Report. Prior were funded Provincial Psychiatric Hospital beds.

5 Details for other types of beds are not kept separately, they are included as part of the acute, chronic and rehabilitation beds reporting.

6 There is no central repository for this information.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	1,131,333	1,007,464	1,004,042	1,011,283 [7]	1,017,199 [7]
b. chronic care	17,165	18,943	20,236 [8]	20,432	20,897
c. rehabilitative care	18,865	20,837	22,937 [8]	27,004	29,599
d. out-patient diagnostic care	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
e. surgical day care (out-patient)	896,833	943,045	983,916	1,012,618	not available
f. alternative level of care	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
g. newborns	134,505	134,136	130,062	134,475	not available
h. other	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
i. total separations	not available [9]	not available [9]	not available [9]	not available [9]	not available [9]
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	6.52	6.59	6.95	7.50	7.80
b. chronic care	129.10	128.87	118.13	114.93	106.87
c. rehabilitative care	30.30	29.85	26.32	26.45	25.38
d. newborns	2.83	2.90	2.96	2.91	not available
e. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
b. chronic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
c. rehabilitative care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
d. out-patient diagnostic care	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
e. surgical day care (out-patient)	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
f. other	not available [11]	not available [11]	not available [11]	not available [11]	not available [11]
g. total payments to facilities providing insured hospital services	7,100,000,000	7,700,000,000 [12]	8,700,000,000 [12]	9,200,000,000	10,300,000,000
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	691.00	761.00	723.63	836.57	845.76 [13]
b. chronic care	274.00	287.00	287.28	324.16	356.66 [13]
c. rehabilitative care	385.00	436.00	503.34	470.40	498.44 [13]
d. other	not available [10]	not available [10]	not available [10]	not available [10]	not available [10]

7 Acute separation included Provincial Psychiatric Hospitals.

8 Chronic and Rehabilitation are revised to match internal reporting.

9 Data is not collected by these classifications -e.g. alternative level of care is included with acute separations.

10 Data is not collected under the category of "others".

11 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.

12 Data has been revised to include Provincial Psychiatric Hospitals.

13 Preliminary information.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. out-patient diagnostic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
e. surgical day care (out-patient)		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
f. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
b. chronic care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
c. rehabilitative care		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
d. other		not available [14]	not available [14]	not available [14]	not available [14]	not available [14]
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total insured hospital services provided at private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
b. private diagnostic imaging facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]
c. Total payments to private for-profit health care facilities		not available [15]	not available [15]	not available [15]	not available [15]	not available [15]

[14] The reliability of the data is questionable and the results of the calculations are questionable and are not supportable or reportable. Facilities in Ontario tend to be mixed (acute/chronic, chronic/rehabilitative beds) with only a minority having one type of activity. Separating by facility type gives a small sample size and significantly understates the amount activity related to chronic and rehabilitative outpatients. Mergers and amalgamations during this period also contribute variability to the figures particularly when viewed by main activity.

[15] Data is not collected within a single system in the ministry.

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	8,431	9,031	9,540	8,633	9,306
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	104,398	155,648	161,882	144,831	140,692
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	32,800,000	41,300,000	39,900,000	36,800,000	48,500,000
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	13,300,000	18,700,000	22,000,000	18,000,000	16,500,000
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	3,890.00	4,573.00	4,182.00	4,262.70	5,211.70
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	127.00	120.00	136.00	124.30	117.30

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	24,141	20,657	20,503	18,542	23,295
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	not available [16]	not available [16]	not available [16]	not available [16]	not available [16]
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	21,400,000	17,000,000	18,800,000	19,300,000	27,200,000
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	not available [17]	not available [17]	not available [17]	not available [17]	not available [17]
24. Average payment for out-of-country, in-patient insured hospital services.	($)	886.00	823.00	918.00	1,043.20	1,167.40
25. Average payment for out-of-country, out-patient insured hospital services.	($)	not available [18]	not available [18]	not available [18]	not available [18]	not available [18]

[16] Included in #20.

[17] Included in #22.

[18] Included in #24.

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	350	350	357	327	319
27. Number of insured surgical-dental services provided by participating dentists.	(#)	70,658	69,400	71,660	74,000	75,600
28. Total payments to dentists for insured surgical-dental services.	($)	7,900,000	8,100,000	8,200,000	8,600,000	9,300,000
29. Average payment per service for insured surgical-dental services.	($)	111.80	116.71	115.21	116.00	123.02

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		10,221	10,227	10,281	10,395	10,508
b. specialists		9,994	10,284	10,392	10,520	10,724
c. other		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
d. total		20,215	20,511	20,673	20,915	21,232
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		26	25	25	22	17
b. specialists		196	188	177	165	134
c. other		not available [19]	not available [19]	not available [19]	not available [19]	not available [19]
d. total		222	213	202	187	151
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		not available [20]	not available [20]	not available [20]	not available [20]	not available [20]
b. specialists		not available [20]	not available [20]	not available [20]	not available [20]	not available [20]
c. other		not available [20]	not available [20]	not available [20]	not available [20]	not available [20]
d. total		not available [20]	not available [20]	not available [20]	not available [20]	not available [20]

[19] All physicians are categorized as general practitioner or specialist.

[20] Ontario has no non-participating physicians, only opted-out physicians who are reported under item #31.

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	80,400,000	79,600,000	79,700,000	77,800,000	76,800,000
b. specialists	89,900,000	91,400,000	93,600,000	99,600,000	102,300,000
c. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
d. total	170,300,000	171,000,000	173,300,000	177,400,000	179,100,000
34. Number of insured physician services provided, by category of service: (#)					
a. medical	84,200,000	84,100,000	82,900,000	81,800,000	81,800,000
b. surgical	21,600,000	2,200,000	22,300,000	22,700,000	23,900,000
c. diagnostic	64,400,000	64,800,000	68,100,000	72,900,000	73,400,000
d. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
e. total	170,200,000	170,900,000	173,300,000	177,400,000	179,100,000
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	1,676,900,000	1,725,200,000	1,734,100,000	1,741,400,000	1,733,200,000
b. specialists	2,587,200,000	2,699,200,000	2,824,300,000	2,936,700,000	3,065,100,000
c. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
d. total	4,264,100,000	4,424,400,000	4,558,400,000	4,678,100,000	4,798,300,000
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	2,605,600,000	2,678,600,000	2,699,800,000	2,731,400,000	2,742,800,000
b. surgical	608,500,000	633,800,000	670,800,000	706,800,000	735,000,000
c. diagnostic	1,050,100,000	1,112,000,000	1,187,800,000	1,239,800,000	1,320,500,000
d. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
e. total	4,264,200,000	4,424,400,000	4,558,400,000	4,678,100,000	4,798,300,000
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	20.86	21.67	21.77	22.40	22.57
b. specialists	28.78	29.53	30.19	29.50	29.96
c. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
d. all physicians	25.05	25.87	26.32	26.40	26.79
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	30.94	31.84	32.59	33.40	33.53
b. surgical	28.19	28.78	30.09	31.10	30.75
c. diagnostic	16.30	17.15	17.45	17.00	17.99
d. other	not available [21]	not available [21]	not available [21]	not available [21]	not available [21]
e. all services	25.05	25.87	26.32	26.40	26.79

[21] All physicians are categorized within general practitioner, specialist and within medical, surgical or diagnostic.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	433,396	455,136	433,463	469,146	497,880
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	13,300,000	14,000,000	14,300,000	15,500,000	17,700,000
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	31.00	31.00	33.00	33.00	35.00

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	207,736	184,107	179,679	157,191	200,428
43. Total payments for out-of-country insured physician services.	($)	7,000,000	11,600,000	15,500,000	8,200,000	10,200,000
44. Average payment per service for out-of-country insured physician services.	($)	34.00	63.00	86.00	51.90	51.00

Manitoba

Registered Persons						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. [1]	(#)	1,142,465	1,144,424	1,149,904	1,152,982	1,156,217

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		95	95	95	96	92
b. chronic care		4 [2]	4 [2]	3 [2]	3 [2]	5 [2]
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not available
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not available
f. other		not applicable	not applicable	not applicable	not applicable	not available
g. total facilities		99	99	98	99	97
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		4,436	4,394	4,406	4,595	not available
b. chronic care		402	402	385	385	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
f. total staffed beds		4,841	4,796	4,791	4,980	5,019 [3]
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		4,439	4,394	4,406	4,595	not available
b. chronic care		402	402	385	385	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. other		not available	not available	not available	not available	not available
f. total approved bed complement		4,841	4,796	4,791	4,980	5,019 [3]

1 The population data is based on records of residents registered with Manitoba Health as at June 1.

2 Includes both chronic care and rehabilitative care.

3 Includes community mental health beds. Community mental health beds are not captured under separations (measure 5) or average length of stay (measure 6).

