External Affairs Canada Affaires extérieures Canada

Reference Papers

No. 94
(Revised June 1975)

HEALTH AND WELFARE IN CANADA

(Prepared in the Department of National Health and Welfare)

PART I -- HEALTH SERVICES

The administration of health services in Canada comes primarily under the jurisdiction of the ten provincial governments, which delegate considerable responsibility for community health to the local and regional authorities.(1) In promoting the health of Canadians, the Federal Government is concerned with health matters of national and international scope. It gives important financial support to provincial medical and hospital insurance programs, and to the development of other health services. In addition, numerous voluntary organizations provide health services and perform public-education and research activities at the national, provincial and local levels, in many cases aided by government grants.

As the chief federal agency in the field of health, the Department of National Health and Welfare deals with many specialized health matters, as well as assisting provincial health departments. The Health Protection Branch protects the Canadian public from health hazards by ensuring adequate standards for the public sale of foods, drugs, cosmetics and medical devices. It also carries out surveillance, control and research activities on the health effects of environmental factors and the control of communicable diseases. The Health Programs Branch administers the federal aspects of the shared-cost provincial hospital and medical-care insurance programs and makes available technical advisory services, manpower-training assistance and health-research grants to provincial health departments, universities and voluntary agencies. The chief function of the Medical Services Branch is to provide or arrange for medical and health services for native Indians and residents of the Yukon and Northwest Territories; its other functions include the provision of quarantine services and immigration medical services and advice on the health and safety of persons involved in civil aviation.(2)

---

(1) The two territorial governments in the sparsely-populated northern parts of Canada also have jurisdiction over certain health services.

(2) The Branch pays health-insurance premiums on behalf of those native people for whom the Federal Government is responsible.

Under the Medical Care Act, the Federal Government contributes, nationally, 50 per cent of the average costs for each person of provincial medical-insurance plans meeting specified conditions. The Hospital Insurance and Diagnostic Services Act provides for federal cost-sharing in provincial hospital-insurance programs. The Health Resources Fund provides the provinces with up to 50 per cent of capital costs towards the building, renovating and equipping of facilities for research and for training health personnel. The National Health Grant is designed to support research studies and demonstration projects. Under the Canada Assistance Plan, the Federal Government contributes 50 per cent of the costs of health-care services that provinces make available to persons who are eligible because of proved financial need.

The various agencies in Canada concerned about environmental health are in the process of developing and implementing programs to assess and determine the health effects and to assess and control the levels of air and water pollution, radiation, industrial toxicants, and other factors of the general, occupational and home environments known to be, or suspected of being, deleterious to human health. The complexity of their task requires the work of specialists in a variety of disciplines falling within the broad spectrum of the physical, life and engineering sciences and the co-operative efforts of governments and other agencies. Individual tasks include field surveys and interpretation of air and water pollution, research into health effects and their causes from all kinds of toxicants, development of guides and standards for pollutants such as chemicals and other hazards in both the working and general environment, and the specifying of health and safety standards for radiation-emitting devices.

The Federal Government discharges its responsibilities for environmental health principally through the Environmental Health Directorate of the Department of National Health and Welfare by providing regulatory authorities with the most reliable assessments of the adverse effects of environmental factors on human health and carrying out its statutory activities in the related fields of radiation protection and occupational hygiene. The Department of the Environment is responsible for research and regulatory functions having to do particularly with the effects of air and water pollution, solid-wastes management, pesticides and other contaminants, water quality and noise.

Most of the provinces have agencies in their health departments to deal with occupational and environmental health problems. As with the Federal Government, there is a close liaison between

the health officials and officials responsible for assessment and control of the environment. Co-ordination of the many activities within provinces and between the provinces and the Federal Government is usually provided by advisory boards and committees.

Health research is conducted or supported by a number of federal agencies: The Medical Research Council, the Defence Research Board, the Departments of National Health and Welfare and the Department of Veterans Affairs. The National Research Council conducts studies in radiation biology and other life sciences important to health. The principal federal agencies concerned with health statistics are Statistics Canada, the Health Economics and Statistics Division of the Department of National Health and Welfare, and, as a by-product of program activities, certain other units in that Department.

Public Health

Public health comprises those institutions, services and activities that are concerned with the health of the community as a whole, rather than health care for individuals. It includes: environmental sanitation, which is concerned with the purity of air, water and soil; occupational hazards to health, including protection from radiation, work and traffic safety, and noise abatement; the control of infectious diseases, such as tuberculosis and venereal disease; case-finding activities regarding diabetes, glaucoma, tuberculosis and cancer; control of food standards, food contamination and food additives; the safety of drugs; maternal and child health; preventive activities concerning cancer; alcohol and drug addiction; mental illness and retardation; poison-control centres; quarantine; and health education. Health indicators include not only vital statistics and statistics on contagious diseases but indices of hospital morbidity and utilization of medical services and drugs.

Tuberculosis

The incidence of new active cases of tuberculosis decreased from 49 in 100,000 of the population in 1956 to 17.9 in 100,000 in 1972, while the death-rate during that period fell from 7.8 to 2.1 in 100,000.

The provinces maintain case registries, supervise preventive and case-finding activities and provide free treatment in tuberculosis sanatoria, general hospitals and out-patient clinics. Voluntary organizations promote case-finding and health-education activities.

Cancer

The standardized cancer death-rate has been rising steadily for many years, to 137.5 in 100,000 of the population in 1970, but the rate declined slightly in 1971 to 136.2. For females, the rate fell from 114.2 to 111.5. For males, the 1971 rate was virtually unchanged at 160.3. Public and voluntary agencies

engage in detection, treatment, public education and research. Free diagnostic and treatment services are now available in all provinces, supported by hospital and medical-care insurance. The larger general hospitals operate special cancer clinics.

Mental disorders

Provincial mental-health divisions administer or support diagnostic and treatment services for the mentally ill and the mentally retarded. Out-patient departments and psychiatric units of general hospitals, which provide short-term in-patient treatment, and separate community mental-health centres are established in most cities and larger towns. The large mental hospitals admit patients who need long-term care, and the hospitals for the mentally defective care for the more severely retarded.

Although they are not so readily available, diagnostic and treatment services have been established in most large cities for emotionally-disturbed children, the mentally-retarded, persons with alcohol or drug addiction and court offenders.

Mental-health treatment is one of the main areas in which provincial funds are spent. During 1971, mental institutions cost $436 million; about 223,000 patients were treated in clinics and out-patient departments. During 1973, there were 121,000 admissions and the number of in-patients under care at the end of the year was 58,000.

Hospital Insurance

Insured services

Federal-provincial agreements under the Hospital Insurance and Diagnostic Services Act require all provinces and territories to make available to all residents who are covered, on a pre-payment or tax-financed basis, standard ward accommodation and the services ordinarily supplied by hospitals to in-patients -- including meals, nursing care, laboratory, radiological and other diagnostic procedures and most drugs. All provinces set limitations on payments for out-of-province in-patient care, and some require prior approval except in case of emergency. Care in mental and tuberculosis institutions is not included in provincial programs, except in Ontario and in Nova Scotia (where treatment in mental institutions is covered), but such care is provided under separate legislation.

Out-patient hospital services may be included in the insurance programs at provincial discretion; consequently, the services covered vary from province to province. All jurisdictions insure a range of services comparable in comprehensiveness to those available to in-patients. Examples of such services, for most

provinces, are emergency care to accident victims, follow-up care in fracture cases, occupational therapy, physiotherapy and speech therapy, out-patient cytology and cancer radiotherapy, day-care surgical services and minor surgery, and psychiatric day care and night care. British Columbia levies an authorized charge of $1 or $2 daily for out-patient services, depending on type. Nova Scotia insures out-patient care within the province only.

