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HEALTH AND WELFARE IN CANADA

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PART I - HEALTH SERVICES

Provincial governments in Canada are mainly responsible for public health services, hospital and medical insurance programs, and for treatment of chronic diseases such as tuberculosis, mental illness and defect, and alcoholism. Many of the preventive health services, including disease detection and control and health education, are delegated to city health departments and district health units or regions. In addition to the governmental health services, lay and religious voluntary agencies supply a variety of community health services and operate most of the hospitals. Personal health care is largely provided by physicians in private practice and the paramedical professions. Some provinces have introduced government administered or regulated medical care programs.

The responsibilities of the Federal Government in matters affecting the nation's health have become increasingly important. It carries out certain statutory and co-ordinating health functions of national importance, assists the provincial health services and hospital insurance plans through the National Health Grants Program and the hospital insurance shared-cost agreements and assists with joint financing of medical insurance. It also participates in international health work, including health-oriented projects in developing countries and the training of their health personnel supported by Canada's bilateral aid programs.

In 1966, the Federal Government enacted three significant measures, dependent upon provincial participation, designed to raise the standard of Canadian health services: the Health Resources Fund, for which $500 million will be appropriated over the 15-year period 1966-1981 to assist the provinces in expanding their medical schools and other health-training facilities and to foster health research; the Medical Care Act, effective July 1968, which authorizes federal payments towards the cost of provincial medical care plans; and the health-care services provision of the Canada Assistance Plan for persons

in financial need. The federal contribution to these health programs is approximately half of total expenditure.

Over the years, federal departments have provided direct health care to certain groups: the Department of National Health and Welfare administers health services to Indians, Eskimos and other residents of the two northern territories, to immigrants, to seamen and to other groups; the Department of Veterans Affairs operates a nation-wide system of hospital, treatment and domiciliary care services for sick, disabled and indigent veterans.

Control and regulatory functions relating to matters of national health concern, also carried out by the federal health department, include: a program to ensure the purity and safety of food and drugs; the activities of the national Environmental Health Centre, which provides research, control, and advisory services on such matters as water-resources management, air pollution and other environmental health problems; a radiation-protection program; and the testing and research advisory services of the Laboratory of Hygiene. The Department of Agriculture also carries specific responsibilities connected with food production to protect the public health.

Health research is conducted or supported by a number of federal agencies: the Medical Research Council, the National Research Council, the Defence Research Board, and the Departments of National Health and Welfare and Veterans Affairs. The principal federal agencies concerned with health statistics are the Dominion Bureau of Statistics and the Research and Statistics Directorate of the Department of National Health and Welfare.

Public Health Services

Provincial health departments, together with city health departments and district or regional health units, carry out the basic preventive health services and specialized services for specific diseases and various health problems. The traditional public health services comprise environmental sanitation, communicable-disease control, maternal and child health, nutrition, dental health, occupational health, public health laboratories and vital statistics. Also well established are the provincial programs for treatment of the venereal diseases, tuberculosis, cancer, alcoholism, mental illness, mental retardation and specialized services for institutional and community or home care of the chronically ill, some of which are operated by voluntary agencies aided by public grants.

More emphasis is being given to the newer environmental health problems of air, water and soil pollution, protection of radiation workers, and the hazards of pesticides. Special programs to deal more effectively with specific health problems include traffic-safety measures, poison-control centres, mass health-screening programs for tuberculosis, diabetes, glaucoma and other chronic diseases, rehabilitation of the chronically ill and disabled, health education on the effects of drug abuse and smoking, and family-planning services.

Tuberculosis Services: During the period 1956-1967, the incidence of new active cases of tuberculosis of all forms decreased by over 50 per cent from 49.4 in 100,000 of the population (7,930 cases) to 23 in 100,000 (4,601 cases); corresponding death-rates dropped from 7.8 to 3.2, a record low. Despite the decline in the incidence of tuberculosis and associated disability,

provincial health departments have not lessened their anti-tuberculosis activities. In most provinces, there is an organized tuberculosis-control division that maintains a tuberculosis case registry, supervises the preventive and case-finding activities of the local health services and provides free treatment in out-patient clinics and sanatoria; in four provinces the sanatoria are privately operated but are supported by tax funds. Voluntary tuberculosis associations are active in each province in case-finding and health education.