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	136,499	132,650	127,903	124,917	123,662
b. chronic care	1,757	1,876	1,905	1,780	1,753
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	111,931	115,136	116,305	92,957	93,885
f. alternative level of care	not available	not available	not available	not available	not available
g. newborns	14,814	14,807	14,403	14,333	14,053
h. other	not available	not available	not available	not available	not available
i. total separations	265,001	264,469	260,516	233,987	233,353
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	9.49	9.72	9.91	9.10	8.90
b. chronic care	74.30 [2]	69.04 [2]	78.40 [2]	72.19 [2]	64.40 [2]
c. rehabilitative care	not available	not available	not available	not available	not available
d. newborns	3.89	3.47	3.47	3.33	3.37
e. other	not available	not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	not available	not available	953,834,797	1,046,407,229	1,046,407,229
b. chronic care	not available	not available	65,153,895	70,872,152	70,872,152
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services	not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

[2] Includes both chronic care and rehabilitative care.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	1
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	0
c. Total private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not available
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	0
c. Total insured hospital services provided at private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not available
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not applicable	not applicable	not applicable	not applicable	not available
b. private diagnostic imaging facilities		not applicable	not applicable	not applicable	not applicable	0
c. Total payments to private for-profit health care facilities		not applicable	not applicable	not applicable	not applicable	not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada). (#)	3,307	2,571	3,037	2,892	2,714
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada). (#)	28,007	21,570	29,217	26,479	26,059
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada). ($)	11,292,528	8,655,520	12,152,757	11,427,627	12,918,117
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada). ($)	3,451,891	2,694,973	4,089,018	3,776,489	3,783,059
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada). ($)	3,414.73	3,366.60	4,001.57	3,951.50	4,759.81
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada). ($)	123.25	124.94	139.87	142.60	145.17

Insured Hospital Services Provided Outside Canada					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. (#)	588	565	567	557	569
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. (#)	5,782	6,053	6,335	6,676	6,025
22. Total payments for out-of-country, in-patient, insured hospital services. ($)	1,058,815	1,028,127	1,065,302	2,008,580	1,847,910
23. Total payments for out-of-country, out-patient, insured hospital services. ($)	690,877	905,479	2,435,560	3,267,764	914,251
24. Average payment for out-of-country, in-patient insured hospital services. ($)	1,800.71	1,819.69	1,878.84	3,607.40	3,249.89
25. Average payment for out-of-country, out-patient insured hospital services. ($)	119.49	149.59	384.46	489.00	151.73

Insured Surgical-Dental Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan. **(#)**	102	105	101	not available	116
27. Number of insured surgical-dental services provided by participating dentists. **(#)**	2,925	3,318	3,256	3,401	3,455
28. Total payments to dentists for insured surgical-dental services. **($)**	589,378	590,125	660,870	677,295	714,590
29. Average payment per service for insured surgical-dental services. **($)**	201.50	177.86	202.97	199.15	206.83

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician: **(#)**					
a. general practitioners	900	915	948	not available	954
b. specialists	938	939	not available	not available	1,010
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,838	1,854	not available	not available	1,964
31. Number of physicians opted-out of the health insurance plan, by type of physician: **(#)**					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable
32. Number of physicians not participating in the health insurance plan, by type of physician: **(#)**					
a. general practitioners	not applicable	not applicable	not applicable	not applicable	not applicable
b. specialists	not applicable	not applicable	not applicable	not applicable	not applicable
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	not applicable	not applicable	not applicable	not applicable	not applicable

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	5,859,568	5,931,022	6,211,011	6,244,197	6,161,451
b. specialists	7,698,155	8,147,749	8,741,628	9,198,787	9,779,269
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	13,557,723	14,078,771	14,952,639	15,442,984	15,940,720
34. Number of insured physician services provided, by category of service: (#)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	not available	not available	not available	not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	103,068,422	114,868,502	132,200,004	140,703,474	143,846,209
b. specialists	165,946,999	178,359,474	199,231,274	214,392,377	221,948,290
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	269,015,421	293,227,976	331,431,278	355,095,851	365,794,499
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. total	376,500,221	416,902,176	467,886,678	496,268,700	521,611,200
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	17.59	19.37	21.28	22.53	23.35
b. specialists	21.56	21.89	22.79	23.31	22.70
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	19.84	20.83	22.17	22.99	22.95
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	not available	not available	not available	not available	not available
b. surgical	not available	not available	not available	not available	not available
c. diagnostic	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available
e. all services	not available	not available	not available	not available	not available

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	206,521	183,497	192,272	211,464	212,795
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	6,121,559	5,568,205	6,148,444	7,381,785	7,691,159
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.640	30.340	31.980	34.900	36.14

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	6,587	7,116	6,763	6,345	5,826
43. Total payments for out-of-country insured physician services.	($)	519,928	520,712	500,757	529,029	607,066
44. Average payment per service for out-of-country insured physician services.	($)	78.93	73.17	74.04	83.40	104.20

Saskatchewan

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	1,031,933	1,041, 256	1,021,762	1,024,788	1,024,827

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	71	71	68	66	65
b. chronic care	0	0	0	0	0
c. rehabilitative care	1	1	1	1	1
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	0	0	0	0	0
g. total facilities	72	72	69	67	66
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	3,078	2,944	2,802	2,544	2,544
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	142	142	142	142	67
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other [1]	735	718	670	714	876 [1]
f. total staffed beds	3,955	3,804	3,614	3,400	3,487
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

[1] "Other" staffed beds include beds used for a variety of other sub-acute purposes. Examples include observation, respite care, palliative care, convalescent care and long term care. This count includes 66 Department of Veteran's Affairs beds located in the Wascana Rehabilitation Centre.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	143,604	133,768	131,063	124,481	not available
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	1,058	927	984	842	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	53,890	55,426	55,526	55,269 [2]	not available
f. alternative level of care	not available	not available	not available	not available	not available
g. newborns	12,819	12,597	11,992	12,248	not available
h. other	3,309	4,065	4,646	4,374 [3]	not available
i. total separations	214,680	206,783	204,211	197,214 [4]	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	5.80	5.60	5.70	5.7	not available
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	30.50	34.70	31.90	35.0	not available
d. newborns	3.51	3.72	3.60	3.4	not available
e. other	15.40	15.80	15.40	15.5 [3]	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	565,682,800	619,538,151	680,326,248	720,174,393 [5]	not available
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	35,437,299	36,824,546	38,249,010	39,656,384	not available
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	not applicable	not applicable	not applicable	not applicable	not applicable
g. total payments to facilities providing insured hospital services	601,120,099	656,362,697	718,575,258	759,830,777	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

[2] Surgical day care (out-patient) cases are defined as cases that involve day procedures that are on the Canadian Institute for Health Information's 1991 list of operative procedures. The surgical day case count for 2001-2002 is an estimate because two reporting changes in 2001-2002 made it impossible to obtain counts that are fully comparable to previous years:
(a) ICD-10/CCI (Canadian Classification of Interventions) coding was implemented in some Saskatchewan hospitals. Some procedures formerly reported under operative codes were reported under CCI codes that translate to non-operative CCP codes.
(b) There were some changes (reductions) in the reporting of procedures that have been moved out of operating rooms to ambulatory care. The Department will further reassess the method used for counting/tracking day surgery after 2002-2003, when CCI data will be available for all facilities.

[3] "Other" separations and length of stay are for patients treated in psychiatric units in acute care hospitals

[4] "Total separations" exclude long term care separations.

[5] Includes all acute care base funding and special payments, including medical remuneration, specialized services, and tertiary capital ($2M), but does not include funding to inpatient mental health care or substance abuse payments.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	4,275	4,917	4,527	4,692	4,422
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	40,328	43,296	46,199	45,320	50,401
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	18,311,400	21,235,200	20,208,100	22,037,200	23,447,100
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	5,180,800	5,622,500	6,046,600	5,836,500	7,144,800
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,283.37	4,318.73	4,463.91	4,696.76	5,302.37
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	128.47	129.86	130.88	128.78	141.76

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	244	380	272	252	287
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	1,576	1,553	1,369	1,172	1,049
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	1,907,500	1,891,000	1,039,500	1,009,400	1,891,800
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	400,200	481,600	377,600	375,900	359,400
24. Average payment for out-of-country, in-patient insured hospital services.	($)	7,817.62	4,976.32	3,821.69	4,005.56	6,591.64
25. Average payment for out-of-country, out-patient insured hospital services.	($)	253.93	310.11	275.82	320.73	342.61

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	113	97	92	94	94
27. Number of insured surgical-dental services provided by participating dentists.	(#)	18,500	18,100	19,900	18,900	18,500
28. Total payments to dentists for insured surgical-dental services.	($)	1,272,000	1,309,000	1,404,700	1,275,400	1,264,200
29. Average payment per service for insured surgical-dental services.	($)	68.76	72.32	70.59	67.48	68.34

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		907	940	1,016	937	936
b. specialists		595	610	593	696	700
c. other		0	0	0	0	0
d. total		1,502	1,550	1,609	1,633	1,636
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	6,742,712	6,785,673	6,873,539	6,760,156	6,631,582
b. specialists	3,127,345	3,163,046	3,250,953	3,700,801	3,637,879
c. other	0	0	0	0	0
d. total	9,870,057	9,948,719	10,124,492	10,460,957	10,269,461
34. Number of insured physician services provided, by category of service: [6] (#)					
a. medical	6,048,849 [7]	6,028,070 [7]	6,071,567 [7]	6,017,477 [7]	5,788,055 [7]
b. surgical	735,770 [8]	723,626 [8]	787,655 [8]	994,321 [8]	984,405 [8]
c. diagnostic	2,345,180 [9]	2,312,606 [9]	2,288,038 [9]	2,262,256 [9]	2,179,286 [9]
d. other	740,258 [10]	884,417 [10]	977,232 [10]	1,186,903 [10]	1,317,715 [10]
e. total	9,870,057	9,948,719	10,124,492	10,460,957	10,269,461
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	128,784,792	133,042,948	134,989,267	137,541,402	139,410,263
b. specialists	122,465,930	125,735,201	129,470,569	144,566,069	151,061,558
c. other	0	0	0	0	0
d. total	251,250,722	258,778,149	264,459,836	282,107,471	290,471,821
36. Total payments to physicians for insured physician services, by category of service: [6] ($)					
a. medical	143,548,623 [7]	148,848,496 [7]	151,152,270 [7]	160,742,594 [7]	162,032,557 [7]
b. surgical	51,255,592 [8]	50,843,890 [8]	51,681,286 [8]	56,027,014 [8]	58,596,690 [8]
c. diagnostic	40,473,208 [9]	41,503,336 [9]	43,216,810 [9]	44,488,404 [9]	48,355,683 [9]
d. other	15,973,299 [10]	17,582,427 [10]	18,409,471 [10]	20,849,458 [10]	21,486,890 [10]
e. total	251,250,722	258,778,149	264,459,837	282,107,470	290,471,821
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	19.10	19.61	19.64	20.35	21.02
b. specialists	39.16	39.75	39.83	39.06	41.52
c. other	0.00	0.00	0.00	0.00	0.00
d. all physicians	25.46	26.01	26.12	26.97	28.29
38. Average payment per service for insured physician services, by category of service: [6] ($)					
a. medical	23.73 [7]	24.69 [7]	24.90 [7]	26.71 [7]	27.99 [7]
b. surgical	69.66 [8]	70.26 [8]	65.61 [8]	56.35 [8]	59.52 [8]
c. diagnostic	17.26 [9]	17.95 [9]	18.89 [9]	19.67 [9]	22.19 [9]
d. other	21.58 [10]	19.88 [10]	18.84 [10]	17.57 [10]	16.31 [10]
e. all services	25.46	26.01	26.12	26.97	28.29

[6] Fee-for-service.