Coverage

Each province makes insured services available to all its covered residents on uniform terms and conditions, without exclusion on grounds of age, income or pre-existing conditions. Residents of the provinces are defined as persons legally entitled to remain in Canada who make their homes, and are ordinarily present, in the provinces; tourists, transients or visitors to the province are specifically excluded. Members of the Armed Forces, the Royal Canadian Mounted Police, and inmates of penitentiaries are not covered, since they are otherwise provided for.

Residence in the province is the major eligibility determinant under federal-provincial hospital-insurance programs. Most provinces require a three-month waiting period, but interprovincial arrangements provide for continuity of coverage when insured persons move from one province to another. Immigrants may qualify for immediate coverage in all provinces except British Columbia, and in that province under specified circumstances (see "Waiting Periods for Immigrants", Page 20).

Financing

The cost of insured hospital services is borne almost entirely by the federal and provincial governments.

The federal contribution for each year is the aggregate in that year of 25 per cent of the *per capita* cost of in-patient services in Canada, plus 25 per cent of the *per capita* cost of in-patient services in the province (less the *per capita* amount of authorized charges), all multiplied by the average number of persons insured during the year. In addition, the Federal Government contributes to out-patient services an amount that is in the same proportion to the cost of these services (less authorized charges) as the amount contributed for in-patient services to the cost of in-patient services. The Hospital Insurance and Diagnostic Services Act provides that the capital cost of land, buildings and physical plant, payments of capital debt, interest on debt, and payments on any debt incurred before the effective date of the agreement shall be excluded before calculation of the federal share.

The provinces raise their share of the cost of hospital services in a variety of ways reflecting local conditions and preferences.

Each province and territory makes at least some use of general tax revenues to finance its program. Newfoundland, Prince Edward Island, New Brunswick, Quebec, Saskatchewan, Manitoba and the Yukon finance entirely from this source.

Ontario raises a part of its cost by a premium combined with medical insurance of $132 for single persons and $264 for couples and families. Alberta levies an annual premium of $69 for single persons and $138 for families under the Health Insurance Premiums Act, which includes both hospital and medical insurance. The tendency in all "premium" provinces has been to combine hospital and medical insurance levies in the interests of administrative simplicity.

In Alberta, British Columbia and the Northwest Territories, part of the financing is derived from use or admission fees. These fees, designated in the regulations as "authorized charges", are payable by the patient at the time of service and are deductible from provincial payments to hospitals. Alberta charges $5 for the first day only of adult or child in-patient care in general hospitals, and in auxiliary hospitals $3 a day after 120 days. British Columbia charges $1 a day for in-patient care (except for newborn infants) and $1 or $2 for out-patient services, as previously mentioned. The Northwest Territories charges $1.50 a day for in-patient care.

Medical-Care Insurance

In addition to hospital care under the hospital insurance and diagnostic services program, a number of other services, mainly those of physicians, are provided under a variety of prepaid arrangements.

Federal medicare legislation

The Medical Care Act was passed by the Canadian Parliament in December 1966 and became operative July 1, 1968. The Federal Government contributes to participating provinces half the costs of insured services in provincial medical-care plans that satisfy the following criteria:

a) A plan must be operated on a non-profit basis by a public authority subject to provincial audit.

b) It must make available all medically-necessary services rendered by medical practitioners and insured services on uniform terms and conditions to all residents of a province; these services must be provided without exclusion because of age, ability to pay, or other circumstances.

c) A plan must cover no fewer than 95 per cent of the total number of insurable residents of the province.

d) For persons normally resident in Canada, a plan must provide "portability" -- that is, full coverage of services after three months of residence in a province and out-of-province coverage during the periods of waiting while a person establishes residence in another province.

The Medical Care Act also empowers the Federal Government to include additional health-care services provided by non-physician professional personnel, under terms and conditions specified by the Governor-in-Council; so far, only dental surgery in a hospital is a benefit.

There is provision in the act for provincial authorities to designate non-governmental organizations as agencies permitted to undertake restricted functions in connection with the premium-collection or claims-payment administration of the provincial plan. Such agencies must be non-profit and the payment of claims must be subject to assessment and approval by the provincial authority. Carriers have been used in this way by a few provincial plans but most, in 1972, were being phased out in favour of centralized administration.

Provinces can finance services in any manner they wish, but the act contains a proviso whose intent is that no insured person shall be impeded in obtaining, or precluded from, reasonable access to insured services as a consequence of direct charges associated with such services. The significance of this requirement is that extra charges, if imposed, must be not more than nominal. A province may adopt any method it wishes of paying the providers of services, subject only to the proviso that the schedules of authorized payments are on a basis that assures reasonable compensation for the services rendered.

The formula for calculating federal contributions to the cost of provincial plans is such that provinces with relatively low *per capita* costs are assisted by something more than half their provincial costs. In general terms, the federal contribution to a participating province is an amount equal to 50 per cent of the *per capita* cost for the year of all insured services in participating provinces, multiplied by the number of insured persons in each province. The Federal Government makes no contribution to administrative costs incurred by the provinces.

Provincial medical-care plans

Before the establishment over the last few years of government-administered medical insurance in most provinces, prepayment

arrangements to cover the cost of physicians' services, mainly voluntary as regards enrolment, had developed rapidly in both the public and private sectors.

By the end of 1968, some 17.2 million Canadians -- 82 per cent of the total population -- were receiving basic medical or surgical coverage or both. The voluntary plans operating only in the private sector covered about 10.9 million persons (52 per cent) and public plans of various kinds covered 6.3 million (30 per cent).

By early 1972, with public medical-care programs implemented in all ten provinces and the two sparsely-settled territories, insurance for physicians' services covered virtually the entire eligible population.

The four criteria for acceptability set out in the federal legislation leave each province with substantial flexibility in determining the administrative arrangements for the operation of its medical-care insurance plan and in choosing the way in which its plan is financed -- e.g., through premiums, sales tax, other provincial revenues or by a combination of methods.

In addition to the comprehensive physicians' services that must be provided as insured benefits by participating provinces, most plans also make provision for other health care benefits that are part of the basic contract but receive no contribution from the Federal Government. Refraction services by optometrists are included in the majority of provincial plans. A restricted volume of services provided by such practitioners as chiropractors, podiatrists (chiropodists), osteopaths and naturopaths is also insured by some provinces. Residents may, if they wish, continue to seek insurance, generally from private voluntary agencies, covering such additional services as dental care, special duty nursing and prescribed drugs.

Additional benefits are made available in some provinces to patients with certain specified conditions. As an example, in Saskatchewan provision was made in 1973 for full payment of the cost of prescribed drugs, up to a limit of $1,000 a year for each patient, required by any resident with chronic end-stage kidney disease who is in receipt of kidney dialysis service on pre- and post-operative kidney transplant service. This program represents an expansion of comparable prepayment services applicable to such conditions as cystic fibrosis. A program covering the cost of hearing aids was set up in 1973.

Seven of the 12 provincial and territorial medical plans finance their portion of total costs entirely from general taxation

revenues, and there is thus virtually no direct cost to families, apart from additional billing that doctors may in some instances impose. Four of the plans employ premium levies to help finance their share of costs, and one employs a payroll tax. Typically, in these plans, premiums are paid for welfare recipients and residents 65 years and over, and various devices are used to keep the financial burden low for families that are poor but just above the poverty-line entitling them to welfare assistance.

Each of the 12 plans in operation is described briefly in the paragraphs that follow, in chronological order of entry into the national program.

