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PART I
Health Services

The administration of health services in Canada comes primarily under the jurisdiction of the ten provincial governments, which in turn 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, besides assisting provincial health departments. The Health Protection Branch shields 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 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]

The Federal Government contributes to the cost of provincially-operated hospital and medical-care insurance plans in this manner: Originally, the federal contribution to the provinces was based on the cost of insured services incurred by the provinces, with the Federal Government reimbursing the provinces for approximately 50 per cent of the cost of insured services. Late in 1976, following several years of negotiations, the provinces and the Federal Government agreed to new financial arrangements for health insurance, among other fiscal matters, and

[1]The two territorial governments in the sparsely-populated northern region 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.

Parliament passed the necessary enabling legislation shortly thereafter. Beginning April 1, 1977, federal contributions to the established programs of hospital insurance, medical care and post-secondary education are no longer directly related to provincial costs but take the form of the transfer to the provinces of "tax-room" and associated equalization, as well as cash payments. The tax-room transferred will normally increase faster than the rate of growth of the gross national product. At the outset, the cash payments will approximate the value of the tax-room transferred, and will be in the form of *per capita* payments (based on federal contributions for the programs in 1975-76). These payments will increase yearly in accordance with changes in the gross national product, and will be adjusted gradually so that all provinces, at the end of five years, will be receiving equal *per capita* cash contributions.

Since April 1, 1977, the Federal Government has also been making an additional equal *per capita* cash contribution to the provinces towards the cost of certain extended health-care services: nursing-home intermediate care, adult residential care, converted mental hospitals, health aspects of home care and ambulatory health-care services.

The newly established programs-financing arrangements are expected to provide the provinces with more money than they would have received under the previous arrangements and to provide for greater equality among the provinces in what they receive from the Federal Government. These new arrangements also provide the provinces with greater flexibility in the use of their own funds while safeguarding the national standards of comprehensiveness of coverage with regard to services, universality of coverage with regard to people, portability of benefits, accessibility to services uninhibited by excessive user charges, and non-profit administration by a public agency.

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 Research and Development Program 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 not covered by the national health-insurance programs or the extended health-care services program that provinces make available to persons who are eligible because of proved financial need.

The various agencies in Canada concerned with environmental health are at present 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, harmful to human health. The complexity of their task requires the work of specialists in a variety of 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 environments, 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 in the Health Protection Branch 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 by 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, namely the Medical Research Council, the Defence Research Board, the Department 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 and the Long-Range Planning Branch of the Department of National Health and Welfare, and, as a by-product of program activities, certain other units in that department.

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 health services, 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 concerned with 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. Development of health indicators is an important activity; such indicators include not only vital statistics on contagious diseases but indices of hospital morbidity and use 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 14.9 in 100,000 in 1974, while the death-rate fell from 7.8 to 1.5 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

Cancer is the second leading cause of death in Canada, accounting for about one out of five deaths. The death-rate increased slightly from 149.7 in 100,000 of the population in 1973 to 150.4 in 1974. That for females rose from 132.8 in 1973 to 134.4 in 1974, and for males fell very slightly, from 166.5 to 166.3. Public and voluntary agencies engage in detection, treatment, public education and research. Most diagnostic and treatment services are now available free 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 apart from the medical-care and hospital-insurance programs. During 1973, the last year for complete financial figures, mental institutions cost $52.8 million. During 1975, there were 132,000 admissions and the number of in-patients under care at the end of that year was 53,000. In addition, about a quarter of a million patients were treated in mental-health clinics and psychiatric out-patient departments.

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 normally supplied by hospitals to in-patients – including meals, nursing care, laboratory, radiological and other diagnostic procedures and most drugs. Care in mental and tuberculosis institutions, nursing homes, homes for the aged, infirmaries or other institutions whose purpose is the provision of custodial care, is not provided under the Hospital Insurance and Diagnostic Services Act. Care in mental and tuberculosis institutions is provided by the provinces under separate legislation.

Out-patient hospital services may be included in the provincial insurance plans at provincial discretion; consequently, the services vary from province to province. Nevertheless, most jurisdictions insure a range of services generally 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.