Mental Ilness and Defect: Mental health divisions of the provincial health departments administer the public diagnostic and treatment services and assist the privately-operated services for the mentally ill and mentally defective. Community treatment facilities include out-patient mental health centres and psychiatric units of general hospitals that also provide short-term in-patient treatment. The large public mental hospitals, nearly all provincially operated, admit the majority of patients needing long-term care, and the public "hospital schools" for mental defectives, established in all but one province, care for the more severely retarded. In addition, specialized diagnostic and treatment services have been organized in the larger cities for emotionally-disturbed children, the mentally retarded, alcoholics and court offenders. Three treatment centres for drug addicts are operated in Ontario and British Columbia.

Cancer: The standardized cancer death-rate in Canada has steadily risen to a high of 132.0 in 100,000 of the population in 1966. Official and voluntary agencies in all provinces engage in cancer detection and treatment, public education and clinical research. Cancer-control programs have been established in the health departments in three provinces, while provincially-supported cancer foundations carry this responsibility in four provinces. With some variance among the provinces, a range of free diagnostic and treatment services is now available as a result of the federal Cancer Control Grant and the hospital insurance programs; cancer clinics are located at the larger general hospitals in each province. The cancer-control programs in Alberta, Saskatchewan and New Brunswick also pay for the costs of medical and surgical services; elsewhere, some of these costs are covered under the voluntary and public medical-care insurance schemes.

Hospital Insurance

Insured Services: Under federal-provincial hospital-insurance and diagnostic-services programs, all provinces and territories make available, on a prepayment or tax-financed basis, to all covered residents, standard ward accommodation and the services ordinarily supplied by a hospital to in-patients, including meals, nursing, laboratory, radiological and other diagnostic tests and most drugs. All provinces have limitations on payments for out-of-province in-patient care, and some provinces require prior approval except in cases of emergency. Care in mental and tuberculosis institutions is not included in provincial programs, except in Ontario, but is provided under separate legislation.

Out-patient hospital services may be included in the programs at provincial discretion; consequently the services insured and the conditions of availability vary widely from province to province. The following summary indicates the range of coverage by province. Some provinces insure out-patient care within the province only.

Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Saskatchewan, Alberta and the Yukon insure a comprehensive range of services, providing, on an out-patient basis, virtually all services that are available to in-patients.

Ontario insures the following out-patient services: emergency care to accident victims; follow-up care in fracture cases; the use of radiotherapy, occupational-therapy, physiotherapy and speech-therapy facilities in hospitals in Canada; and the hospital component of all other out-patient services as defined in the regulations.

Manitoba insures out-patient emergency care for accident victims; specified surgical procedures; certain procedures related to medical rehabilitation and electro-shock therapy; services provided by the Manitoba Cancer Treatment and Research Foundation; and services provided by the pre-school development clinic administered by the Children's Hospital of Winnipeg.

The Northwest Territories insures out-patient emergency care to accident victims and certain diagnostic procedures and necessary interpretations.

British Columbia insures out-patient cancer therapy at specified facilities operated by the British Columbia Cancer Foundation, as well as Day-Care Surgical Services that include any diagnostic and therapeutic procedures requiring anaesthetic that permit discharge within 24 hours. Authorized charges of $1 a day for cancer therapy and $2 for Day-Care Surgical Services are made to insured persons.

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 province are defined as persons legally entitled to remain in Canada who make their home, and are ordinarily present, in the province; 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, being 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. Persons coming from outside Canada may qualify for immediate coverage in Alberta, Saskatchewan and Newfoundland.

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 in respect 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 is 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 revenue to finance its program. Newfoundland, Prince Edward Island, New Brunswick, Quebec and the Yukon Territory finance entirely from this source. Nova Scotia, in addition, imposes a general sales tax, the proceeds of which are devoted to financing hospital care. Ontario finances about 40 per cent of its cost by a premium of $66 a year for single persons and $132 for families. Manitoba and Saskatchewan finance part of their costs from annual premiums or taxes of $24 for single persons and $48 for families. Manitoba also levies a supplementary tax on individual and corporate incomes, while Saskatchewan levies a general sales tax under the Education and Health Tax Act. In Alberta part of the cost is financed by a 4 mill levy on real property. In Alberta, Saskatchewan, British Columbia and the Northwest Territories, part of the financing is provided from co-insurance charges or utilization fees.