It must be noted that, although most doctors are paid on a fee-for-service basis, alternative or additional arrangements include salary, sessional payments, contract service, capitation and incentive pay.

Saskatchewan

This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The Medical Care Insurance Commission, which is the principal administering agency, makes payments to doctors for the bulk of the services provided under the plan. About 5 per cent of the population obtains its insured services under terms and conditions identical to those of the Commission by way of the separate administering agency known as the Swift Current Health Region. Also, the provincial authority arranges for payment for physicians' services in mental and tuberculosis institutions and for cancer control. Premiums were discontinued as of January 1, 1974, and the provincial share of the cost is now financed entirely from general revenues.

Medical benefits include home, office and hospital visits, surgery, obstetrics, psychiatric care outside mental hospitals, anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions. Refractions by optometrists and chiropractic services are also insured benefits. In addition, the plan pays for referred services by dentists for care of cleft palate and for orthodontic oral surgery.

The Medical Care Insurance Commission pays for approved physician's services on the basis of 100 per cent of the negotiated payment schedule and in accordance with the Commission's assessment rules. This payment schedule is about 85 per cent of the current fee schedule established and published by the physicians themselves through their own provincial association, and used primarily for non-insured patients. Participating chiropractors are paid in

accordance with a formula combining contracted total payments amounts for x-rays plus fee for service payments for visits, the payments being progressively discounted as volume per chiropractor increases. Optometrists are paid $11.50 per refraction.

Physicians may choose to receive payment in three ways. First, the physician may receive directly from the Medical Care Commission payment at 100 per cent of the negotiated schedule, and accept this payment as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also, the physician receives the amount agreed on. Thirdly, a physician may choose to submit his bill directly to the patient, who pays him either before or after seeking reimbursement from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. No physician is compelled to confine himself to one or the other of these modes of payment. Physicians may also be paid through clinics that are financed by *per capita* contributions from the provincial authority.

British Columbia

This province became a participant under the federal Medical Care Act on July 1, 1968. The plan is governed by a public commission, originally with jurisdiction over a number of "licensed carriers", which are non-profit agencies charged with responsibility for day-to-day management of the separate components of the program. These are being phased out in favour of centralized administration. In addition to physicians' services and a limited range of oral surgery in hospital, the benefits include refractions by optometrists, some orthoptic services, limited physiotherapy, special nursing, chiropractic and naturopathy. Additional benefits include orthodontic services for cleft palate and harelip.

Participation in the program is voluntary. Premiums are $5 a month for single persons, $10 a month for two-person families and $12.50 a month for families of three or more. For eligible residents (they must have lived in the province the preceding 12 months), the government offers subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. There are no special waivers of premiums as in Alberta and Ontario for persons 65 years and over.

The method of payment to physicians is similar to that in use in Saskatchewan, in this case the plan's payment schedule being about 100 per cent of the current negotiated fee-schedule of the

provincial medical association. Physicians either bill patients for services rendered or accept payment direct from the public authority. In the former case, the physician has to notify the patient in writing, before rendering a service, that he is a non-participating physician, and the patient has to agree in writing that he is prepared to pay more than the amount of reimbursement he may receive from the public authority. In the latter case, the physician may also charge a fee in excess of the tariff, provided the patient has been duly notified and agrees in writing to the extra charge, and the amount of the extra charge is made known to the Commission.

Newfoundland

This province, with Nova Scotia and Manitoba, became a participant on April 1, 1969. The plan covers all medically-required services by doctors, as well as a limited amount of oral surgery in hospital. Refractions by optometrists are not a benefit.

All eligible residents are covered and there are no premium levies, the provincial portion of total costs for insured services being met from general revenues.

In Newfoundland, payments by the plan are limited to 90 per cent of the physicians' fee-schedule. Physicians must formally select, and use exclusively, one of the modes of payment available. A participating physician must accept the 90 per cent as payment in full. A non-participating physician may impose additional charges, provided he informs the beneficiary that he is not a participating physician and that he reserves the right to charge in excess of the amount payable by the plan.

For many years, large numbers of doctors in Newfoundland have contracted with the provincial government and with certain voluntary agencies to receive salaries for service in outlying areas. These arrangements were continued after April 1, 1969, when the province joined the national medical plan.

Nova Scotia

Nova Scotia became a participating province on April 1, 1969. All eligible residents are covered. Registration is required but there are no premiums, the entire amount of the provincial portion of the costs of insured services being obtained from general revenues.

The insured services include all medically-necessary procedures by practitioners, as well as a number of oral-surgery procedures in hospitals. Refractions by optometrists constitute another benefit.

Under the plan, benefit payments amount to 85 per cent of the

negotiated physicians' fee-schedule. Physicians who choose to take part must accept all payments direct from the plan. Both participating and non-participating physicians may "extra-bill", but they must obtain the written consent of the patient before rendering a service, and the amount of the extra charge has to be made known to the Commission.

The Nova Scotia plan is administered by a non-profit carrier designated by the public authority as its sole agent with respect to fee-for-service accounts. This agency carries out all functions relating to eligibility-checking and the processing and payment of claims, subject to review and audit by the public authority.

Manitoba

Manitoba began participating under the federal Medical Care Act on April 1, 1969. Registration is compulsory for all eligible residents. Premiums were discontinued as of July 1, 1973, and the provincial share of the cost is now financed entirely from general revenues.

The insured benefits cover all medically-required services provided by medical practitioners and limited dental surgery in hospitals. Also included, with limitations, are the services of chiropractors and refractions by optometrists.

Physicians may choose to participate in the plan and to accept all payments from public authority, or they may elect to receive payments direct from all their patients. In the former case, the amount received (85 per cent of the physicians' fee-schedule) must be accepted as payment in full. A non-participating physician must give a patient "reasonable notice" if he intends to "extra-bill". Payment is also made for prosthetic devices and certain limb and spinal orthotic devices and services that are medically required. Contact lenses following congenital cataract surgery and artificial eyes are also benefits.

Alberta

Alberta became a participating province under the federal Medical Care Act on July 1, 1969, with administration by a Health Care Insurance Commission. A combined annual premium of $69 for single persons and $138 for families covers both medical and hospital insurance. Subsidies reduce the premiums to $24 for single persons and to $48 for families with no taxable income in the previous year; to $36 for single persons whose taxable income does not exceed $500; and to $72 for families whose combined taxable income does not exceed $1,000. Premium payments are waived for household heads 65 years of age or over. The levy is also waived if it is the spouse only who is 65 years or over.

Registration and payment of applicable premiums are compulsory.

Failure to comply makes residents liable to a waiting period of three months following registration before becoming eligible for insured services.

In addition to the benefits of physicians' services and a limited range of oral surgery, the cost of which are shared with the Federal Government, the Alberta program includes refractions by optometrists, services and appliances provided by a podiatrist, a limited range of osteopathic services, certain additional dental services, and chiropractic services.

Residents objecting in principle to claiming benefits under the new combined hospital and medical program can "opt out", with no liability for premium payment. For hospital and related care, they are at liberty to obtain private insurance coverage but application of the federal Medical Care Act prevents private carriers from offering insurance for physicians' services.

The plan also offers subscribers the option of purchasing insurance for additional health services (again, with subsidy provisions) from the voluntary Alberta Blue Cross agency. The optional membership offers coverage for hospital-differential charges for semi-private and private-ward care, ambulance services, drugs, appliances, home-nursing care, naturopathic services, clinical psychological services, and dental care needed because of accidental injury.