In some provinces, prior approval is required for out- of-province in-patient care, except in cases of emergency, and limits may apply to the plan payments. Nova Scotia and British Columbia (with the exception of out-patient dialysis for chronic renal failure) do not insure out-patient services outside the province, and other provinces may have limitations on their rates of payment for such services. For services outside Canada, nearly all provinces have limits on volumes of services and rates of payment. (For greater detail in respect to each province, see the appended "Summary of Provincial Health Insurance Plans".)

Several provinces include services in their insurance plans that are not insured under the Hospital Insurance and Diagnostic Services Act. For example, Nova Scotia covers mental-health services in psychiatric hospitals and mental-health centres; Ontario provides ambulance services, private physiotherapy services, and extended health-care benefits (care in nursing homes or homes for the aged for persons requiring medical supervision and a stipulated level of regular skilled nursing service); Manitoba covers care in personal-care homes (providing extended care, personal care and hostel care); and Alberta provides nursing-home care. The cost of ambulance services, nursing-home and extended-care benefits is partially defrayed by user charges. (Again reference should be made to the Appendix.)

Quebec, Alberta and British Columbia levy authorized charges directly on patients for insured services. In Quebec, all in-patients in hospital centres for prolonged care, as well as those in prolonged-care units in hospital centres for short-duration care, are charged $7 a day, with the exception of patients with limited resources and children under 18 years of age. In Alberta, most in-patients in general hospitals (other than newborn infants) are charged $5 for the first day of hospital care; for all patients in auxiliary institutions whose stay exceeds 120 days, there is an authorized charge of $5 a day after the one-hundred-and-twentieth day. British Columbia has an authorized charge of $4 a day for in-patients (excluding the newborn) in general hospitals and $4 a day for adult in-patients in extended-care hospitals; out-patients pay $1 for out-patient cancer therapy, physiotherapy, diabetic day-care, dietetic-counselling sessions, psychiatric day-care, night-care and psychiatric out-patient services, renal-dialysis treatment, and day-care rehabilitation services, and $2

for day-care surgical services and for each emergency or minor surgical out-patient treatment.

Coverage

Each province makes insured services available to all its covered residents on uniform terms and conditions, without exclusion on grounds of age, occupation, 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 Canadian Forces and of the Royal Canadian Mounted Police, and inmates of federal penitentiaries, are not covered, since they are protected under other arrangements.

Residence in the province is the major eligibility determinant under the Federal-Provincial Hospital Insurance Program. Payment of premiums is also required in Ontario and Alberta for families able to pay. Most provinces require a waiting-period of up to three months before new residents become eligible for coverage, 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, where the normal waiting-period of up to three months applies.

Financing

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

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 share of program costs. Newfoundland, Prince Edward Island, New Brunswick, Saskatchewan, Manitoba and the two territories finance entirely from this source. Nova Scotia designates a sales tax to be used in part to finance hospital-insurance operations. Quebec has an income-tax surcharge and a tax on wages and salaries paid by employers that in part finance hospital-insurance operations.

Ontario raises a part of its contribution by a premium, combined with medical insurance, on an annual basis, of $192 for single persons and $384 for families of two or more persons. Alberta levies an annual premium of $76.80 on single persons and $153.60 on families of two or more persons 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 interest of administrative simplicity.

In Alberta, British Columbia and Quebec, part of the financing is derived from use of authorized charges. These fees are payable by the patient at the time of service and are deductible from provincial payments to hospitals.

In addition to hospital care under the Hospital Insurance Program, a number of other services, mainly those of physicians, are provided under provincial medical-care insurance plans.

Federal medicare legislation

The Medical Care Act was passed by the Canadian Parliament in December 1966 and became operative July 1, 1968. The Act enables the Federal Government to contribute towards the costs of the insured services of the national program provided by provincial medical-care insurance plans that meet the following criteria:

a) A plan must be operated on a non-profit basis by a public authority responsible to the provincial government for its financial transactions.
b) It must make available all medically-required services rendered by medical practitioners, and these insured services must be provided on uniform terms and conditions to all residents of the province; there can be no exclusions because of age, ability to pay, or other circumstances.
c) The provincial plan must cover no less than 95 per cent of the total number of insurable residents of the province.
d) For persons normally resident in the province, the provincial plan must provide "portability" – that

is: coverage after about three months of residence in the province; out-of-province coverage during the waiting-period while a person establishes residence in another province; and coverage during periods of temporary absence from the province, generally up to one year.[3]

The Medical Care Act also empowered the Federal Government to include in the national program additional health-care services provided by non-physician professional personnel, under terms and conditions specified by the Governor in Council. A limited range of oral surgery, provided by dental surgeons in a hospital where hospitalization is necessary for proper performance of the surgery, has been included under this provision.