[7] Includes visits, hospital care, psychotherapy.

[8] Includes surgeries, surgical assistance, obstetrics, anaesthesia.

[9] Includes x-rays, laboratory services, diagnostics.

[10] Includes surcharges, premiums, on-call physician services.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	374,900	392,400	425,800	444,430	458,100
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	10,897,500	12,237,200	13,767,600	15,520,000	16,948,900
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.07	31.19	32.33	34.92	37.00

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	658,400	1,186,900	722,400	588,100	1,129,300
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

Alberta

Registered Persons						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)	2,912,925	2,957,045	3,007,582	3,072,384	3,124,487

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care		102	102	102	103	100
b. chronic care		104	104	105	106	110
c. rehabilitative care		1	1	1	1	1
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not provided
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not provided
f. other		0	3	3	3	3
g. total facilities		207	210	211	213	214
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		6,404	6,275	6,365	6,533	not provided
b. chronic care		6,179	6,179	6,430	6,701	not provided
c. rehabilitative care		240	240	240	240	not provided
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not provided
e. other		not applicable	not applicable	not applicable	not applicable	not provided
f. total staffed beds		12,823	12,694	13,035	13,474	not provided
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care		9,788	9,788	9,788	not applicable	not provided
b. chronic care		6,114	6,114	6,164	not applicable	not provided
c. rehabilitative care		240	240	240	not applicable	not provided
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not provided
e. other		not applicable	not applicable	not applicable	not applicable	not provided
f. total approved bed complement		16,142	16,142	16,192	not applicable	not provided

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2002-2003.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**
5. Number of separations from all facilities providing insured hospital services, by type of care: **(#)**					
a. acute care	not available	not available	not available	not available	not provided
b. chronic care	not available	not available	not available	not available	not provided
c. rehabilitative care	not available	not available	not available	not available	not provided
d. out-patient diagnostic care	not available	not available	not available	not available	not provided
e. surgical day care (out-patient)	not available	not available	not available	not available	not provided
f. alternative level of care	not available	not available	not available	not available	not provided
g. newborns	not available	not available	not available	not available	not provided
h. other	not available	not available	not available	not available	not provided
i. total separations	346,092	346,316	343,099	not available	not provided
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: **(# of days)**					
a. acute care	not available	not available	not available	not available	not provided
b. chronic care	not available	not available	not available	not available	not provided
c. rehabilitative care	not available	not available	not available	not available	not provided
d. newborns	not available	not available	not available	not available	not provided
e. other	not available	not available	not available	not available	not provided
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: **($)**					
a. acute care	not applicable	not applicable	not applicable	not applicable	not provided
b. chronic care	not applicable	not applicable	not applicable	not applicable	not provided
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not provided
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not provided
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not provided
f. other	not applicable	not applicable	not applicable	not applicable	not provided
g. total payments to facilities providing insured hospital services	not applicable	not applicable	not applicable	not applicable	not provided
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: **($)**					
a. acute care	not applicable	not applicable	not applicable	not applicable	not provided
b. chronic care	not applicable	not applicable	not applicable	not applicable	not provided
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not provided
d. other	not applicable	not applicable	not applicable	not applicable	not provided

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not provided
b. chronic care		not applicable	not applicable	not applicable	not applicable	not provided
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not provided
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not provided
e. surgical day care (out-patient)		not applicable	not applicable	not applicable	not applicable	not provided
f. other		not applicable	not applicable	not applicable	not applicable	not provided
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not applicable	not applicable	not applicable	not applicable	not provided
b. chronic care		not applicable	not applicable	not applicable	not applicable	not provided
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not provided
d. other		not applicable	not applicable	not applicable	not applicable	not provided
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not provided
b. private diagnostic imaging facilities		not available	not available	not available	not available	not provided
c. Total private for-profit health care facilities		not available	not available	not available	not available	not provided
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	not available	not available	not available	not provided
b. private diagnostic imaging facilities		not available	not available	not available	not available	not provided
c. Total insured hospital services provided at private for-profit health care facilities		not available	not available	not available	not available	not provided
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available	not available	not available	not available	not provided
b. private diagnostic imaging facilities		not available	not available	not available	not available	not provided
c. Total payments to private for-profit health care facilities		not available	not available	not available	not available	not provided

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	4,714	4,820	4,656	4,205	72,250 [2]
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	57,574	59,443	56,408	61,230	not provided
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	13,269,781	13,632,730	14,699,049	12,328,205	23,707,079 [2]
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	6,706,065	6,920,702	5,287,271	7,115,105	not provided
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	2,814.97	2,828.37	3,157.01	2,931.80	not provided
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	116.48	116.43	93.73	116.20	not provided

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	4,005	5,215	4,151	4,457	7,437 [2]
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	3,777	5,097	3,945	3,942	not provided
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	356,747	483,648	374,005	416,635	546,853 [2]
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	275,687	364,087	298,725	309,119	not provided
24. Average payment for out-of-country, in-patient insured hospital services.	($)	89.08	92.74	90.10	93.48	not provided
25. Average payment for out-of-country, out-patient insured hospital services.	($)	72.99	71.43	75.72	78.42	not provided

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2002-2003.

[2] Includes both in-patient and out-patient services.

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
26. Number of dentists participating in the health insurance plan.	(#)	232	250	232	250	234
27. Number of insured surgical-dental services provided by participating dentists.	(#)	11,920	14,292	14,708	14,585	not provided
28. Total payments to dentists for insured surgical-dental services.	($)	1,853,322	2,092,003	2,116,386	2,167,898	2,394,458
29. Average payment per service for insured surgical-dental services.	($)	155.48	146.38	143.89	148.64	not provided

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		2,464	2,545	2,659	2,746	2,841
b. specialists		1,978	2,096	2,197	2,333	2,365
c. other		not applicable	not applicable	not applicable	not applicable	not provided
d. total		4,442	4,641	4,856	5,079	5,206
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		not applicable	not applicable	not applicable	not applicable	0
b. specialists		not applicable	not applicable	not applicable	not applicable	0
c. other		not applicable	not applicable	not applicable	not applicable	0
d. total		not applicable	not applicable	not applicable	not applicable	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	not provided
b. specialists		0	0	1	0	not provided
c. other		0	0	0	0	not provided
d. total		0	0	1	0	not provided

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2002-2003.

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
33. Number of insured physician services provided, by type of physician (fee-for-service):	(#)					
a. general practitioners		15,543,092	15,914,666	16,132,591	16,132,591	not provided
b. specialists		10,798,883	11,319,078	11,710,080	11,710,080	not provided
c. other		0	0	0	0	not provided
d. total		26,341,975	27,233,744	27,842,671	27,842,671	not provided
34. Number of insured physician services provided, by category of service:	(#)					
a. medical		19,119,550	19,829,029	20,328,498	20,647,611	not provided
b. surgical		1,211,712	1,238,043	1,316,312	1,396,422	not provided
c. diagnostic		5,036,153	5,274,903	5,588,934	5,798,638	not provided
d. other		0	0	0	0	not provided
e. total		25,367,415	26,341,975	27,233,744	27,842,671	not provided
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician:	($)					
a. general practitioners		383,842,634	410,502,506	430,681,658	474,076,958	not provided
b. specialists		464,270,463	493,040,446	528,392,197	587,092,735	not provided
c. other		0	0	0	0	not provided
d. total		848,113,097	903,542,952	959,073,855	1,061,169,693	1,225,626,637
36. Total payments to physicians for insured physician services, by category of service:	($)					
a. medical		549,507,274	586,587,852	618,596,110	684,971,654	not provided
b. surgical		133,916,239	140,067,988	150,223,933	164,427,152	not provided
c. diagnostic		164,689,584	176,887,112	190,253,812	211,770,887	not provided
d. other		0	0	0	0	not provided
e. total		848,113,097	903,542,952	959,073,855	1,061,169,693	not provided
37. Average payment per service for insured (fee-for-service) physician services, by type of physician:	($)					
a. general practitioners		24.70	25.79	26.70	29.39	not provided
b. specialists		42.99	43.56	45.12	50.14	not provided
c. other		0.00	0.00	0.00	0.00	not provided
d. all physicians		32.20	33.18	34.45	38.11	not provided
38. Average payment per service for insured physician services, by category of service:	($)					
a. medical		28.74	29.58	30.43	33.17	not provided
b. surgical		110.52	113.14	114.12	117.75	not provided
c. diagnostic		32.70	33.53	34.04	36.52	not provided
d. other		0.00	0.00	0.00	0.00	not provided
e. all services		33.43	34.30	35.22	38.11	not provided

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2002-2003.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	359,653	380,635	418,587	493,798	559,503
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	9,983,110	11,397,620	12,436,188	11,998,825	13,880,981
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	27.76	29.94	29.71	24.30	24.81

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [1]
42. Number of services paid for out-of-country, insured physician services.	(#)	25,192	21,989	20,891	22,928	21,289
43. Total payments for out-of-country insured physician services.	($)	862,852	871,292	907,010	1,043,997	976,232
44. Average payment per service for out-of-country insured physician services.	($)	34.25	39.62	43.42	45.53	45.86

[1] These figures are considered preliminary until the release of the Alberta Ministry of Health and Wellness' Alberta Health Care Insurance Plan Statistical Supplement, 2002-2003.

British Columbia

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	3,924,490	3,943,991	4,022,789	4, 076,892	4,106,488

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	94	94	94	94	92
b. chronic care	17	17	18	18	18
c. rehabilitative care	3	3	3	3	3
d. out-patient diagnostic care	25	25	25	25	25
e. surgical day care (out-patient)	not applicable	not applicable	not applicable	not applicable	not applicable
f. other	0	0	0	0	0
g. total facilities	139	139	140	140	138
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed: [1] (#)					
a. acute care	7,352	7,688	7,646	7,321	7,093
b. chronic care [2]	7,364	7,247	7,261	7,830	7,421
c. rehabilitative care	160	156	162	163	150
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	362	not applicable	not applicable	not applicable	not available
f. total staffed beds	15,238	15,091	15,069	15,314	14,664
4. Approved bed complement for all facilities providing insured hospital services, by type of bed: (#)					
a. acute care	not applicable	not applicable	not applicable	not applicable	not applicable
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
f. total approved bed complement	not applicable	not applicable	not applicable	not applicable	not applicable

For items 1-10: All data is preliminary for 2002-2003. Data has been restated for all years to reflect changes in data sources. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

[1] Neither approved nor staffed bed counts are available for 2002-2003. Data provided reflects 'average occupied beds', calculated as total days of care / 365.25 days, rounded up to the nearest whole number.