These co-insurance charges or utilization fees, referred to in the legislation as "authorized charges", are payable by the patient at the time of service and are deductible from provincial payments to hospitals. In Alberta, daily authorized charges for adult and child in-patient care are $5.00 for the first day and $2.50 for each subsequent day of care in general hospitals and $1.50 in auxiliary hospitals; for newborn infants the charge is $1.00 a day. All out-patient services in Alberta are subject to a 20 percent co-insurance charge. In Saskatchewan, authorized charges for adults and children are $2.50 a day for the first 30 days of in-patient care and $1.50 a day for the next 60 days; there is no authorized charge for adults and children after the ninetieth day of in-patient care, or for newborn infants at any time. In British Columbia, all patients (except newborns) are required to pay $1.00 a day for in-patient services and $1.00 or $2.00 for out-patient care as previously mentioned. In the Northwest Territories, a charge of $1.50 a day for in-patient hospital care is imposed.

Medical Care Insurance[1]

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 is now committed to contributing to participating provinces half the costs of insured services in provincial medical care plans that satisfy the following criteria:

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(1) Program descriptions of hospital and medical insurance plans are as of March 31, 1969, and thus do not indicate changes made later in the year in coverage, benefits, or administration.

(a) are operated on a non-profit basis by a public authority subject to provincial audit;

(b) make available all medically necessary services rendered by medical practitioners as insured services on uniform terms and conditions to all residents of a province;

(c) cover not fewer than 90 per cent of the total number of insurable residents of the province during the first year of operation, with a commitment that coverage must rise to 95 per cent within three years;

(d) provide for "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.

For a participating province to benefit from the federal program, its own plan must provide for the financing of comprehensive physicians' services for all eligible residents of the province without regard to their age, ability to pay, or other circumstances. The Medical Care Act, in addition, 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.

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.

Provinces can finance services in any manner they wish, but the Act contains a proviso the intent of which is that no insured person shall be impeded or precluded from reasonable access to insured services as a consequence of direct charges associated with the services received. A province may adopt any method it wishes of paying the providers of services, subject only to the proviso that the tariffs 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 would be assisted by something more than half their provincial costs. In general terms, the federal contribution to a participating province is an amount equal to (a) 50 per cent of the per capita cost for the year of all insured services in all participating provinces, (b) multiplied by the number of insured persons in each province respectively. The Federal Government will make no contribution to administration costs incurred by the province.

Two provinces, British Columbia and Saskatchewan, became participants in the federal plan from the date of its inception, July 1, 1968. Manitoba,

Nova Scotia and Newfoundland were scheduled to enter in April 1969, and it is expected that additional provinces will be participants within a few years. This was the progression experienced when the federal hospital insurance program was introduced in 1957-58.

Provincial Medical Care Plans

Government financing of personal health care has been increasing in two directions concurrently.

First, for the indigent, most provincial governments have assured payments to physicians and several, as well, to dentists, pharmacists (for prescribed drugs), optometrists and others. Such programs have operated in several provinces for many years. The remaining provinces have recently made similar provisions. Under the Canada Assistance Plan, the cost of the services can be shared by the Government of Canada.

Second, for the general population, some provincial governments have introduced programs intended to ensure, if necessary by using tax revenue, that all residents can have physicians' services insurance. In Saskatchewan, coverage is compulsory and no other agency is permitted to compete in the service area covered by the public plan. In British Columbia since 1965 and in Ontario since 1966, public agencies administer optional programs available to individual applicants. In Alberta in 1963, the government established minimum benefits and maximum premiums for existing voluntary insurance plans. In 1967 this arrangement was superseded by a plan similar to those in British Columbia and Ontario.

All these schemes cover a comprehensive range of physicians' services, and in British Columbia and Alberta make provision, in addition, for other health-care benefits to be included as part of the basic contract or as options at a somewhat higher premium cost. As already noted, the British Columbia and Saskatchewan plans are eligible to receive federal financial contributions towards the cost of insured services.

As of early 1969, the publicly-administered plans in Alberta offered individual contracts only. Private voluntary agencies continued to offer group contracts. In Ontario, the public plan shared to a limited extent the group contract field with voluntary agencies but in the main offered individual contracts.