Payments to physicians are made at 100 per cent of the fee-schedule of the provincial medical association. Doctors may elect to bill patients for fees beyond those paid by the plan. In such cases, they are required to notify patients beforehand, and must indicate to them the total amounts and the amounts that will be paid by the plan.

Ontario

Ontario began taking part on October 1, 1969. Enrolment is compulsory for employee groups of 15 or more persons, and provision is made for the voluntary creation of a mandatory group if there are from five to 14 employees.

Insured benefits cover all medically-required services by medical practitioners and oral surgeons in specified hospital settings, optometrists' refractions and, with limitations, certain paramedical services offered by chiropractors, osteopaths and podiatrists. Additional benefits are ambulance costs and partial out-of-hospital physiotherapy costs.

Doctors are permitted two ways of receiving payment. Those billing the medical plan directly are paid at a rate of 90 per cent of the

negotiated fee of the provincial medical association for the service rendered; they cannot charge the patient for the balance. Doctors choosing to bill patients direct cannot be paid by the plan. Patients must pay their doctors for billed amounts, but can recover from the plan 90 per cent of the fees for the services rendered.

The levy for the combined hospital-medical premium is $132 a year for single persons and $264 a year for couples and families. Premiums are waived for welfare recipients and for all residents 65 years of age or older. Premium-subsidy assistance was extended on April 1, 1972, to cover hospital as well as medical insurance. Single persons and families with no taxable income in the current year are eligible for 100 percent assistance in premium payments. A single person with taxable income under $1,000 and a couple or family with taxable income under $2,000 are eligible for 50 per-cent assistance.

The public authority in Ontario at first made use of administering agencies. By early 1972, the activities of private carriers were phased-out and their functions absorbed into the program of the public carrier.

Quebec

This province entered the national program on November 1, 1970. Registration of all eligible residents is compulsory and, as with other plans, the benefits include all medically-required physicians' services and also refractions by optometrists, and a limited range of dental services.

The medical services are provided for the most part by doctors engaged in private fee practice and are paid for on the basis of claims submitted. Doctors who participate receive their entire remuneration, directly or indirectly, from the provincial agency, the Quebec Health Insurance Board, in accordance with a negotiated schedule of benefit payments for each service provided, and they cannot extra-bill. They may choose, however, to be paid by the patient, who is reimbursed by the Board. Doctors who choose not to participate must collect all fees (except for emergency care) from the patient, who cannot, as in other provinces, seek reimbursement from the provincial agency. He must pay the entire amount himself.

For financing of part of the provincial share of costs a tax on earnings is used. Each tax-payer whose net annual income is $5,200 or more if married or $2,600 or more if single, contributes 0.8 per cent of such income up to a maximum of $125 as regards employees who get at least three-quarters of their income from wages and salaries and up to $200 in other cases. Employers also

contribute 0.8 per cent of their payrolls. Welfare recipients and others who happen to have earnings below the income thresholds are covered without payment of the tax on earnings.

Prince Edward Island

This province began participating on December 1, 1970. Benefits are comparable to those in other provinces. Registration is required but is not a condition of eligibility. All funds required to meet the provincial share of costs are obtained from general revenue sources. Doctors who decide to collect directly from patients can extra-bill, but only up to the amount for the service as listed in the medical association fee-schedule and only after they have told the patient their intention, obtained the patient's written consent, and notified the provincial agency of the amount. Doctors who elect to bill the provincial agency directly are paid by the agency 92 per cent of the fee-schedule. This they must accept as payment in full unless, again, they notify the patient of their intention to extra-bill for the additional percentage and obtain the patient's written consent.

New Brunswick

This province began participating on January 1, 1971. Registration is by the family head and is required, although it is not an eligibility requirement. Doctors must indicate whether or not they intend to participate in the plan; if they so decide, they are obliged to accept 90 per cent of their fee-schedule as payment in full. Those doctors who decide to deal directly with particular patients concerning payment may extra-bill beyond amounts indicated at the 90 percent rate.(3)

The New Brunswick plan, like others, is generally comprehensive, including limited oral surgery in hospital.

Northwest Territories

The NWT entered the national program on April 1, 1971. Doctors who elect to submit accounts to the territorial insurance agency must accept from the agency, as payment in full, the amounts set forth in the agency's benefit schedule. Those who choose to collect directly from patients must initially give notice to the agency that they are not participating and must inform the patient beforehand of their intention. As in three of the Atlantic Provinces, refractions by optometrists are not benefits. Financing of the NWT share of costs is entirely from general revenues.

Because of isolated conditions in this far northern area, it is common, as in the outport areas of Newfoundland, for many doctors to work as salaried employees of third-party institutions and agencies.

---

(3) It should be noted that all provinces permit specialists to extra-bill for non-referred care if the specialist rate is higher than the rate the plan will pay for such service.

Yukon Territory

With the entry on April 1, 1972, of this sparsely-inhabited (population 20,000) area into the nation-wide program, virtually the entire eligible population of Canada was insured for hospital care and physicians' services.

Like three of the provinces, the Yukon plan employs premium levies to finance its share of total costs. Registration of all residents is required, but coverage for insured services is not contingent on premium payment.

Premiums are $78 a year for single persons, $150 for couples and $174 for families. Employers are required to deduct the premiums from the wages or salaries of employees and remit the amounts to the plan. Sharing of the cost of premiums under collective-bargaining agreements is permissible.

Premium assistance is available for low-income families. Individuals and families with no taxable income in the previous year are eligible to have the entire amount of the premium paid on their behalf. Half the premium levies are paid for single persons with taxable income of $500 or less, for couples with combined income of $1,000 or less, and for families with taxable income of $1,300 or less. The Federal Government pays premiums on behalf of the native people for whom it is responsible.

Claims for payment may be made by a doctor either to the plan directly or to the patient. When a patient is billed directly by a doctor, he must be supplied with an itemized account that can be used when seeking reimbursement from the plan. Doctors who choose to bill patients can make any mutually-satisfactory arrangement for remuneration, providing this is done before rendering service; otherwise they must accept what the plan pays as payment in full.

Health-Care Programs for Welfare Recipients

Provincial programs providing certain medical-care and other health-care benefits to recipients of welfare allowances were in operation in each province before the introduction of province-wide medical-care insurance. Organized provincial schemes providing stipulated health services were introduced in Ontario in 1942, Saskatchewan in 1945, Alberta in 1947, British Columbia in 1949, Nova Scotia in 1950, Manitoba in 1960, Quebec in 1966, Prince Edward Island in 1966, and New Brunswick in 1967. Newfoundland has for many years operated a plan that provides care as required for persons in need. The total number of persons eligible for benefits under such programs is estimated at about 5 per cent of the Canadian population.

Since 1966, the Federal Government has, under the Canada Assistance Plan, paid half the cost for needy persons of personal health-care services not already insured under the hospital and medical insurance legislation. The coverage at present for the principal services is as follows:

Physicians' services Following the implementation of public medical-care insurance plans in the provinces, as already described, provincial welfare recipients became automatically enrolled for insured services, and without premium payment in applicable provinces. Under such programs for recipients of welfare, payment-rates to physicians are identical to those applicable to the general population. Benefits may be a little broader, and may include such ordinarily non-insured items as travelling allowance and telephoned advice, the cost of these additional items being generally shared under the Canada Assistance Plan. Extra-billing by physicians, where practised, is usually waived.

Hospital care Hospital-care insurance programs in every province provide automatic coverage to welfare-allowance recipients without payment of premiums or charges by them.