All years have been restated to reflect the new methodology.

Note that surgical day care cases do not generate a day count; they are, therefore, excluded from bed calculations.

Newborns, stillbirths, and non-residents are included; out-of-province care to BC residents is excluded.

[2] For all years, the bed count for chronic care facilities is calculated as the sum of total days of care provided in each facility in the year / 365 days. 100% occupancy is assumed. See note 4 for the definition of facilities.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	**1999-2000**	**2000-2001**	**2001-2002**	**2002-2003**
5. Number of separations from all facilities providing insured hospital services, by type of care: [3,4,5,8] **(#)**					
a. acute care	392,319	391,817	378,822	353,117	340,635
b. chronic care	4,608	4,884	4,700	4,890	4,955
c. rehabilitative care	1,256	1,261	1,421	1,495	1,408
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	258,648	284,895	289,900	293,346	302,370
f. alternative level of care	not applicable	not applicable	not applicable	not applicable	not applicable
g. newborns	42,169	41,698	40,204	39,669	39,696
h. other	2,287	not applicable	not applicable	not applicable	not applicable
i. total separations	701,287	724,555	715,047	692,517	689,064
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: [6,7,8,9] **(# of days)**					
a. acute care	6.60	6.90	7.10	7.20	7.30
b. chronic care	604.00	598.00	586.00	618.00	633.60
c. rehabilitative care	46.47	45.00	41.50	39.76	38.90
d. newborns	2.75	2.70	3.00	3.02	3.00
e. other	57.70	not applicable	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: [10] **($)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. out-patient diagnostic care	not available	not available	not available	not available	not available
e. surgical day care (out-patient)	not available	not available	not available	not available	not available
f. other	not available	not available	not available	not available	not available
g. total payments to facilities providing insured hospital services	not available	not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: **($)**					
a. acute care	not available	not available	not available	not available	not available
b. chronic care	not available	not available	not available	not available	not available
c. rehabilitative care	not available	not available	not available	not available	not available
d. other	not available	not available	not available	not available	not available

For items 1-10: All data is preliminary for 2002-2003. Data has been restated for all years to reflect changes in data sources. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

3 For items 5a, 5c to 5i, newborns and stillbirths are included, as are non-residents. Out-of-province care to BC residents are excluded.

4 For item 5b, data was formerly reported through the Discharge Abstract Database (DAD), but this was discontinued in 2001-2002. All years have been restated from the Continuing Care Data Warehouse for extended care facilities that formerly reported through the DAD. The definition of 'separation' is the same as that used for acute care.

5 For 1998-1999, item 5h, discharge planning unit (DPU) cases were classified as 'other'. DPU was replaced by Alternative Level of Care (ALC) only in 1999-2000 and for all subsequent years. ALC cases are already counted in acute separations, part 5a, for all years.

6 For item 6, all categories, cases are assigned to year by separation date, so average length of stay calculations may include days from previous years.

7 For item 6a, the calculation of acute average length of stay is now based on total days in the facility, including ALC for all years. For 1998-1999 only, DPU is shown separately under 6e ('other'). This results in a slightly shorter acute average length of stay for that year. (See note 5) If DPU is included in the calculation of acute average length of stay, the value for 1998-1999 would be 6.9.

8 For items 5c and 6c data has been restated for all years. Changes from earlier reports reflect updates, definition changes, and restatements from CIHI.

9 For 1998-1999, item 6e, the value presented is for DPU only. See notes 5 and 7.

10 Payments to Health Authorities for the provision of the full range of regionally delivered services are as follows: $4.4 billion in 1999-2000, $5.1 billion in 2000-2001, $5.4 billion in 2001-2002, and $6.1 billion in 2002-2003.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available	not available
f. other		not available	not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		not available	not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available	not available
d. other		not available	not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care: [11]	(#)					
a. private surgical facilities		not available	1	1	1	1
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total private for-profit health care facilities		not available	1	1	1	1
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		not available	810	634	689	612
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total insured hospital services provided at private for-profit health care facilities		not available	810	634	689	612
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		not available	558,000	348,700	353,100	358,600
b. private diagnostic imaging facilities		not available	not available	not available	not available	not available
c. Total payments to private for-profit health care facilities		not available	558,000	348,700	353,100	358,600

For items 1-10: All data is preliminary for 2002-2003. Data has been restated for all years to reflect changes in data sources. Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year.

[11] There are approximately 50 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.

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)	7,994	7,231	8,113	8,113	7,618
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)	73,807	70,070	83,765	80,732	83,152
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)	35,830,522	34,477,406	35,882,521	40,898,996	40,195,515
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)	9,075,191	9,585,916	9,149,496	10,604,141	11,223,254
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)	4,482.00	4,768.00	4,422.84	5,041.17	5,276.39
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)	123.00	137.00	109.23	131.35	134.97

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)	2,793	2,494	2,097	1,964	1,795
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)	435	324	720	637	949
22. Total payments for out-of-country, in-patient, insured hospital services.	($)	3,492,437	5,375,289	6,463,676	9,246,228	2,294,341
23. Total payments for out-of-country, out-patient, insured hospital services.	($)	100,863	65,137	134,789	119,928	543,969
24. Average payment for out-of-country, in-patient insured hospital services.	($)	1,250.00	2,155.00	3,082.34	4,707.86	1,278.18
25. Average payment for out-of-country, out-patient insured hospital services.	($)	232.00	201.00	187.21	188.27	573.20

Insured Surgical-Dental Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan. (#)	283	272	283	275	249
27. Number of insured surgical-dental services provided by participating dentists. (#)	50,899	54,638	55,643	43,505	36,680
28. Total payments to dentists for insured surgical-dental services. ($)	5,455,250	5,893,820	6,321,864	5,401,691	5,400,000
29. Average payment per service for insured surgical-dental services. ($)	107.18	107.87	113.61	124.16	147.22

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	4,276	4,277	4,359	4,430	4,471
b. specialists	3,225	3,268	3,297	3,380	3,421
c. other	0	0	0	0	0
d. total	7,501	7,545	7,656	7,810	7,892
31. Number of physicians opted-out of the health insurance plan, by type of physician: (#)					
a. general practitioners	4	4	3	3	3
b. specialists	13	10	5	3	3
c. other	0	0	0	0	0
d. total	17	14	8	6	6
32. Number of physicians not participating in the health insurance plan, by type of physician: (#)					
a. general practitioners	1	1	1	1	1
b. specialists	0	0	0	0	0
c. other	0	0	0	0	0
d. total	1	1	1	1	1

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	21,891,611	22,942,977	23,037,717	22,786,171	23,099,256
b. specialists	29,872,189	32,791,108	34,565,990	36,207,479	38,541,400
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	51,763,800	55,734,085	57,603,707	58,993,650	61,640,656
34. Number of insured physician services provided, by category of service: (#)					
a. medical	24,012,366	25,129,877	25,201,483	24,994,070	25,423,944
b. surgical	4,163,434	4,431,716	4,417,069	4,317,461	4,393,613
c. diagnostic	23,588,000	26,172,492	27,985,155	29,682,119	31,823,099
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	51,763,800	55,734,085	57,603,707	58,993,650	61,640,656
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	629,435,878	658,975,986	665,989,273	720,481,512	749,814,981
b. specialists	848,273,150	933,134,583	969,589,022	1,076,308,991	1,153,801,097
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. total	1,477,709,028	1,592,110,569	1,635,578,295	1,796,790,503	1,903,616,078
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	879,483,221	928,286,068	942,736,513	1,025,573,356	1,068,072,122
b. surgical	229,199,294	250,524,151	252,828,480	279,700,734	296,852,610
c. diagnostic	369,026,513	413,300,350	440,013,302	491,516,413	538,691,346
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. total	1,477,709,028	1,592,110,569	1,635,578,295	1,796,790,503	1,903,616,078
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	28.75	28.72	28.91	31.62	32.46
b. specialists	28.40	28.46	28.05	29.73	29.94
c. other	not applicable	not applicable	not applicable	not applicable	not applicable
d. all physicians	28.55	28.57	28.39	30.46	30.88
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	36.63	36.94	37.41	41.03	42.01
b. surgical	55.05	56.53	57.24	64.78	67.56
c. diagnostic	15.64	15.79	15.72	16.56	16.93
d. other	not applicable	not applicable	not applicable	not applicable	not applicable
e. all services	28.55	28.57	28.39	30.46	30.88

Insured Physician Services Provided to Residents in Another Province or Territory [12]						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	680,230	552,056	579,550	541,922	492,996
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	19,841,176	16,979,901	18,547,284	18,842,752	22,425,511
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	29.17	30.76	32.00	34.77	45.49

Insured Physician Services Provided Outside Canada [13]						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	80,717	77,424	77,968	71,871	61,768
43. Total payments for out-of-country insured physician services.	($)	3,346,453	3,485,618	3,281,561	3,009,750	2,671,752
44. Average payment per service for out-of-country insured physician services.	($)	41.46	45.02	42.09	41.88	43.25

[12] Numbers for items 39-41 have been restated for all years, due to a change in the calculation method.

[13] Numbers for items 42-44 have been restated for all years, due to a change in the calculation method. Figures for 2002-2003 are preliminary, and will be revised upwards in next year's report. Out of country claims are frequently submitted after the end of the fiscal year, and processing takes time. In addition, there was a significant backlog of unpaid claims at the end of 2002-2003.

Yukon

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)	31,925	31,255	31,133	31,036	30,534

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care	2	2	2	2	2
b. chronic care	0	0	0	0	0
c. rehabilitative care	0	0	0	0	0
d. out-patient diagnostic care	0	0	0	0	0
e. surgical day care (out-patient)	0	0	0	0	0
f. other	13 [1]	13 [1]	13 [1]	13 [1]	13 [1]
g. total facilities	15	15	15	15	15
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care	59	61	61	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total staffed beds	68	70	70	70	70
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care	59	61	61	61	61
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. other	9 [2]	9 [2]	9 [2]	9 [2]	9 [2]
f. total approved bed complement	68	70	70	70	70

[1] Includes 12 health centres and one satellite health station.