In Newfoundland, the population in the Cottage Hospital Districts (i.e., isolated outlying areas) have for many years been able to enrol in a medical service scheme (in addition, all children under 16 years of age throughout the province were covered under the Children's Health Service, at no direct charge to their families, for physicians' services in hospital). The entry of Newfoundland into the national plan on April 1, 1969, means that all residents are eligible for insured physicians' services in office, home and hospital.

All these plans except the Children's Health Service used premiums. To ensure that the premium burden upon individuals is not too heavy, Saskatchewan and Newfoundland covered about three-quarters of the total cost from general tax revenues. In Ontario, Alberta and British Columbia, premiums of the needy,

as defined by a simple test of income adequacy, are subsidized from general tax revenues.

Saskatchewan - Only Saskatchewan has a universal-coverage medical care program. This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory. The premium for a family is $24 a year; for a single person, $12. The premiums cover approximately 25 per cent of the costs of the program.

In 1968 small co-charges to be paid by the beneficiary at the time of receiving service were imposed with respect to certain services. The fees are $1.50 a visit to a physician's office and $2 a visit by a physician with respect to home, emergency, and hospital out-patient services. Fees are waived for welfare recipients and patients under the separate cancer program, and levels of maximum family liability are scheduled to be established in 1969.

Among the medical services covered are home, office and hospital visits, surgery, obstetrics, psychiatric care, 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.

Physicians may elect to receive payment in four ways. First, the physician may receive payment of 85 per cent of the tariffs in the current schedule of fees of the organized profession, directly from the public administering authority, 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 85 per cent of the tariff as payment in full. Thirdly, a physician may elect to submit his bill directly to the patient who pays him and seeks reimbursement authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. Fourthly, patient and physician may, if they agree, settle their accounts privately without involving any public authority or approved health agency. With respect to items of service on which a utilization fee must be paid, the 85 per cent applies to the balance after this fee has been paid.

Alberta - The Alberta Medical Plan was introduced in October 1963. It provided for public regulation of approved voluntary plans with regard to minimum benefits and maximum premiums, and was primarily designed to help residents having poor health or low income to purchase voluntary medical care insurance from approved non-profit and commercial agencies. It was required that the benefits provided be comprehensive and that there could be no exclusion because of age, pre-existing health conditions, or a previous record of high utilization. The government contributed premium subsidies for persons with little or no taxable income.

On July 1, 1966, this plan was supplemented by an extended health-benefit plan which, for an additional premium, made available many other benefits, including prescribed drugs, optometry, physiotherapy, ambulance service, osteopathy, chiropractic, podiatry, naturopathy, and certain other medical supplies and appliances. A deductible amount, co-insurance charges, and limited liability on some services applied to the extended plan.

The subsidy was established at 80 per cent of the premiums for subscribers with no taxable income in the preceding year, 50 per cent for subscribers with family taxable incomes from $1 to $500, and 25 per cent for subscribers with family taxable incomes from $501 to $1,000.

On July 1, 1967, these plans were superseded by the Alberta Health Plan, operated by the Department of Health for all residents voluntarily seeking individual or family enrolment. Group contracts were not originally available through this plan. The new Alberta plan is divided into two parts, Basic Health Services and Optional Health Services; the latter is further subdivided into Option A, Option B, and Option C. Any subscriber to the Basic Plan is eligible to contract for additional benefits by paying additional premiums under any one or more of the Options.

The Basic Plan covers all services of physicians, including health examinations, with payment of 100 per cent of the tariff; special dental surgery, limited optometric services; podiatric services and appliances in accordance with the agreed schedule of fees; osteopathic services prepaid at $4 a unit. Option A offers as additional benefits certain hospital and ambulance services that are not already insured under the provincial hospital plan. These additional benefits include the hospital admission charge, the daily co-insurance charge in a standard ward (limited to 180 days a year in a chronic hospital), the differential charge when a semi-private room is occupied, hospital out-patient charges remaining due after appropriate government credits have been used, and ambulance benefits up to $100 a year. Option B covers 80 per cent of the cost of prescribed drugs and prosthetic applicances. The subscriber pays 20 per cent. Purchase and repair of artificial limbs, eyes, and braces, prescribed by a physician, are also covered up to $300 a year. Option C offers chiropractic and naturopathic services up to a maximum charge of $4 a visit and $10 for X-rays for chiropractic services, and a maximum of $4 a visit for naturopathy. The combined annual maximum is $100.