Prescribed-drug benefits In British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Quebec and Newfoundland, virtually all provincial public-assistance recipients are enrolled under schemes providing prescribed-drug benefits. In Quebec, recipients of the Guaranteed Income Supplement are entitled to the same benefits as social assistance recipients. Drug benefits consist of practically all available prescription drugs and some unprescribed ones. Payment-rates to pharmacies or dispensing physicians are negotiated by provincial governments. In Saskatchewan and New Brunswick, certain patients may be required to pay co-charges.

The Ontario and Nova Scotia governments subsidize the cost of drugs provided by municipalities operating welfare programs for those in need. Direct supplemental drug allowances are also available to the needy, under provincial auspices.

Most provinces supply, through their health departments, certain drugs that are important in the prevention of infections (venereal disease, rheumatic fever, and tuberculosis), where therapy costs can be very high.

Dental-care benefits Dental benefit plans are operated for selected recipients of welfare in most provinces. In British Columbia, special means tests are applied to public-assistance recipients in order to qualify them for enrolment. A separate program is operated in that province for the children under 13 years of age of all welfare

recipients. The Ontario program provides dental benefits to persons in receipt of mothers' allowances and dependent fathers' allowances. This includes parents and children under the age of 18. Provincial assistance is also available for essential dental services to others at municipal discretion. All provincial public-assistance recipients qualify for dental benefits of schemes operated in Alberta and Saskatchewan, and selected categories in Manitoba. Quebec has introduced a program that emphasizes care among lower age categories.

Benefits under these dental plans usually exclude certain specified services and require prior authorization for some services. In the three most westerly provinces, posterior bridgework, prophylaxis and paedodontics are excluded. Prior authorization is required in British Columbia and Saskatchewan for dentures, relines, gold inlays, orthodontia and periodontia. Payments to dentists are at negotiated fixed rates under each of these plans. The patient is required to pay a co-charge of approximately 50 per cent of the cost of dentures in Alberta and Saskatchewan.

A limited range of in-hospital dental surgery performed by physicians and dentists is a benefit under provincial medical-care insurance plans.

Optical-care benefits

Health-benefit schemes for welfare recipients included certain optical-care services and eyeglasses in the four most westerly provinces.

With the nation-wide implementation of public medical-care insurance programs, refractions performed by physicians became general benefits under most schemes, and refractions by optometrists as well in a number of provinces.

Frames, lenses and fittings continue to be benefits of the provincial health-benefit schemes in the Western provinces. Certain restrictions generally govern the amount that will be paid for frames -- e.g., for cosmetic purposes.

Other health-care benefits

Other health benefits provided under programs in some province include home nursing, appliances, physiotherapy, podiatry, chiropractic, and emergency transportation, usually at the discretion of the provincial authority. All such payments, including those initiated by municipalities, are sharable under the Canada Assistance Plan. Some of these benefits are now included under provincial medical-care insurance plans.

Special health-care programs for elderly and other age-specific persons

There is no Canada-wide insurance plan to cover the costs of drugs, dental care, eyeglasses and other appliances, although in most provinces, as noted above, some or all of these are benefits (cost-shared under the Canada Assistance Plan Act) for residents in receipt of welfare and related income-support allowances. The trend during 1973 and 1974 in certain provinces was to broaden services made available on the basis not only of income but of age.

In addition to amending its drug program for social-assistance recipients by increasing the number of medicaments to 2,015 from 1,808, and by eliminating deterrent charges on certain drugs, the Province of Quebec extended its coverage to include persons 65 years of age and over who were in receipt of the Old Age Security pension and were also receiving the maximum amount of guaranteed monthly income supplement. The "maximum" provision was abandoned on January 1, 1975.

In 1973, Manitoba introduced a prescribed-drug benefit program for Old Age Security pensioners 65 years of age and over; under this program, reimbursement is 80 per cent of expenditures in excess of $50 a year. British Columbia initiated a program in 1974 for pensioners 65 and over that covers the full cost of drugs. This province already had a program covering the full cost of drugs for welfare recipients and another, which is optional, for low-income but self-supporting residents; this second program pays half the cost of each prescription beyond an initial $2 payable by the subscriber.

Alberta made an extended range of health-care benefits available in 1973 without charge to all pensioners 65 or over. This program covers the cost of drugs in full (after the pensioner has paid the first $20 in any year), and the cost of glasses, hearing-aids, dental work and certain appliances. Persons under 65 continue to be eligible for these and other services on an optional basis by paying a reduced premium.

Several provinces began or expanded dental-care programs covering all children in specified age groups. In 1974, Saskatchewan introduced a province-wide program, centred on school clinics, that makes use of the services of dental therapists and dentists who are on referral to provide all care needed by six-year-olds in the first year of the scheme. New age groups are to be added every year until all children from three to 12 are covered.

The Quebec program pays for dental care for children under eight, which is provided on a fee-for-service basis, mainly in dentists' offices. Manitoba is developing a program for children that is to

be administered by the existing health-insurance agency.

The four Atlantic Provinces (Newfoundland, Nova Scotia, New Brunswick and Prince Edward Island) have been trying to develop preventive programs for children, beginning usually at seven and under or from four to nine. Some clinics were operating in 1974.

Federal programs

The Federal Government has usually provided a range of health benefits to needy war veterans, Indians and Eskimos. These groups are now covered under provincial or territorial public hospital and medical-insurance plans. The Federal Government continues to provide such extended health care as is necessary where it is not among the benefits of provincial health-insurance programs.

Waiting Periods for Immigrants and Others

As already noted, all provinces have in operation insurance plans that, in the main, pay the full cost of virtually all medically-required hospital care and of physicians' services, whether rendered in patients' homes, in doctors' offices, or in hospitals. The insured services include surgery and diagnostic tests. The normal waiting period for a new resident in a province is three months after establishing residence there.

All provinces provide first-day coverage on arrival, discharge or release, as applicable, to bona fide residents who have no immediate previous opportunity to acquire coverage. This applies to the following groups in all provinces except British Columbia, where it applies only to new residents in Group (a):

(a) newborn children, non-Canadian spouses of Canadian residents assuming residence in Canada for the first time; members of the Canadian Armed Forces and the Royal Canadian Mounted Police; penitentiary prisoners (on discharge or release);

(b) landed immigrants; repatriated Canadians; returning Canadians; returning landed immigrants; Canadian citizens establishing residence in Canada for the first time.

In most plans, eligibility for coverage is contingent on any registration or premium payment requirement, or both, having been met. It is important in Canada, when moving residence within the country, to maintain any pre-existing coverage until the waiting period in the new province of residence has been fulfilled.

In all provincial and territorial plans there can be no exclusions or limitations of membership or of benefits by reason of age,

economic status or previous medical condition. The basic insured benefit is hospital care and physicians' services, but some plans also insure, sometimes as an added option, such benefits as the services of optometrists, druggists for prescribed medicaments, physiotherapists, podiatrists (chiropodists), chiropractors, osteopaths and naturopaths.

In addition to the medical examination of immigrants, the Department of National Health and Welfare helps immigrants obtain treatment after arrival in Canada. It pays for medical and dental care of unsponsored and indigent immigrants who become ill *en route* or while awaiting employment who do not qualify for provincial health services. In provinces that do not extend hospital care to immigrants prior to usual waiting periods, these costs are shared equally for a period not exceeding one year by agreement between the Department of Manpower and Immigration and the provincial governments.

Health Insurance for Canadians Travelling Abroad

In recognition of the mobility of Canadians, federal legislation requires that the benefits of provincial hospital and physicians' services insurance plans be portable when the beneficiary is temporarily absent from the province of residence. This may generally be interpreted to mean anywhere in the world.