[2] Day surgery beds.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care	3,117	2,967	3,021	2,986	3,044
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	1,606	1,624	1,619	1,542	1,686
f. alternative level of care	0	0	0	0	0
g. newborns	392	374	363	340	316
h. other	0	0	0	0	0
i. total separations	5,115	4,965	5,003	4,868	5,046
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care	4.50	4.70	4.70	4.70	4.50
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. newborns	2.90	3.00	3.10	3.00	2.90
e. other	not applicable	not applicable	not applicable	not applicable	not applicable
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care	19,023,617	19,587,158	20,350,026	21,920,937	22,515,448
b. chronic care	not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care	not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care	not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)	0	0	0	0	0
f. other	4,796,107 [1]	5,502,144 [1]	5,483,948 [1]	5,997,920 [1]	6,133,453 [1]
g. total payments to facilities providing insured hospital services	23,819,724	25,089,302	25,833,974	27,918,907	28,648,901
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care	694.50	694.50	694.50	732.50	837.50
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

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care		110.00	110.00	110.00	110.00	110.00
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. out-patient diagnostic care		not applicable	not applicable	not applicable	not applicable	not applicable
e. surgical day care (out-patient)		400.00	400.00	400.00	400.00	400.00
f. other		not applicable	not applicable	not applicable	not applicable	not applicable
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care		349.71	337.15	335.46	356.23	359.56
b. chronic care		not applicable	not applicable	not applicable	not applicable	not applicable
c. rehabilitative care		not applicable	not applicable	not applicable	not applicable	not applicable
d. other		not applicable	not applicable	not applicable	not applicable	not applicable
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total private for-profit health care facilities		0	0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities		0	0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities		0	0	0	0	0
b. private diagnostic imaging facilities		0	0	0	0	0
c. Total payments to private for-profit health care facilities		0	0	0	0	0

Insured Hospital Services Provided to Residents in Another Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada). (#)	769	735	719	663	666
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada). (#)	6,637	7,025	6,760	6,547	7,241
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada). ($)	4,196,661	4,683,562	4,218,846	4,299,055	5,861,530
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada). ($)	826,425	920,769	861,375	945,804	1,037,692
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada). ($)	5,457.30	6,372.20	5,867.66	6,484.25	8,801.10
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada). ($)	124.52	131.07	127.43	144.47	143.31

Insured Hospital Services Provided Outside Canada					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services. (#)	13	11	9	15	9
21. Total number of claims paid for out-of-country, out-patient, insured hospital services. (#)	53	67	54	40	26
22. Total payments for out-of-country, in-patient, insured hospital services. ($)	45,440	22,125	27,520	50,599	9,339
23. Total payments for out-of-country, out-patient, insured hospital services. ($)	7,354	7,080	8,368	4,431	2,451
24. Average payment for out-of-country, in-patient insured hospital services. ($)	3,495.39	2,011.37	3,057.78	3,373.27	1,037.67
25. Average payment for out-of-country, out-patient insured hospital services. ($)	138.76	105.68	154.97	110.78	94.27

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)	12	9	11	11	8
27. Number of insured surgical-dental services provided by participating dentists.	(#)	297	214	222	214	150
28. Total payments to dentists for insured surgical-dental services.	($)	64,397	59,458	50,876	51,078	37,342
29. Average payment per service for insured surgical-dental services.	($)	217.19	277.84	229.17	238.69	248.95

Insured Physician Services Within Own Province or Territory [3]						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		40	41	43	49	53
b. specialists		4	5	6	5	6
c. other		0	0	0	0	0
d. total		44	46	49	54	59
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners		0	0	0	0	0
b. specialists		0	0	0	0	0
c. other		0	0	0	0	0
d. total		0	0	0	0	0

[3] Includes only resident family physicians and specialists.

Insured Physician Services Within Own Province or Territory [4]					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	151,743	153,542	164,497	160,932	186,479
b. specialists	14,170	11,704	14,789	11,881	11,040
c. other	0	0	0	0	0
d. total	165,913	165,246	179,286	172,813	197,519
34. Number of insured physician services provided, by category of service: (#)					
a. medical	120,830	123,333	131,685	131,004	154,591
b. surgical	23,110	22,092	25,670	26,653	26,388
c. diagnostic	21,972	19,822	18,978	15,156	16,540
d. other	0	0	0	0	0
e. total	165,913	165,247	176,333	172,813	197,519
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners	5,058,606	5,248,704	5,803,619	5,692,583	6,740,552
b. specialists	1,321,577	1,189,271	1,263,380	1,143,968	971,283
c. other	0	0	0	0	0
d. total	6,380,183	6,437,975	7,066,999	6,836,551	7,711,835
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical	5,026,530	5,144,453	5,729,729	5,550,975	6,386,109
b. surgical	1,005,170	978,628	1,028,529	1,057,467	1,029,697
c. diagnostic	348,483	314,893	308,741	228,109	296,029
d. other	0	0	0	0	0
e. total	6,380,183	6,437,975	7,066,999	6,836,551	7,711,835
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners	33.34	34.18	35.28	35.38	36.15
b. specialists	93.27	101.61	85.43	96.29	87.98
c. other	0.00	0.00	0.00	0.00	0.00
d. all physicians	38.45	38.96	39.42	39.56	39.04
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical	41.60	41.71	43.51	42.38	41.31
b. surgical	43.50	44.30	40.07	39.68	39.02
c. diagnostic	15.86	15.89	16.27	15.05	17.90
d. other	0.00	0.00	0.00	0.00	0.00
e. all services	38.46	38.96	40.08	39.56	39.04

[4] Measures 33 to 38 do not include services and costs provided by Alternative Payment physicians.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)	29,834	31,020	36,828	32,461	34,853 [5]
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)	1,207,371	1,404,195	1,642,495	1,601,642	1,799,019 [5]
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)	40.47	45.27	44.60	49.34	51.62 [5]

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)	not available	not available	not available	not available	not available
43. Total payments for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available
44. Average payment per service for out-of-country insured physician services.	($)	not available	not available	not available	not available	not available

[5] Includes BC & Alberta only.

Insured Physician Services Within Own Province or Territory, Visiting Specialists, Locum Doctors and Member Reimbursements					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
45. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners	30,391	27,757	32,986	18,663	21,896
b. specialists	10,443	11,332	7,009	11,323	12,830
c. all physicians	40,834	39,089	39,995	29,986	34,726
46. Number of insured physician services provided, by category of service: (#)					
a. medical services	33,007	31,609	31,099	23,431	25,402
b. surgical services	4,483	5,141	6,121	4,888	7,510
c. diagnostic services	3,344	2,339	2,775	1,667	1,814
d. all insured physician services	40,834	39,089	39,995	29,986	34,726
47. Total payment to (fee-for-service) physicians for insured services by category of physicians: ($)					
a. general practitioners	994,636	907,848	1,156,197	699,718	788,293
b. specialists	681,869	727,972	303,424	885,944	1,192,364
c. all physicians	1,676,505	1,635,820	1,459,621	1,585,662	1,980,657
48. Total payment to physicians for insured services, by category of service: ($)					
a. medical services	1,477,892	1,436,115	1,133,717	1,224,899	1,392,766
b. surgical services	121,755	132,349	260,188	285,503	481,940
c. diagnostic services	76,857	67,356	65,716	75,261	105,951
d. all insured physician services	1,676,504	1,635,820	1,459,621	1,585,663	1,980,657
49. Average payment for insured (fee-for-service) physicians services by category of physicians: ($)					
a. general practitioners	32.73	32.71	35.05	37.50	36.00
b. specialists	65.29	64.24	43.29	78.25	92.94
c. all physicians	41.06	41.85	36.50	52.88	57.04
50. Average payment for insured physician services by category of service: ($)					
a. medical services	44.78	45.43	36.46	52.28	54.82
b. surgical services	27.16	25.74	42.51	58.41	64.17
c. diagnostic services	22.98	28.80	23.68	45.15	58.41
d. all insured physician services	41.06	41.85	36.50	52.88	57.04

Northwest Territories

Registered Persons						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st.	(#)		41,000	41,673	42,886 [1]	40,399 [1]

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [2]
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care:	(#)					
a. acute care			4 Hospitals [3]	4 Hospitals [3]	4 Hospitals [3]	4 Hospitals [3]
b. chronic care			not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
c. rehabilitative care			not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
d. out-patient diagnostic care			not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
e. surgical day care (out-patient)			not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
f. other			28 [4]	28 [4]	28 [4]	28 [4]
g. total facilities			32	32	32	32
3. Number of staffed beds in all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			not available	not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available	not available
e. other			not available	not available	not available	not available
f. total staffed beds			212	220	173	not available
4. Approved bed complement for all facilities providing insured hospital services, by type of bed:	(#)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			not available	not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available	not available
e. other			not available	not available	not available	not available
f. total approved bed complement			212	220	173	not available

1 2001-02 figure is as of September 18, 2002, and the 2002-03 figure is as of September 2, 2003.

2 Hospital data for 2002-2003 is incomplete at time of publication.

3 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.

4 Includes Health Centres and Public Health Units. Figures for measures 3 through 25 do not include Health Centre and Public Health Unit activity.

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [2]
5. Number of separations from all facilities providing insured hospital services, by type of care: **(#)**					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		7,955	7,217	6,984	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. surgical day care (out-patient)		2,772	2,445	2,254	not available
f. alternative level of care		not available	not available	not available	not available
g. newborns		472	725	533	not available
h. other		59,634	65,405	67,562	not available
i. total separations		70,833	75,792	77,333	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: **(# of days)**					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		15.20	11.10	26.57	not available
d. newborns		2.89	3.01	2.97	not available
e. other		4.65	4.36	4.01	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: **($)**					
a. acute care		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
b. chronic care		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
c. rehabilitative care		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
d. out-patient diagnostic care		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
e. surgical day care (out-patient)		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
f. other		not applicable [3]	not applicable [3]	not applicable [3]	not applicable [3]
g. total payments to facilities providing insured hospital services		36,215,847 [3]	40,282,046 [3]	44,268,039 [3]	48,451,358 [3]
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: **($)**					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		1,443.67	1,761.67	1,904.15	not available
d. other		1,346.70	1,472.54	1,681.33	not available

[2] Hospital data for 2002-2003 is incomplete at time of publication.