Premium rates for the Basic Plan are $76 a year for single persons, $152 for families of two persons, and $200 for families of three or more. Options A and B cost an additional $24, $48 or $72 a year, and Option C costs $12, $24 and $36 extra a year, depending upon the number of persons. For individuals or families with little or no taxable income, premiums both for the Basic Plan and some of the Options may be reduced, by means of contributions from the general revenues of the province. These premium reductions vary: for the Basic Plan, the rates to subscribers are $12, $12 and $16 for those with no taxable income and $20, $40 and $48 for those with taxable income up to $500 if single and $1,000 if a family. There are no subsidies for Option A but it is 50 per cent of the regular premium for Options B and C.

British Columbia - The British Columbia medical plan took effect in September 1965. As of early 1969, it is governed by a public commission that also directed the administration and audit of a number of non-profit private agencies charged with responsibility for day-to-day management of the separate components of the province's public physicians' services program under the federal Medical Care Act. The benefits included most physicians' services as well as limited physiotherapy, special nursing, chiropractic and naturopathy. For eligible residents, the government offered 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 for $1 to $1,000.

The premiums are $60 a year for a single subscriber, $120 for a family of two, and $150 for a family of three or more.

Ontario - The Ontario medical-services insurance plan began paying benefits in July 1966. The plan offers to all eligible Ontario residents, on an individual and family enrolment basis, an insurance plan that covers most physicians' services.

The government pays as a subsidy the full premium of applicants who have no taxable income during the preceding year and of recipients of public assistance. It pays 50 per cent of the premium for single applicants with taxable income of $500 or less; 50 per cent of the premium for families of two persons and with taxable income of $1,000 or less; and 60 per cent of the premium for families of three or more persons and with taxable income of $1,300 or less. As already noted, in 1968 some group enrolment was permitted.

The premiums since July 1, 1968, have been $70.80 a year for single-person subscribers, $141.60 for 2-adult families, and $177 for families of three or more persons.

Voluntary Insurance

Apart from the public programs of health insurance that have been described, a substantial part of the population of Canada has made use of voluntary insurance mechanism to finance provision of physicians' services. Until recently, such plans, which may be non-profit or commercial in orientation, covered about two-thirds of the population. At present, their operations as regards physicians' services are in some provinces being incorporated into public authority administrations operation programs under the federal Medical Care Act.

Public Assistance Health Plans

For several years Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia and Manitoba have operated programs providing a range of personal health-care services for various categories of welfare recipients. Quebec and Prince Edward Island began programs in 1966 to provide comprehensive physicians' services to such recipients, and New Brunswick commenced a similar scheme in 1967. In Saskatchewan, British Columbia, Ontario and Alberta, physicians' services, once provided under these programs, are now financed through the public plans already described.

Coverage extends to virtually all recipients of provincial welfare aid in most of the programs. Historically, the basis for eligibility has applied to certain well-defined categories of welfare assistance. The trend more recently has been to determine eligibility for welfare-assistance and health-program enrolment on the basis of a test of need that takes into account not only the available income of an applicant but his normal minimum living requirements.

In addition to comprehensive physicians' services, dental and optical care benefits and prescribed drugs are provided in most provinces. Other services that may be provided include physiotherapy, podiatry, chiropractic treatment, home nursing and transportation.

Newfoundland has for many years administered two programs that cover most low-income groups in the province. These have been the Cottage Hospital Medical Care Plan, covering outlying districts for physicians' services provided by doctors employed by the government, with provision for referral to specialists. The Children's Health Service has covered in-hospital care for all children under the age of 16 in all parts of the province. In addition, recipients of public assistance are eligible, if individually certified, for a wide range of health-care services.

Canada Assistance Plan

Provincial programs that provide health-care services for welfare recipients are now being supported financially for these services by a new federal program known as the Canada Assistance Plan. This program provides for federal payment of half the cost of personal health-care services, as well as welfare services. The provinces are free to make available a wide range of health and other services, including home-nursing and homemakers' services. The only eligibility test under the legislation is that associated with financial need determined on a uniform basis within the province, regardless of the cause of need and without reference to employment status.