Although there is a high degree of conformity in out-of-province benefits within the borders of Canada, payments for insured services, especially for hospital care, received out of Canada are not standardized. Generally, for emergency and out-patient hospital services, payments tend to approximate going charges in the host country. In-patient services (i.e., for persons occupying a hospital bed) are generally paid for at the daily rates prevailing in the home province of the visitor. Higher rates may be paid in exceptional circumstances, such as when the required service is not available in the home province, and where prior authorization has been obtained from the provincial insuring authority.

As regards physicians' care, provinces generally limit the amount payable for the insured service received outside Canada to the amount payable for similar services in the home province, although, again, there are exceptions and the actual rates paid in reimbursing the patient may approximate or be equal to the amounts charged to the patient by the foreign physician.

Subject to satisfying premium-paying requirements in three pro-

vinces, Canadian residents visiting or studying abroad retain their entitlement to insured hospital and physician benefits in the host country for at least 12 months, and often longer, after leaving Canada. In one province, the period of absence is limited to six months. Students can remain insured beyond a year depending upon circumstances. Other residents, temporarily absent for more than a year, can in some provinces continue their insured status if the insuring authority is satisfied as to reasons for absence and intention to return to the home province.

Rehabilitation Services

Public and voluntary agencies provide rehabilitation services to disabled and handicapped persons, including remedial treatment, special education and vocational rehabilitation. The Federal Government is responsible for the rehabilitation of disabled veterans and, in co-operation with the provinces, for aid to handicapped Indians and Eskimos. Special services are established for handicapped children, blind persons, the mentally retarded and for persons handicapped by tuberculosis, psychiatric disorders, arthritis, paraplegia, cystic fibrosis and other conditions.

Medical rehabilitation, financed under the provincial hospital insurance and medical-care insurance plans, is available at 36 hospital rehabilitation units and at 15 separate in-patient rehabilitation centres. In addition, there are some 20 out-patient rehabilitation centres for children, supported by voluntary agencies and provincial health departments. Workmen's compensation boards in five provinces operate rehabilitation centres for injured workmen. Twelve prosthetic-service centres, operated by the Department of National Health and Welfare, are established in the larger cities across the country. Universities offer courses in physiotherapy, occupational therapy, audiology and speech therapy and in prosthetics and orthotics.

Under a federal-provincial vocational rehabilitation program, provincial welfare departments arrange for handicapped persons to have assessment, counselling, vocational training and job placement as required. In some areas, local committees and voluntary agencies engage in finding jobs for the handicapped besides the Canada Manpower Centres (national employment offices).

Voluntary Health Agencies

National, provincial and local voluntary organizations play an important role in supplementing government health services, including health information and the support of training and research

Many services are organized to serve people with specific afflictions -- for instance, blindness, cerebral palsy, deafness, epilepsy, diabetes, mental disorders, hemophilia and paraplegia. Two of the largest provincial organizations that care for crippled children and for disabled adults are affiliated with the Canadian Rehabilitation Council for the Disabled.

The Victorian Order of Nurses cares for the sick at home; the Canadian Red Cross provides homemaker services, lends sick-room supplies, and collects blood from volunteers for hospital use; the Order of St. John provides care and operates first-aid stations at mass gatherings. In most cities and towns, voluntary agencies operate workshops for the disabled and provide assessment, training and sheltered employment.

Various national organizations carry out or support research, professional training and health education. Among these are the National Cancer Institute, the Canadian Heart Foundation, the Canadian Arthritis and Rheumatism Society and the Muscular Dystrophy Association.

PART II -- INCOME SECURITY AND SOCIAL SERVICES

A wide range of income-security and social-service programs is provided by the federal, provincial and local governments. The Department of National Health and Welfare has the major federal role in income security and welfare. Other federal agencies with important social-security functions are the Unemployment Insurance Commission, the Department of Veterans' Affairs and the Department of Indian and Northern Affairs. The publicly-funded and -administered programs are complemented by a wide range of services provided by voluntary agencies.

The Department of National Health and Welfare administers the Canada Pension Plan, the Canada Assistance Plan, the Old Age Security and Guaranteed Income Supplement programs, and the Family and Special Allowances. Through the Canada Assistance Plan, the Federal Government shares in the financing of provincial social-assistance programs, child-welfare services, services for the elderly, including institutional care, and a variety of social services for needy persons.

In January 1973, the Government of Canada called for a joint federal-provincial review of the Canadian system of social security. As its contribution to the conference held in April of that year, the Government published a working paper entitled *Income*

Security for Canadians, in which the following guiding principles were set out:

"First, the social security system must assure to people who cannot work, the aged, the blind and the disabled, a compassionate and equitable guaranteed annual income.

"Second, the social security system as it applies to people who can work must contain incentives to work and a greater emphasis on the need to get people who are on social aid back to work.

"Third, a fair and just relationship must be maintained between the incomes of people who are working at or near the minimum wage, the guaranteed incomes assured to people who cannot work, and the allowances paid to those who can work but are unemployed.

"Fourth, it must be recognized that Provinces may wish to have the structures of social security vary in accordance with the social needs, income standards and the cost of living in different communities.

"Finally, it must be accepted that the reconsideration of Canada's social security system must be conducted jointly by the Federal Government and the Provinces. A better social security system can only be realized if a reasonable consensus can be reached between the Governments of Canada and the Provinces."

The conference agreed to set up federal-provincial working parties on income maintenance, employment, and social services. It also agreed to complete the review by April 1975. The first results of these efforts are reflected in the changes of the Family Allowance, the Canada Pension Plan, and the Old Age Security programs, as outlined below(4).

Family allowances

Family Allowances are payable for any dependent child under 18 years of age who is resident in Canada and is maintained by at least one resident of Canada who is a Canadian citizen, a landed immigrant, or a person admitted to Canada as a non-immigrant in prescribed circumstances. The application should be made by the person who maintains the child, and the first payment of the allowance will normally be made for the month after these conditions are met. In 1974, the monthly allowance was $20 a child in all provinces except Quebec and Alberta (*see below*). As it is increased annually at the beginning of each year in accordance with the rise of the consumer price index, this amount was raised to $22.08 in January 1975.

---

(4) For more detailed descriptions of federal and provincial welfare programs, see *Social Security in Canada* (1974), published by the Department of National Health and Welfare and the *Canada Year Book*.

A province may, by legislation, vary the Family Allowance rate paid to people living in that province, basing it on the number of children in a family, their ages, or both, provided that (a) no rate in respect of a child is less than 60 per cent of the current federal rate and (b), over the course of three years, total federal payments in a province with its own rate-structure are not more or less than the amount that would have been paid had the uniform federal rate been in effect.

In 1975, families in Quebec receive a monthly payment of $13.25 for the first child, $19.87 for the second, $32.84 for the third and $36.16 for the fourth and for each subsequent children, plus $5.52 for each child between 12 and 17 years of age. In addition, the Province of Quebec pays a monthly allowance of $3.31 for the first, $4.42 for the second, $5.52 for the third and $6.62 for the fourth and each subsequent child. In Alberta the rates vary only with the child's age. The monthly rates are $16.40 for children up to six, $20.80 for those from seven to 11, $27.30 for those 12 to 15, and $30.60 for those 16 to 17. Prince Edward Island pays an additional $10 a month for the fifth and each subsequent child.

The Family Allowance is taxable; persons who claim their children as dependents for tax purposes must also declare the allowances received as income. The payment of the allowance, however, is normally made to the mother.

The program is administered by the Department of National Health and Welfare through regional offices in each provincial capital. The regional director located at Edmonton also administers the accounts of residents in the Yukon Territory and the Northwest Territories.