[3] Northwest Territories does not have facilities that provide these services as their primary type of care. Instead, the 4 hospital acute care facilities provide long term care, extended care, day surgery, out-patient services, diagnostic services and rehabilitative care.

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003 [2]
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			107.33	118.91	131.82	not available
d. out-patient diagnostic care			not available	not available	not available	not available
e. surgical day care (out-patient)			390.43	433.19	409.67	not available
f. other			106.52	117.64	129.80	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			148.50	175.44	232.98	not available
d. other			557.18	568.95	606.13	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities			0	0	0	0
b. private diagnostic imaging facilities			0	0	0	0
c. Total private for-profit health care facilities			0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities			not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities			not applicable	not applicable	not applicable	not applicable
c. Total insured hospital services provided at private for-profit health care facilities			not applicable	not applicable	not applicable	not applicable
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities			not applicable	not applicable	not applicable	not applicable
b. private diagnostic imaging facilities			not applicable	not applicable	not applicable	not applicable
c. Total payments to private for-profit health care facilities			not applicable	not applicable	not applicable	not applicable

[2] Hospital data for 2002-2003 is incomplete at time of publication.

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Hospital Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)		1,076	952	991	1,040
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)		7,828	8,105	8,366	8,663
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)		7,414,480	6,741,844	7,432,531	9,716,439
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)		1,200,552	1,775,206	1,838,847	2,280,191
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)		6,890.78	7,081.77	7,500.03	9,342.73
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)		153.37	219.03	219.80	263.21

Insured Hospital Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)		6	5	3	1
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)		12	16	15	12
22. Total payments for out-of-country, in-patient, insured hospital services.	($)		10,606	3,744	13,771	1,595
23. Total payments for out-of-country, out-patient, insured hospital services.	($)		2,363	2,205	2,851	2,775
24. Average payment for out-of-country, in-patient insured hospital services.	($)		1,767.63	748.87	4,590.49	1,595.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)		196.91	137.84	190.06	231.28

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Surgical-Dental Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan.	(#)		not available	not available	not available	not available
27. Number of insured surgical-dental services provided by participating dentists.	(#)		not available	not available	not available	not available
28. Total payments to dentists for insured surgical-dental services.	($)		not available	not available	not available	not available
29. Average payment per service for insured surgical-dental services.	($)		not available	not available	not available	not available

Insured Physician Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners			35 [5]	29 [5]	24 [5]	37 [5]
b. specialists			18 [5]	18 [5]	13 [5]	16 [5]
c. other			106 [6]	151 [6]	175 [6]	156 [6]
d. total			159 [7]	198 [7]	212 [7]	209 [7]
31. Number of physicians opted-out of the health insurance plan, by type of physician:	(#)					
a. general practitioners			0	0	0	0
b. specialists			0	0	0	0
c. other			0	0	0	0
d. total			0	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician:	(#)					
a. general practitioners			0	0	0	0
b. specialists			0	0	0	0
c. other			0	0	0	0
d. total			0	0	0	0

[5] Southam Medical Database, Canadian Institute for Health Information. 2002/03 numbers are estimates from NWT Department of Health and Social Services.

[6] This is an estimate of the number of locum physicians. For measures 33 through 38, locum physicians are captured within the general practitioners and specialists categories.

[7] Estimate based on total active physicians for each fiscal year.

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners		142,395	82,242	32,473	18,615
b. specialists		9,495	5,471	5,622	5,511
c. other		not available	not available	not available	not available
d. total		151,890	87,713	38,095	24,126
34. Number of insured physician services provided, by category of service: (#)					
a. medical		not available	not available	not available	not available
b. surgical		not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available
d. other		not available	not available	not available	not available
e. total		213,665	200,198	199,744	194,622
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners		5,589,151	3,357,266	1,226,780	824,617
b. specialists		650,639	599,167	616,393	616,650
c. other		not available	not available	not available	not available
d. total		6,239,790	3,956,433	1,843,173	1,441,267
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical		not available	not available	not available	not available
b. surgical		not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available
d. other		not available	not available	not available	not available
e. total		12,334,580	17,037,488	20,032,822	19,865,194
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners		39.3	40.82	37.78	44.30
b. specialists		68.5	109.52	109.64	111.89
c. other		not available	not available	not available	not available
d. all physicians		41.08	45.11	48.38	59.74
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical		not available	not available	not available	not available
b. surgical		not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available
d. other		not available	not available	not available	not available
e. all services		57.7	85.10	100.29	102.07

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)		44,476	40,091	42,351	42,974
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)		2,340,523	2,779,834	2,149,607	2,623,129
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)		52.62	69.34	50.76	61.04

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)		212	186	98	91
43. Total payments for out-of-country insured physician services.	($)		18,197	18,166	9,393	5,871
44. Average payment per service for out-of-country insured physician services.	($)		85.83	97.67	95.85	64.51

Statistics for 1998-1999 are not provided as effective April 1, 1999, Nunavut Territory was formed from part of the Northwest Territories.

Nunavut

Registered Persons					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
1. Total number of persons registered under the health care insurance plan as of March 31st. (#)		not available	26,829	28,630	29,478

Insured Hospital Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
2. Number of facilities providing insured hospital services (excluding psychiatric hospitals and nursing homes), by the facility's primary type of care: (#)					
a. acute care		1	1	1	1
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available
f. other		25 [1]	25 [1]	25 [1]	25 [1]
g. total facilities		not available	not available	not available	not available
3. Number of staffed beds in <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. other		not available	not available	not available	not available
f. total staffed beds		not available	not available	not available	not available
4. Approved bed complement for <u>all</u> facilities providing insured hospital services, by type of bed: (#)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. other		not available	not available	not available	not available
f. total approved bed complement		not available	not available	not available	not available

[1] Health Centres.

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospitals Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
5. Number of separations from all facilities providing insured hospital services, by type of care: (#)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available
f. alternative level of care		not available	not available	not available	not available
g. newborns		not available	not available	not available	not available
h. other		not available	not available	not available	not available
i. total separations		not available	not available	not available	not available
6. Average length of in-patient stay in all facilities providing insured hospital services, by type of care: (# of days)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. newborns		not available	not available	not available	not available
e. other		not available	not available	not available	not available
7. Payments to facilities providing insured hospital services, by the facility's primary type of care: ($)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. out-patient diagnostic care		not available	not available	not available	not available
e. surgical day care (out-patient)		not available	not available	not available	not available
f. other		not available	not available	not available	not available
g. total payments to facilities providing insured hospital services		not available	not available	not available	not available
8. Average in-patient per diem cost for all facilities providing in-patient insured hospital services, by type of care: ($)					
a. acute care		not available	not available	not available	not available
b. chronic care		not available	not available	not available	not available
c. rehabilitative care		not available	not available	not available	not available
d. other		not available	not available	not available	not available

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospital Services Within Own Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
9. Average out-patient cost per visit for all facilities providing out-patient insured hospital services, by type of care:	($)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			not available	not available	not available	not available
d. out-patient diagnostic care			not available	not available	not available	not available
e. surgical day care (out-patient)			not available	not available	not available	not available
f. other			not available	not available	not available	not available
10. Average (in-patient and out-patient) cost per visit for all facilities providing insured hospital services, by type of care:	($)					
a. acute care			not available	not available	not available	not available
b. chronic care			not available	not available	not available	not available
c. rehabilitative care			not available	not available	not available	not available
d. other			not available	not available	not available	not available
11. Number of private for-profit health care facilities providing insured hospital services, by the facility's primary type of care:	(#)					
a. private surgical facilities			0	0	0	0
b. private diagnostic imaging facilities			0	0	0	0
c. Total private for-profit health care facilities			0	0	0	0
12. Number of insured hospital services provided at private for-profit health care facilities, by the facility's primary type of care:	(#)					
a. private surgical facilities			0	0	0	0
b. private diagnostic imaging facilities			0	0	0	0
c. Total insured hospital services provided at private for-profit health care facilities			0	0	0	0
13. Total payments to private for-profit health care facilities providing insured hospital services by the facility's primary type of care:	($)					
a. private surgical facilities			0	0	0	0
b. private diagnostic imaging facilities			0	0	0	0
c. Total payments to private for-profit health care facilities			0	0	0	0

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Hospital Services Provided to Residents in Another Province or Territory		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
14. Total number of claims paid for out-of-province/territory, in-patient, insured hospital services (in Canada).	(#)		1,842	1,549	1,782	2,524
15. Total number of claims paid for out-of-province/territory, out-patient, insured hospital services (in Canada).	(#)		9,656	8,682	9,155	10,677
16. Total payments for out-of-province/territory, in-patient, insured hospital services (in Canada).	($)		8,546,013	7,612,791	7,681,154	18,640,982
17. Total payments for out-of-province/territory, out-patient, insured hospital services (in Canada).	($)		1,470,018	1,352,594	1,525,710	1,740,038
18. Average payment for out-of-province/territory, in-patient insured hospital services (in Canada).	($)		4,639.00	4,915.00	4,310.41	7,385.49
19. Average payment for out-of-province/territory, out-patient insured hospital services (in Canada).	($)		152.00	156.00	166.65	162.00

Insured Hospital Services Provided Outside Canada		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
20. Total number of claims paid for out-of-country, in-patient, insured hospital services.	(#)		14	0	0	0
21. Total number of claims paid for out-of-country, out-patient, insured hospital services.	(#)		5	1	53	3
22. Total payments for out-of-country, in-patient, insured hospital services.	($)		12,010	0	0	0
23. Total payments for out-of-country, out-patient, insured hospital services.	($)		1,130	110	128,398	982
24. Average payment for out-of-country, in-patient insured hospital services.	($)		857.00	0.00	0.00	0.00
25. Average payment for out-of-country, out-patient insured hospital services.	($)		226.00	110.00	2,422.60	327.28