Rehabilitation Services

In all provinces, public and voluntary agencies co-operate to provide rehabilitation services to assist disabled or chronically ill persons to greater independence. Provincial health, welfare or education departments administer vocational rehabilitation programs for disabled adults who can be restored to gainful employment. Independent, specialized programs are operated for war veterans, injured workmen, handicapped children and for persons with various disabilities such as blindness, tuberculosis, mental illness, mental retardation, arthritis, cystic fibrosis, paraplegia and other conditions. In all provinces, legislation is in force providing for payment of compensation, as well as rehabilitation services, for workmen disabled in the course of their employment.

Under the terms of the Vocational Rehabilitation of Disabled Persons Act, 1961, the federal Department of Manpower and Immigration shares equally with nine provinces the cost of co-ordination, assessment and provision of any needed services to disabled persons, and of staff training and research. The federal program is administered through five regional offices. In each province the provincial co-ordinator or director of rehabilitation is responsible for identifying disabled persons with a vocational potential and referring them to the appropriate agency for restorative (including prostheses as necessary) vocational assessment and training, counselling and job placement services as required. The local employment offices, known as Canada Manpower Centres, employ special service officers to place handicapped persons in suitable work.

The transfer of Prosthetic Services from the Department of Veterans Affairs to the Department of National Health and Welfare on January 1, 1966, extended coverage for these services to civilians in accordance with federal agreements with provincial health departments. Prosthetic services are available from a central prosthetic establishment and 11 district centres across the country. Research for the development and improvement of prosthetic or orthotic appliances is also carried out and, more recently, a training program to produce qualified prosthetists and orthotists has been established in Canada.

The development of rehabilitation programs has been given impetus under the Medical Rehabilitation and Crippled Children Grant available to all provinces under the National Health Grants program by which some $2.8 million is allocated to extend and improve medical rehabilitation services for the chronically ill and disabled and to support the training of rehabilitation personnel, through student bursaries and grants to schools of physiotherapy, occupational therapy and speech therapy. Ten university schools now offer training in physiotherapy and/or occupational therapy; another three provide training in audiology and speech therapy. Other grants are used for the rehabilitation of the tuberculous, mentally ill, and mentally retarded. Hospital care for the chronically ill and disabled is available under the provincial hospital services plans, which now cover most medical rehabilitation services. The Department of Veterans Affairs provides comprehensive medical-social services for chronically ill and aging veterans and several federal agencies co-operate with provincial and voluntary health agencies to assist handicapped Indians, Eskimos, and new immigrants. Provincial health departments, together with community agencies, provide rehabilitation services to mental and tuberculous patients and other handicapped.

Over and above moneys available under the Department of National Health and Welfare's regular grant programs, a sum of $500,000 is being provided annually over a five-year period commencing in 1967-68 as a special mental retardation grant to promote the development of new research and demonstration projects in this field across Canada.

Under the Canada Pension Plan and the Quebec Pension Plan implemented in 1966, supplementary disability pensions and rehabilitation benefits for survivors have been granted since February 1968 to disabled widows and widowers, and to a widow with a disabled and dependent child who is over 18 years. Disabled contributors will be eligible for these benefits starting May 1970.

Voluntary Health Agencies

Voluntary agencies continue to play an important role in supplying a variety of professional and voluntary services. These include direct services to patients, health education and information services and the support of health research. Some national, provincial and local voluntary agencies provide services to persons with specific disabilities such as arthritis and rheumatism, blindness, cystic fibrosis, cerebral palsy, deafness, epilepsy, diabetes, mental illness, mental retardation, haemophilia and paraplegia. Two of the largest provincial voluntary organizations, the societies for crippled children (Easter Seals) and the foundations for the disabled (March of Dimes) have merged their programs in seven provinces and are affiliated with the Canadian Rehabilitation Council for the Disabled at the national level. Other community agencies provide specialized services to the general population as needed; examples of these are the home-nursing and co-ordinated home-care services administered by the Victorian Order of Nurses, homemakers' services supplied by community agencies and the Canadian Red Cross, which also operates a loan cupboard for sick-room supplies, physiotherapy and counselling service provided in the home by the Canadian Arthritis and Rheumatism Society, the training of volunteers in first aid and home nursing by the St. John Ambulance Association, as well as the operation of various rehabilitation centres, sheltered workshops and recreation services for the handicapped operated by community agencies.