Old age security program and the guaranteed income supplement

The Federal Government pays a monthly Old Age Security (OAS) pension to a person aged 65 and over who has resided in Canada for ten years immediately prior to the approval of his or her application. Any gaps in the ten-year period may be offset if the applicant had been present in Canada after the age of 18 for periods equal to three times the total of the gaps. In this case, however, the applicant must also have lived in Canada for one year immediately prior to the month in which his application for pension may be approved. The pension is also payable to aged persons who have left Canada before reaching their present age but have had 40 years' residence in Canada since the age of 18. A pensioner may absent himself from Canada and continue to receive payments. If he has lived in Canada for 20 years since his eighteenth birthday, payment outside Canada may continue indefinitely. If not, payment is continued for only six months after the month of departure and is resumed upon his return to Canada.

Persons in receipt of the OAS pension, who have little or no other income, may apply for the Guaranteed Income Supplement (GIS). Receipt of the Supplement depends on the pensioner's income other than the OAS. For every $2 a month of other income, the monthly Supplement is reduced by $1. The GIS is not paid to persons living outside Canada for more than six months.

In January 1975, the monthly OAS pension stood at $120.06; the maximum monthly GIS for a single pensioner was $84.21 and $74.79 for both partners in a pensionable couple. Both the OAS pension and the GIS are indexed every quarter-year to reflect the rises in the consumer price index.

The Old Age Security program and the Guaranteed Income Supplement are administered by the Department of National Health and Welfare through regional offices located in each provincial capital at which applications for pension are received. The regional office in Edmonton administers the program for residents of the Yukon and Northwest Territories.

Canada Pension Plan

The Canada Pension Plan (CPP) is a compulsory, contributory, earnings-related plan, which, with the Quebec Pension Plan (discussed below), covers most employed members of the Canadian labour force between the ages of 18 and 70. Both plans provide: a retirement pension; survivors' benefits, which consist of a surviving spouse's pension, orphans' benefits and a lump-sum death benefit; and disability benefits consisting of pensions for disabled contributors and benefits for their dependent children.

Employees contribute 1.8 per cent of "pensionable earnings" (defined in 1975 as earnings between $700 and $7,400 of both employees and self-employed persons), which is matched by employers. Self-employed persons contribute 3.6 per cent of their "pensionable earnings".

Quebec Pension Plan

The CPP is in force everywhere across the country except in Quebec, which has its own plan -- the Quebec Pension Plan. Both plans began in January 1966, are closely co-ordinated and have established administrative arrangements for dealing with dual contributors so that pension credits are automatically transferred when a person moves from an area covered by one plan to an area covered by the other (i.e., to or from Quebec).

Persons exempt from contributing to these two plans include those who earn less than the minimum "pensionable earnings", migratory workers in certain primary industries (namely farming and fishing), persons employed by their spouses, and employees of foreign governments and international organizations (unless covered by special agreements).

Pension plan provisions

A *retirement pension* is payable, upon application, at the age of 65, whether or not the recipient works and receives wages. The pension amounts to 25 per cent of a contributor's updated pensionable earnings averaged over the years contributions were required.

Although a retirement pension is payable as early as the age of 65, persons between the ages of 65 and 69 who are employed can continue to contribute to the CPP or the QPP in order to increase their future benefits. One cannot, however, both draw a pension and continue to pay contributions.

Disability benefits are paid to contributors who, having contributed for at least five of the ten years preceding the onset of disability, are adjudged to be suffering from a severe and prolonged physical or mental disability. This benefit, which begins three months after the claimant is declared to be disabled, consists of a fixed monthly amount ($37.27 in 1975) and 75 per cent of the contributor's imputed retirement pension.

Survivors' benefits are paid to the surviving widow or widower of a person who, by 1975, has contributed to one of the two plans for at least four years. The full survivor's benefit is payable to: (a) a disabled spouse; (b) a spouse with dependent children; (c) a spouse 45 years of age or older. A partial survivor's pension is payable to a spouse between the ages of 35 and 45. The full survivor's pension for a spouse under the age of 65 includes a flat-rate component ($37.27 in 1975) and 37.5 per cent of the contributor's actual or imputed retirement pension. When such a spouse reaches the age of 65, the pension changes to 60 per cent of the deceased contributor's retirement pension.

Orphans' benefits are paid on behalf of unmarried, dependent children up to the age of 18, or 25 if the orphan continues to attend school or university full-time. The same monthly benefits are payable to children of persons receiving a disability pension. The rate for each of the first four children equals the flat-rate component of the survivor's pension, namely $37.27 in 1975. The rate for each additional child is half this amount. However, each child receives the same amount, since the total orphans' benefits for a family are divided equally among the children. An orphan may receive a benefit in respect of only one deceased contributor.

A lump-sum *death benefit*, equal to six times a contributor's monthly retirement pension, up to a maximum of 10 per cent of that year's maximum pensionable earnings ($740 in 1975), is paid to the estate of a deceased contributor who, by 1975, has contributed to the plan for at least four part years. Benefits are adjusted annually to reflect the full increases in the cost of living.

Benefits are payable no matter where the beneficiary resides, whether in Canada or abroad.

Unemployment insurance

The main income-maintenance scheme for unemployed persons in Canada is the Unemployment Insurance Program, which is administered by the Unemployment Insurance Commission through its head office and local and regional offices throughout the country. The Unemployment Insurance Commission is a Crown Corporation reporting to the Parliament of Canada through the Minister of Manpower and Immigration.

The Program is considered to be social insurance with premiums (contributions) collected through the tax system from all employees and their employers. In 1975, the maximum contribution by an employee is $2.59 a week ($134.68 a year) and the employer's share is $3.63 a week ($188.76 a year). Participation in the scheme is compulsory for all persons who work for an employer and for employers. Virtually the only persons excluded from unemployment insurance are those who are self-employed (with the exception of fishermen, who are also covered) and people over 70 years of age. Approximately 96 per cent of the working force in Canada is insured.

When a claim is filed, the basic entitlement is determined by the number of weeks of insurable employment in the preceding 52 weeks. This initial entitlement can be from eight to 15 weeks. When initial entitlement is exhausted, a further ten weeks is payable in what is referred to as a re-established benefit period. This is ten weeks for all claims. When these benefits are exhausted, further benefits may be payable based on the length of employment in the preceding 52 weeks, the national rate of unemployment and the rate of unemployment in the region in which the claimant resides. The maximum number of weeks for which a claimant may qualify is 51.

The unemployment insurance benefits are related to insurable earnings, or a person's wages from employment, up to a maximum ($9,620 in 1975 or $185 a week). The basic rate payable is 66 2/3 per cent of the average insurable earnings in the last 20 insurable weeks in the last 52 weeks. If a person has eight or more insurable weeks but fewer than 20, the 66 2/3 per cent is applied to the average insurable earnings in all the weeks in question. The maximum weekly benefit payable is $123 in 1975 and the minimum is $20. For persons with a dependant, the rate is increased to an amount equal to 75 per cent of the average insurable earnings in the later stages of a claim, but the $123 maximum still applies. A claimant whose average insurable earnings at the time his claim was filed were $62 a week or less is entitled to the 75 percent

ratio from the outset of this claim if he has a dependant.

A person who has less than eight weeks of insured employment in the 52 weeks preceding his claim cannot qualify. A person with eight to 19 weeks in the preceding year can qualify and is identified as a "minor attachment claimant". A person with 20 or more weeks is designated a "major attachment claimant".