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

Provinces can finance services in any manner they wish, but the Medical Care Act contains a provision whereby no insured person may be impeded in the effort to obtain, or precluded from reasonable access to, insured services, either directly or indirectly, whether by charges made to the insured person or otherwise. The significance of this requirement is that extra charges, if imposed, must not be more than nominal. A province may adopt any method it wishes to pay the providers of services, subject only to the provision that the provincial schedules of benefits are on a basis that assures reasonable compensation for the services rendered.

Provincial medical-care insurance plans

Before the establishment in the late 1960s and early 1970s of universal government-administered medical-care insurance in all 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 – over 82 per cent of the total population – were receiving basic medical or surgical coverage or both. The voluntary plans,

[3]The rules vary from province to province and the individual provincial plan should be consulted about portability of coverage during periods of temporary absence. Also, as is mentioned later, in most provinces immigrants are entitled to immediate coverage upon registration in the province of legal residence.

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 insurance plans 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 of the provincial medical-care insurance plans 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 – through premiums, sales tax, other provincial revenues or a combination of these methods.

In addition to the comprehensive range of medically-required services of medical practitioners that must be provided as insured benefits by participating provinces, and the limited surgical-dental benefit, most plans also make provision for other benefits. But they receive no contribution in respect of these additional benefits from the Federal Government under the national health-insurance programs. Refraction services by optometrists are included in the majority of provincial plans. The services provided by such practitioners as chiropractors, podiatrists (chiropodists), osteopaths and naturopaths are also insured by some provinces, generally on a restricted basis. Residents may, if they wish, continue to purchase insurance, generally from private voluntary agencies, covering such additional services as dental care, special-duty nursing and prescribed drugs. Most provinces have, during the last two to four years, introduced public programs to cover the cost of prescribed drugs for elderly persons, and two – Manitoba and Saskatchewan – have broadened their coverage to include almost the entire eligible population of the province.

Additional benefits are made available in some provinces to residents with certain specified conditions. For example, Saskatchewan residents are eligible, with certain exceptions, for: the benefits provided by a subsidized hearing-aid plan; the provision of prosthetic and orthotic devices; the provision of wheel-chairs, walkers, commodes, and other aids to daily living; and a dental plan for children.

Seven of the 12 provincial and territorial medical-care insurance plans finance their share of plan costs entirely from general taxation revenues, and in these jurisdictions there is virtually no direct cost to families, apart from any additional billing that some doctors may make as described in the outlines of each

provincial plan. Four of the plans employ premium levies to help finance their share of costs, and one employs a payroll tax. Typically, in the premium plans, the premiums are paid on behalf of welfare recipients and residents 65 years of age and over, and various devices are used to keep the financial burden low for families with limited incomes just above the poverty-line that entitle them to welfare assistance.

Each of the 12 provincial and territorial medical-care insurance plans, as of January 1, 1977, is described briefly in the paragraphs that follow. Provinces operate many other types of personnal-health service program in addition to those described below.

It must be noted that, though most doctors are paid on a fee-for-service basis, alternative payment arrangements exist in most provinces, including salary, sessional payments, contract service, capitation and incentive payments.

The Medical Care Commission is the public authority responsible to the provincial Minister of Health for the Medical Care Plan (MCP) in Newfoundland, into which the former Children's Health Service and the Cottage Hospital Medical Care Plan were absorbed. The provincial plan is a non-premium one, which is funded from provincial revenues and covers all eligible residents of the province – who are required, however, to register before claims may be accepted. No special provisions are required, therefore, for those with limited incomes. New residents entering the province from another participating province or territory are subject to a waiting-period of up to the last day of the second month following arrival in New foundland before being eligible for benefits, but otherwise there is no waiting-period. Each insured person is supplied with an identification card, which must be presented to a physician when medical services are sought. When an insured person ceases to reside in Newfoundland, his coverage is extended up to the last day of the second month following the taking-up of residence in another province but ceases on his departure if he is leaving to dwell outside Canada.