immediately before application. A recent amendment authorizes payment to persons who have had 40 years of residence in Canada since 18 years of age, thus making those eligible for the pension who left Canada before reaching the qualifying age. The qualifying age at present (1969) is 66 or over, and will be reduced by a further year, so that in 1970 the pension will be payable to qualified applicants aged 65 or over. The pension payment is adjusted by the Pension Index developed for the Canada Pension Plan. A pensioner who resides outside Canada permanently but has 25 years of residence in Canada since attaining the age of 21 may continue to receive his pension indefinitely. Otherwise, payment of the pension is continued for six months, in addition to the month of departure, to pensioners absent from Canada, and, is then suspended, to be resumed the month the pensioner returns to Canada. The program is financed through a 3 percent sales tax, a 3 percent tax on corporation income and, subject to a maximum of $240 a year, a 4 percent tax on taxable personal income. The Department of National Health and Welfare administers the program.

Guaranteed Income Supplement

This program, which started in January 1967, is designed to provide a guaranteed minimum income to old-age security pensioners. For 1969 it provides a supplementary benefit of up to $31.20 a month for old-age security pensioners. This means that the supplement, plus the $78 a month old-age security pension, will ensure that these pensioners will have a guaranteed minimum monthly income of $109.20. The benefit payment is subject to an income test. The benefit will depend on the amount of income an applicant has in addition to his old-age security pension. For purposes of the program, income is determined in exactly the same way as under the Canadian Income Tax Act. Pensioners with only the old-age security pension will receive a guaranteed annual income of $1,310.40 for a single person and $2,620.80 for a married couple both of whom are pensioners. Pensioners with income in addition to their old-age security pension will receive partial benefits. The rule used to determine the amount of the partial benefit is that the maximum monthly supplement, $31.20 for 1969, will be reduced by $1 for each full $2 of monthly income which a pensioner has in addition to his old-age security pension and any supplement that may have been received. The program provides two options for persons who retire from regular employment -- one for persons retiring in the year preceding the benefit year and the other for persons who retire in the benefit year. The income of married couples is accorded special treatment. Marital status for the program depends on actual status on the last day of the year preceding the benefit year. Payments will be made outside Canada but will cover temporary absences from the country only, and in the same way as the old-age security program. The program is administered by the Department of National Health and Welfare. The Department of National Revenue assists by checking income information received on returns made under this program with information received under the Income Tax Act.

Unemployment Insurance

The Unemployment Insurance Act provides for a program of unemployment insurance which is administered by the Unemployment Insurance Commission through its head office, five regional offices and local offices located in large centres across the country. Unemployment insurance is compulsory and in general all employees, irrespective of length of residence, are insurable except salaried personnel earning more than $7,800 a year, and persons working in certain excluded occupations, such as teaching, private domestic service and employment

in charitable institutions and non-profit hospitals. Employment in agriculture and horticulture became insurable effective April 1, 1967.

Insured workers make contributions on a scale graded according to wages and ranging from 20 cents to $1.40 a week. Employers contribute a sum equal to that paid by the employee and the Federal Government contributes an amount equal to a fifth of the combined employer and employee contributions. Rates of benefit are related to the insured person's contributions and range from $13 to $42 a week for a person without dependants or, for a person with one or more dependants, from a minimum of $17 a week to a maximum of $53 a week.

To qualify for regular benefit, a person must have at least 30 contribution weeks in insurable employment during the 104 weeks immediately preceding his claim, eight of which must have been made in the immediately preceding 52 weeks or since his last benefit period began, whichever is the shorter period. Moreover, if a claimant had a previous benefit period in the preceding 104 weeks, at least 24 of the 30 contribution weeks must be in the 52 weeks preceding his new claim or since the commencement date of his last claim, whichever is the longer period. The number of weeks of regular benefit that may be authorized varies from a minimum of 12 to a maximum of 52. Claimants must be employed, capable of and available for work.

An unemployed person who is unable to fulfill the contribution requirements for regular benefit may qualify for seasonal benefit, which may be paid in the period from the week in which December 1 occurs to the week in which May 15 occurs, if he has at least 15 contribution weeks since the previous March or if he had a claim that terminated subsequent to the week in which the preceding May 15 occurred.