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Surgical-Dental Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
26. Number of dentists participating in the health insurance plan. **(#)**		27	21	not available	not available
27. Number of insured surgical-dental services provided by participating dentists. **(#)**		0	not available	not available	not available
28. Total payments to dentists for insured surgical-dental services. **($)**		0	not available	not available	not available
29. Average payment per service for insured surgical-dental services. **($)**		0.0	not available	not available	not available

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
30. Number of physicians participating in the health insurance plan, by type of physician: **(#)**					
a. general practitioners		85	59	81	106
b. specialists		79	55	67	80
c. other		0	0	0	0
d. total		164	114	148	186
31. Number of physicians opted-out of the health insurance plan, by type of physician: **(#)**					
a. general practitioners		not available	0	0	0
b. specialists		not available	0	0	0
c. other		not available	0	0	0
d. total		not available	0	0	0
32. Number of physicians not participating in the health insurance plan, by type of physician: **(#)**					
a. general practitioners		not available	0	0	0
b. specialists		not available	0	0	0
c. other		not available	0	0	0
d. total		not available	0	0	0

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Physician Services Within Own Province or Territory					
	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
33. Number of insured physician services provided, by type of physician (fee-for-service): (#)					
a. general practitioners		not available	61,074	39,035	44,876
b. specialists		not available	29,485	19,733	20,656
c. other		not available	0	0	0
d. total		not available	0	58,768	65,532
34. Number of insured physician services provided, by category of service: (#)					
a. medical		not available	not available	not available	not available
b. surgical		not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available
d. other		not available	not available	not available	not available
e. total		not available	not available	not available	not available
35. Total payments to (fee-for-service) physicians for insured physician services, by type of physician: ($)					
a. general practitioners		2,323,234	2,494,221	1,943,399	2,137,218
b. specialists		1,146,522	1,229,811	1,042,366	1,199,648
c. other			0	0	0
d. total		3,469,756	3,724,032	2,985,765	3,336,866
36. Total payments to physicians for insured physician services, by category of service: ($)					
a. medical		not available	not avialable	not avialable	not avialable
b. surgical		not available	not avialable	not avialable	not avialable
c. diagnostic		not available	not avialable	not avialable	not avialable
d. other		not available	not avialable	not avialable	not avialable
e. total		not available	not avialable	not avialable	not avialable
37. Average payment per service for insured (fee-for-service) physician services, by type of physician: ($)					
a. general practitioners		not available	40.83	49.79	47.62
b. specialists		not available	41.00	52.82	58.08
c. other		not available	0.00	0.00	0.00
d. all physicians		not available	40.92	50.81	50.92
38. Average payment per service for insured physician services, by category of service: ($)					
a. medical		not available	not available	not available	not available
b. surgical		not available	not available	not available	not available
c. diagnostic		not available	not available	not available	not available
d. other		not available	not available	not available	not available
e. all services		not available	not available	not available	not available

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Insured Physician Services Provided to Residents in Another Province or Territory						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
39. Number of services paid for out-of-province/territory, insured physician services (in Canada).	(#)		not available	55,389	39,438	43,064
40. Total payments for out-of-province/territory insured physician services (in Canada).	($)		not available	3,232,940	2,335,998	2,674,445
41. Average payment per service for out-of-province/territory insured physician services (in Canada).	($)		not available	58.00	59.23	62.10

Insured Physician Services Provided Outside Canada						
		1998-1999	1999-2000	2000-2001	2001-2002	2002-2003
42. Number of services paid for out-of-country, insured physician services.	(#)		0	0	12	1
43. Total payments for out-of-country insured physician services.	($)		0	0	14,835	8
44. Average payment per service for out-of-country insured physician services.	($)		0.0	0.00	1,236.25	7.61

Statistics for 1998-1999 are not provided as Nunavut was formed April 1, 1999.

Annex C – 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

Sent to all Ministers of Health [except the Minister for Quebec, who received an equivalent letter in French on July 15, 1985]

Dear Minister:

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

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

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

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and 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
Minister of Health

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

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

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

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

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

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

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

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

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a

provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Diane Marleau
Minister of Health

Annex D – 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.

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 E – Evolution of Federal Health Care Transfers

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

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

The second phase of the federal intervention in support of provincial and territorial health insurance programs came as a result of the recommendations of the Royal Commission on Health Services (Hall Commission) created in 1961. In its final report (1964), the Commission recommended the establishment of a new program that would ensure that all Canadians have access to necessary medical care.

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

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (passed in 1966, came into effect in 1968), the federal contribution in support of medical care was 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory.

Established Programs Financing (EPF)

On April 1, 1977, federal cost sharing in support of health care services was replaced by block funding with the passage of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977,* known also as the EPF Act. Under the EPF Act, federal contributions to the provinces for the three "established" programs—Hospital Insurance, Medical Care and Post-Secondary Education—were no longer tied to provincial expenditures on the basis of cost-sharing formulas. Rather, federal contributions in the base year of 1975-1976 were escalated by the rate of growth of the Gross National Product (GNP). This "block-funded" system of payments was no longer open-ended, and for most of EPF history payments were tied to economic and population growth under various formulae.

Under EPF, cash and tax transfers were provided to the provinces and territories in support of health and post-secondary education. Except for the first few years, the EPF (cash plus tax transfers) was distributed among provinces and territories on an equal per capita basis.

Tax transfers were calculated based on the value of income tax points transferred by the federal government to the provinces and territories in 1977—13.5 personal income tax points and one corporate income tax point.

EPF cash funds were transferred monthly to each province and territory. Starting in 1984-1985, these transfers were subject to provincial/territorial health insurance plans satisfying the criteria and conditions set out in the *Canada Health Act*.

In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion total EPF entitlements (cash and tax), 71.2 percent of which was intended for health care and the rest for post-secondary education.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced the Canada Health and Social Transfer, which replaced the EPF and the Canada Assistance Plan (CAP), the federal provincial cost-sharing plan for social services.

When the CHST came into effect on April 1, 1996, provinces and territories received the same share of the CHST that they had received under the Canada Assistance Plan (CAP), and health and post-secondary education funding made under Established Programs Financing. The provincial and territorial distribution that existed under the previous programs was carried over into the CHST, but has been gradually adjusted to now reflect each province and territory's share of the Canadian population.

The CHST has continued to provide support through both cash and tax transfers for health and other social programs delivered by the provinces and territories.

The CHST is a single block fund, consisting of both cash and tax transfers to the provincial and territorial governments in support of health care, post-secondary education, social assistance and social services. Building on the September 2000 First Ministers' Accord, the 5-year funding framework was extended in the 2003 Federal Budget to fiscal year 2007-2008.

For fiscal year 2002-2003, CHST payments amounted to $35.3 billion in the form of tax point transfers and cash contributions (Source: Finance Canada, September 2003, http://www.fin.gc.ca).

February 2003 First Ministers' Accord

Federal transfers in support of provincial and territorial health care were restructured with the February 2003 Health Care Renewal Accord and the subsequent 2003 Budget. The CHST is augmented by the 5-year $16 billion Health Reform Fund (HRF) beginning in 2003-2004. Two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST) will be established by March 31, 2004 from a split in the CHST (CHT 62 percent: CST 38 percent). Following progress on the primary health care, home care and catastrophic drug reforms, the Health Reform Fund will be folded into the CHT in 2008-2009.

Making CHST Payments

The Department of Finance has been responsible for making CHST payments to the provinces and territories since April 1, 1996. However, the Minister of Health continues to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act,* including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance in advance of the payment dates. The Department of Finance then makes the actual deductions from the twice-monthly CHST payments to the provinces and territories.

Further information of federal fiscal programs and arrangements are available from the Department of Finance (http://www.fin.gc.ca).

History of Federal Transfers Related to Health Care

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

1966 The Canada Assistance Plan (CAP) is introduced, enabling the federal government to pay for, among other things, half the cost of certain health services required by needy persons but not funded though the *Hospital Insurance and Diagnostic Insurance Act*.

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

1977 The *Federal-Provincial-Territorial Fiscal Arrangements and Established Programs Financing Act* (EPF Act) is passed. The Extended Health Care Services Program is established and provides for equal per capita funding.

1982 The EPF Act is renewed. The funding formula is amended so that the national per capita combined transfers are equal.

1984 The *Canada Health Act* (CHA) is passed, amalgamating the provisions of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. The Act also includes the extended health care services provisions, which had previously been included under EPF. The Canada Health Act strengthens the criteria that provinces/territories must meet in order to qualify for full federal funding under the EPF Act.

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

1995 The federal budget announces that EPF and CAP will be replaced by the Canada Health and Social Transfer (CHST) block fund beginning April 1, 1996. CHST entitlements are set at $26.9 billion for 1996-1997 and $25.1 billion for 1997-1998. CHST entitlements for 1996-1997 are to be allocated among provinces and territories in the same proportion as combined EPF and CAP entitlements for 1995-1996.

1996 The federal budget announces a five-year CHST funding arrangement (1998-1999 to 2002-2003) and provides a cash floor transfer to provinces and territories of $11 billion per year.

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

1999 The federal government announces in their budget increases in provincial and territorial CHST cash entitlements of $11.5 billion over five years . The $11.5 billion is provided to address fiscal pressures in the health care sector.

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

Following the First Ministers Meeting of September 11, 2000, the Prime Minister announces an increase in health funding through the CHST of more than $21 billion dollars in cash entitlements over five years. The new money addresses concerns raised by provincial and territorial governments that additional funds are needed to deal with immediate fiscal pressures in the health, post-secondary education and social services / social assistance sectors.

A $1B Medical Equipment Fund is established to enable provinces and territories to immediately purchase and install medical equipment for diagnostic services and treatment. The Fund is allocated on an equal per capita basis.

2003 Federal transfers in support of provincial and territorial health care were restructured with the February 2003 Health Care Renewal Accord and the subsequent 2003 Budget. The CHST is augmented by the 5-year $16 billion Health Reform Fund beginning in 2003-2004. Two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST) will be established by March 31, 2004 from a split in the CHST (CHT 62 percent: CST 38 percent).