Claimants with a "major attachment" are entitled to benefit during periods of unemployment due to sickness that occur during their initial benefit period, even though they may have left their employment because of their illness. Similarly, female claimants with major attachment are entitled to maternity benefits during their initial benefit period. The maximum time for which sickness or maternity benefits are payable is 15 weeks.

A continuing condition for receipt of unemployment insurance benefits is that the person is available for, and willing to accept, suitable employment and that he is searching for such employment. Claimants must report to an Unemployment Insurance Commission office by mail every two weeks that they are meeting these conditions. This report must be received before the person's cheque is mailed. The Unemployment Insurance Commission has a series of special programs and control measures to ensure that claimants comply with these and other parts of the unemployment-insurance legislation.

Premiums (contributions) are an allowable deduction for income tax purposes. Benefits received are considered as taxable income and the tax is deducted at source -- that is, it is subtracted from the amount given to the beneficiary.

As long as the national unemployment rate is 4 per cent or less, the combined premiums of employers and employees finance both the plan and its administrative costs. When the national unemployment rate exceeds 4 per cent, the Federal Government absorbs the extra costs of the "initial" and "re-established" stages of the plan. The Federal Government also bears the full costs of the "extended benefit" period, regardless of the unemployment situation.

Workmen's compensation

Compensation for injury that occurs at work is provided for by a law in each province. Compensation benefits are payable when certain workers sustain personal injuries that arise out of, and in the course of, their employment. It is also payable for disability or death due to an industrial disease resulting from employment. Where the injury results in a worker's death, compensation is payable to his dependants.

The range of industries covered by workmen's compensation is wide and is being expanded steadily. The main groups of workers not covered are domestic servants, farm workers (except in Ontario and Newfoundland), workers employed by financial, insurance and professional undertakings and by non-profit organizations, and workers in certain service industries. However, employers may obtain coverage on a voluntary basis for workers who are excluded from compulsory coverage, an exception being domestic servants.

Compensation benefits include cash awards, all necessary medical aid, hospital care, physical and vocational rehabilitation services. Benefits for disability are based on 75 per cent of average weekly earnings, subject to an annual ceiling. Payments continue for the duration of the disability and, if disability is permanent, a life pension is paid irrespective of future earnings.

Costs are met from employers' contributions to accident funds at rates that are established by the Workmen's Compensation Board according to the hazards in each class of industry.

Employees of the Federal Government have the same coverage, provided by the Government Employees Compensation Act, which is administered by the federal Department of Labour. Under this act, an injured employee is entitled to the benefits provided by the compensation act of the province in which he or she is usually employed. The cost of such claims is paid out of federal funds provided by this department.

Social assistance and the Canada Assistance Plan

Assistance for persons in need is provided by all the provinces and some municipalities through their welfare departments.

Under the Canada Assistance Plan, the Federal Government reimburses the provinces for 50 per cent of the cost of assistance provided to persons in need and for 50 per cent of certain costs of improving or extending welfare services that prevent or remove causes of dependency or assist recipients to achieve self-support.

"Assistance" includes any form of aid to, or on behalf of, persons in need for the purpose of providing basic requirements such as food, shelter and clothing, including: maintenance of children in the care of provincially-approved child-welfare agencies; items necessary for the safety, well-being, or rehabilitation of persons in need, or for handicapped persons -- such as special food or clothing, telephone, or rehabilitation allowance; maintenance in an institution for special care, such as a home for the aged, a nursing home or a welfare institution for children; travel and transportation; funerals and burials; health-care services, welfare services purchased by, or at the request of, provincially

approved agencies; and comfort allowances for inmates of institutions.

Health-care services may include: medical, surgical, obstetrical, optical, dental and nursing services; drugs; dressings; prosthetic appliances; and other items associated with the provision of such services. Welfare services may include: rehabilitation services; case-work; counselling and assessment services; adoption services; and homemaker, day-care, and similar services supplied to persons in need or to persons to whom the service is essential if they are to remain self-supporting.

The only eligibility requirement specified under the Canada Assistance Plan is that of need, which is determined through an assessment of budgetary requirements as well as of income and resources. A province must not require previous residence as a condition of eligibility for assistance or for continued assistance. Rates of assistance and eligibility requirements are set by the province so that they may be adjusted to local conditions and the needs of special groups.

The provinces also administer federal-provincial allowances for blind persons and those who are totally and permanently disabled. To qualify for these allowances, a person must have lived in a province for ten years and must meet certain income requirements. Most provinces no longer accept applications under these categorical programs, but aid them by means of their general assistance programs, whose costs are shared under the Canada Assistance Plan.

Several provinces operate independent income-support programs, which supplement those administered under the Canada Assistance Plan.

Should an immigrant be unemployed and indigent before having had continuous employment in Canada, the Department of Manpower and Immigration provides financial assistance until such time as he is employed. If the immigrant is in need of assistance after having had continuous employment, he receives aid in the same manner as a Canadian, either from the municipality or the province.

Vocational rehabilitation

Under the provisions of the Vocational Rehabilitation of Disabled Persons (VRDP) Act, the Federal Government contributes 50 per cent of the costs incurred by a province in providing a comprehensive program for the vocational rehabilitation of physically and mentally disabled persons. A comprehensive program includes such services as medical, social and vocational assessment, counselling, restoration services, the provision of prostheses, training,

maintenance allowances and the provision of tools, books and other equipment. These services are provided directly by the provincial government or purchased from voluntary agencies.

Other rehabilitation services provided by agencies and voluntary organizations may be funded by a province and are eligible for 50 percent reimbursement from the Federal Government under the Canada Assistance Plan.

New horizons

The New Horizons Program was established to provide an opportunity for retired Canadians to participate more actively in the life of the community by undertaking activities of their own choice and design. Grants are made available to groups of retired persons, consisting generally of no fewer than ten members, for the purpose of planning and operating projects in which their talent and skills are to be employed for their own betterment, for that of other older persons and for the community at large. Projects must be non-profit in nature and of no commercial benefit to others, and no money is allocated to provide salaries for participants.

Projects funded to date have dealt with physical recreation, crafts and hobbies, historical, cultural and educational groups, social services, information services and activity centres.

PART III -- WELFARE SERVICES

Social assistance to needy persons and the various welfare services associated with this form of aid, as well as the care of the aged and disabled and the protection and care of neglected and dependent children, are governed by provincial welfare legislation. Administrative and financial responsibility is shared by the province and its municipalities, federal reimbursement for half the costs of assistance and of certain welfare services being made under the Canada Assistance Plan. Provincial administration of welfare services is carried out through a department of social services or social development in each province. In some provinces, municipalities administer assistance to persons in short-term need.

Institutional care for the aged and infirm is provided under provincial, municipal or voluntary auspices. A number of provinces make capital grants to municipalities, voluntary organizations or limited-dividend companies for the construction of low-rental housing for elderly persons.

Child-welfare services, including protection, foster care and adoption services, are provided by provincial welfare departments or, in some provinces, by children's aid societies. Particular emphasis is placed on preventive services to children in their homes. Subsidized day-care services for the children of working mothers are operated under voluntary and public auspices. At present, these services are established mainly in the larger centres.

A number of voluntary agencies also deal with groups that have special needs, such as the aged, recent immigrants, young persons and released prisoners. Family-welfare agencies or combined family-and-child-welfare agencies in urban centres, for example, offer case-work services to families in need of counselling on such problems as marital relations, parent-child relations and family budgeting. Counselling and recreational services for older or retired people are being developed by many agencies, and child and youth organizations with recreational and character-building programs offer group participation in such activities as physical education, camping and the development of special skills. Welfare councils and community-planning councils contribute to the planning and co-ordination of local welfare services.

Information Division Department of External Affairs Ottawa Canada