Workmen's Compensation

In each province a workmen's compensation act protects workers affected by work-connected disabilities and diseases in industries covered by the legislation. While there is some variation by province, the legislation applies to most industries and occupations. Major groups of workers not covered are farm-workers (except in Ontario), domestic servants, casual workers, employees of most financial, insurance and professional undertakings, and employees of certain service industries in some provinces. Compensation benefits include cash awards, all necessary medical aid, hospital care and physical restoration services, and vocational services to re-establish the injured worker in gainful employment. Cash awards take the form of time-loss compensation for temporary disability, disability pensions for permanent disability, or survivors' benefits to widows or dependants in case of fatal accidents or disease. Benefits to the worker are calculated on 75 per cent of earnings subject to conditions of maximum annual earnings of from $5,000 to $7,000, as fixed in the individual acts. Costs are met from employer contributions to accident funds at rates fixed by the workmen's compensation boards according to the hazard involved in each class of industry.

Social Assistance

Financial aid is provided through provincial or municipal departments of welfare to persons in need, including needy mothers with dependent children, disabled persons, elderly persons, widows, unemployed persons and persons whose

benefits from other sources are adequate to meet their needs. Aid is also provided through institutional care for the elderly or infirm who do not require hospital care but who are unable to care for themselves; these are operated under provincial, municipal or voluntary auspices. Counselling, homemaker and other services are provided as necessary.

The Federal Government shares in the cost of social assistance and services administered by the provinces under the Canada Assistance Plan on a 50:50 basis. Shareable costs include: the costs of social assistance payments, maintenance payments for needy persons in homes for the aged and other welfare institutions, child welfare maintenance payments, health care costs for needy persons, and the costs of certain welfare services. The only criterion of eligibility specified in the Plan is that of need, irrespective of its cause. Rates of assistance and conditions of aid are set by the provinces.

The provinces also administer the three federal-provincial categorical programs of old age assistance, blind persons allowances and disabled persons allowances. The federal contribution may not exceed 50 per cent of $75 a month or the allowance paid, whichever is less, for the old age assistance and disabled persons allowances, or 75 per cent of $75 a month of the allowance paid, whichever is less, for blind persons allowances. To be eligible for an allowance under any of these programs, an applicant must meet the 10 years' residence requirement and the income requirements. Under the Old Age Assistance Act and the Disabled Persons Act, the total income, including the allowance, may not exceed $1,260 a year for an unmarried person, $2,220 a year for a married couple or $2,580 a year for a married couple when the spouse is blind within the meaning of the Blind Persons Act. Under the last-mentioned Act, the total income, including the allowance, may not exceed $1,500 a year for an unmarried person, $1,980 a year for a person with no spouse but with one or more dependent children, $2,580 for a married couple and $2,700 a year for a married couple when both are blind.

A recipient of old age assistance is transferred to Old Age Security on reaching the eligible age, which in 1969 was 66 years. This program will disappear when the eligible age for Old Age Security is lowered to 65 years in 1970.

Five provinces have now merged some or all of these three programs with their general social assistance programs and allowances to the needy aged, blind, or disabled are determined, as for other social assistance recipients, on the basis of need.

Immigrants in their first year in Canada may receive aid through the local authority or they may be referred directly to the local office of the Department of Citizenship and Immigration.

PART III - WELFARE SERVICES

General 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, with federal reimbursement for half the costs of assistance and of certain welfare services being made

under the Canada Assistance Plan. Provincial administration of welfare is carried out through the department of public welfare in each province. Several provincial welfare departments have established regional offices for administrative purposes and to provide consultative services to the municipalities.

As a result of the extensions of federal sharing under the Canada Assistance Plan, provincial departments of welfare are giving increased attention to the improvement of standards of administration and to the development of rehabilitation and other services designed to alleviate or prevent dependency. Also, the availability of federal aid under the national welfare grants program for staff-training, bursaries, and research and demonstration projects has enabled them to strengthen their welfare services.

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 the provincial authority or, in some provinces, by children's aid societies. Particular emphasis is being placed on preventive services to children in their own homes. Day nurseries for the children of working mothers are established only in the larger centres, where they are chiefly under voluntary auspices, except in Ontario, where there are also municipally-sponsored day nurseries which receive provincial grants.

A number of voluntary agencies also contribute to community welfare, including the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups 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 physical education, camping, the development of special skills, and other opportunities for healthful activity. Welfare councils and community-planning councils contribute to the planning and co-ordinating of local welfare services.

Fitness and recreation are encouraged and promoted under the federal Fitness and Amateur Sport Act (1961), under which grants are made to national organizations to assist national and international aspects of the program and to provinces to develop and extend community effort.

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