Annex F – Glossary of Terms Used in the Annual Report

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

Term	Description
Accessibility	The accessibility criterion of the *Canada Health Act* (section 12) requires that health care insurance plans of provinces and territories provide: ❑ insured health care services on uniform terms and conditions, on a basis that does not impede or preclude reasonable access to these services by insured persons, either directly or indirectly; ❑ payment for insured health services according to a system of payment authorized by the law of the province or territory; ❑ reasonable compensation for all insured health care services rendered by physicians and dentists; and ❑ payment to hospitals to cover the cost of insured health care services.
Acute Care	Acute care includes health services provided to persons suffering from serious and sudden health conditions that require ongoing professional nursing care and observation. Examples of acute care include post-operative observation in an intensive care unit, and care and observation while waiting for emergency surgery.
Acute Care Bed	An acute care bed is a bed in a health care facility which has been designated for the treatment or care of an in-patient with an acute disease or health condition.
Acute Care Facility	An acute care facility is a health care facility providing care or treatment of patients with an acute disease or health condition.
Admission	The official acceptance into a health care service facility and the assignment of a bed to an individual requiring medical or health services on a time-limited basis.
Block Fee	This is a fee charged by a physician for services that are not insured by the provincial or territorial health insurance plan, such as telephone advice, renewal of prescriptions by telephone, and completion of forms or documents.
Canada Health Act (CHA)	The *Canada Health Act* received Royal Assent on April 17, 1984, with the unanimous support of the House of Commons and the Senate. The Act, which replaced the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968), sets out the national standards that the provincial and territorial health insurance plans must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST).

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

Term	Description
Coordinating Committee for Reciprocal Billing (CCRB)	Please see "Interprovincial Health Insurance Agreements Coordinating Committee."
Day Surgery Bed	A day surgery bed is a bed in a health care facility designated for short-term (less than 24 hours) surgical services.
Diagnostic Imaging	A procedure that detects or determines the presence of various diseases and/or conditions with the use of medical imaging equipment. Medical imaging equipment may include bone mineral densitometry, mammography, magnetic resonance imaging (MRI), nuclear medicine, ultrasound, computed tomography (CT), and X-ray/fluoroscopy.
Diagnostic Physician Service	For purposes of reporting on the *Canada Health Act*, a diagnostic physician service is any medically required service rendered by a medical practitioner that detects or determines the presence of diseases or conditions.
Discretionary Penalties	Discretionary penalties are outlined in sections 14 to 17 of the *Canada Health Act*. Under these provisions, the federal minister of health may authorize that a reduction in federal payments to a province or territory under the Canada Health and Social Transfer (CHST) be made when a breach of any of the five criteria or two conditions of the *Canada Health Act* have been identified and could not otherwise be resolved through consultations between the respective levels of government. The amount of any deduction is based on the gravity of the default.
Dispute Avoidance and Resolution (DAR)	In April 2002, provincial and territorial governments accepted a *Canada Health Act* dispute avoidance and resolution (DAR) process that would apply to the interpretation of the principles of the *Canada Health Act* as outlined by the Honourable A. Anne McLellan, federal Minister of Health, in a letter to the Honourable Gary Mar, Alberta Minister of Health and Wellness. The *Canada Health Act* dispute avoidance and resolution process commits governments to continue to actively participate in ad-hoc federal, provincial and territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise. Health Canada will also continue to provide advance assessments on provincial and territorial measures and direction, when requested. Please see Annex D of the *Canada Health Act Annual Report, 2002-2003* for a more detailed description of the DAR process.
Eligibility and Portability Agreement	The original Interprovincial/Territorial Agreement on Eligibility and Portability was approved by provincial and territorial Ministers of Health in 1971 and was implemented in 1972. The Agreement sets minimum standards with respect to interprovincial and territorial eligibility and portability of health insurance programs. Provinces and territories voluntarily apply the provisions of this agreement, thereby facilitating the mobility of Canadians and their access to health services throughout Canada. Officials meet periodically to review and revise the Agreement.
Enhanced Medical Goods and Services	These are medical goods or services provided in conjunction with insured services. They are usually a higher-grade service or product that is not medically necessary and provided to a patient for personal choice and convenience.

Term	Description
Epp Letter	In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*. Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the *Canada Health Act*. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the *Canada Health Act*. The letter has been reproduced for reference purposes in Annex C of the *Canada Health Act Annual Report, 2002-2003*.
Established Programs Financing (EPF)	Introduced in 1977, the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, also known as the *EPF Act*, replaced previous federal cost-sharing programs for insured hospital, medical and post-secondary transfers to provinces and territories. The EPF transfer was a block fund which increased annually on the basis of economic and population growth. Under the EPF, cash and tax transfers were provided to provinces and territories in support of health and post-secondary education. Tax transfers consisted of income tax points transferred by the federal government to provincial and territorial governments in 1977. In 1995-1996, the last year of EPF, provinces and territories received $22.0 billion in EPF entitlement (cash plus tax), 71.2 percent of which was intended for health care and the rest for post-secondary education. The EPF transfer was replaced in 1996 by the Canada Health and Social Transfer.
Extended Health Care Services	Section 2 of the *Canada Health Act* defines extended health care services as nursing home intermediate care service; adult residential care service; home care service; and ambulatory health care service.
Extra-billing	Section 2 of the *Canada Health Act* defines extra-billing as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health insurance plan of a province or territory.
Extra-billing and User Charges Information Regulations	The only regulations in force under the *Canada Health Act* are the *Extra-billing and User Charges Information Regulations*, which require provincial and territorial governments to provide to the federal Minister of Health, prior to the beginning of a fiscal year, estimates of extra-billing and user charges that are permitted to exist under their health care insurance plans so that appropriate deductions to federal transfers can be levied. Provincial and territorial governments are also required under these Regulations to provide financial statements showing the amounts of extra-billing and user charges actually charged in a fiscal year so that reconciliations with previously estimated deductions can be applied. A copy of these regulations is provided in Annex B of the *Canada Health Act Annual Report, 2002-2003*.

Term	Description
Family-based Registration	A method for registering or enrolling persons under a health care insurance plan whereby insured persons are registered as family units.
Federal Policy on Private Clinics (Marleau Letter)	On January 6, 1995, federal Minister of Health Diane Marleau wrote to each of her provincial and territorial counterparts, providing them with the federal policy position and legal interpretation that the definition of "hospital" as set out in the *Canada Health Act* includes any facility providing acute, rehabilitative or chronic care and includes those health care facilities known as "clinics." She informed them that after October 15, 1995, it was her intention to interpret facility fees charged to patients in such facilities or clinics as user fees. Any province or territory not in compliance with the federal policy on private clinics faced mandatory penalties under the *Canada Health Act* calculated from October 15, 1995. These penalties take the form of deductions from monthly cash transfer payments under the Canada Health and Social Transfer. The Marleau Letter is included in Annex C of the *Canada Health Act Annual Report, 2002-2003*.
Fee-for-service	This is a method of payment for physicians based on a fee schedule that itemizes each service and provides a fee for each service rendered.
General Practitioner	This is a licensed physician in a province or territory who practises community-based medicine and refers patients to specialists when the diagnosis suggests it is appropriate. Some services a general practitioner may provide are: consultation, diagnosis, reference, counselling, advice on health care and prevention of illness, minor surgeries, and prescribing medicines.
Health Care Facility	A health care facility is a building or group of buildings under a common corporate structure that houses health care personnel and health care equipment to provide health care services (e.g., diagnostic, surgical, acute care, chronic care, dental care, physiotherapy) on an in-patient or out-patient basis to the public in general or to a designated group of persons or residents.
Health Care Insurance Plan	The *Canada Health Act* (section 2) defines a health care insurance plan as a plan or plans established by the law of a province or territory to provide for insured health services as defined under this same Act. (Please refer to definition of insured health services in this glossary.)
Health Insurance Supplementary Fund (HISF)	This is a fund, administered by the Canada Health Act Division to assist eligible individuals who, through no fault of their own, have lost or been unable to obtain provincial or territorial coverage for insured health services under the *Canada Health Act*. The fund was first established in 1972, when the portability of insurance between provinces varied and allowed for discrepancies in eligibility rules whereby a resident of Canada could become temporarily ineligible for health insurance in a province or territory following a change of province or a change of health care eligibility status (e.g., discharge from RCMP or Canadian Forces). The passage of the *Canada Health Act* in 1984 eliminated the discrepancies in interprovincial eligibility periods that were the source of most concerns for which the fund was established. There is currently $28,387 in the fund. There have been 5 applications for claims to the HISF since 1986; however, none of these have qualified under the terms and conditions for reimbursement.

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

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

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

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

Term	Description
Separations	This is the total number of in- and out-patients released from a health facility following discharge, transfer, day surgery or death. Separations include newborns.
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.
Staffed Beds	This is the number of beds for which a health care facility has staff to provide health services.
Surgery	The treatment of disease, injury or other types of ailment by using the hands or instruments to mend, remove or replace an organ, tissue, or part, or to remove foreign matter in the body.
Surgical Day Care	Surgical day care includes health care services involving medical operative procedures delivered in a health care facility which do not require an overnight stay in the facility for post-operative recovery or observation.
Surgical-Dental Services	Section 2 of the *Canada Health Act* defines surgical-dental services as any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.
Surgical Physician Service	For purposes of reporting on the *Canada Health Act*, a surgical physician service is any medically required surgery rendered by a medical practitioner.
Temporarily Absent	Under the portability criterion of the *Canada Health Act* (section 11(1)(b)), the term "temporarily absent" is used to denote when a person is absent from their home province or territory of residence for reasons of business, education, vacation or other reasons, without taking up permanent residence in another province, territory or country.
Third-Party Payers	These are organizations such as workers' compensation boards, private health insurance companies and employer-based health care plans that pay for insured health services for their clients and employees.
Tray Fees	Tray fees are charges permitted under a provincial or territorial health care insurance plan for medical supplies and equipment such as alcohol swabs, instruments, sutures, etc., that are associated with the provision of an insured physician service.

Term	Description
Universality	This criterion of the *Canada Health Act* (section 10) requires that each provincial or territorial health care insurance plan entitle one hundred per cent of the insured persons of the province or territory to the insured health services provided for by the plan on uniform terms and conditions.
User Charge	Section 2 of the *Canada Health Act* defines a user charge as any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charge imposed by extra-billing. Please refer as well to the definition for extra-billing.
Visits	Visits refers to the number of times an individual or group of individuals seeks treatment at a health care facility. It is possible for an individual to visit a health care facility more than once in one calendar day.