Patients have free choice of physicians and physicians have free choice of patients. Physicians must decide whether to participate in the plan for all their insured patients or

to practise completely outside the plan for all their patients. However, insured patients of physicians who opt out do not lose their entitlement to insured benefits. "Opted-out" physicians are required to inform their patients, before treatment, of their status and intentions regarding billing beyond the level of benefit payable by the MCP. Opted-out physicians, however, submit accounts on behalf of their insured patients to the MCP, which, in turn, provides these physicians with a monthly remittance statement indicating the benefits that have been paid to their patients. Participating physicians accept plan-payment as payment in full, but a participating specialist, subject to conditions similar to those applicable to opted-out physicians, may charge a non-referred patient the difference, if any, between the plan-payment and what he would otherwise have received for his services if the patient had been referred to him by another physician.

The MCP pays for insured services received by beneficiaries while in another province in accordance with the level of benefits payable for similar services received in Newfoundland. It pays for insured services received "out-of-country" at a rate the commission considers to be fair for the services provided.

The benefit coverage of the provincial plan is limited to the insured services of the national program – namely, comprehensive coverage for the medically-required services of medical practitioners and certain surgical-dental services undertaken by dental surgeons in hospital.

Prince Edward Island

The Health Services Commission of Prince Edward Island is the public authority responsible to the Minister of Health for the administration and operation of the Health Services Plan.

This is a non-premium plan financed from general provincial revenues. All eligible residents are covered by it, and entitlement to insured services is contingent on residence in the province and registration with the commission.

All beneficiaries are required to be registered with the commission and have a social-insurance number. Family heads or single persons receive a health-service registration certificate following registration. Entitlement to benefits depends on registration. Landed immigrants and certain other classes of newcomers to the province are entitled to benefits from the date of establishing residence, provided the registration requirements are met. In the case of new residents from other provinces, the waiting-period before they become entitled to coverage is two consecutive calendar months from the date of establishing residence in the province.

Patients have free choice of physicians and physicians may choose to practise outside the plan without their patients losing their entitlement to benefits. When a physician renders an insured health service to an entitled person, he may, if prior notice is given, charge a fee in excess of the tariff established by the commission but not exceeding the schedule of fees of the provincial medical association. The extra charge must be agreed to in writing, and the amount made known to the commission. A non-participating physician must give an insured person reasonable notice that his fees will be collected directly rather than through the plan.

Insured services received in another province are paid for at the rate payable for these services by the medical-care insurance plan in the other province in cases of sudden illness, accident or on referral approved by the commission, or at a tariff established by the commission when the services are rendered outside Canada but are considered by the commission to be available in Canada. Insured services received outside Canada and not considered by the commission to be available in Canada may, with prior approval, be paid for at such rates as the commission may decide. The level of benefit payable for other out-of-province insured services is at the level payable for similar services rendered in Prince Edward Island.

The benefit coverage of the provincial plan is limited to the insured services of the national program. A dental program for children of specified ages is operated by another agency of government.

Nova Scotia

The Health Services and Insurance Commission of Nova Scotia is responsible for all of the functions of the earlier Medical Care Insurance Commission and the Hospital Insurance Commission. The commission consists of nine to 12 members appointed by the provincial government and includes nominees of the Nova Scotia Hospital Association and of the Medical Society of Nova Scotia. (Effective February 1, 1977, administration of the provincial hospital-insurance plan was transferred to the Department of Health.)

The medical-care insurance plan in Nova Scotia, called Medical Services Insurance (MSI), is operated by a conjoint public authority, consisting of the Health Services and Insurance Commission and Maritime Medical Care Incorporated. The commission is responsible to the Minister of Public Health. Maritime Medical Care Incorporated, a doctor-sponsored pre-payment agency, is authorized to act on a non-profit basis as the administrative arm and fiscal agent of the public authority, undertaking the registration of insured residents and the payment of claims for insured services at the level authorized by the plan. The corporation is nevertheless permitted, on a private basis, to continue, expand or modify its coverage of services not insured under the provincial plan.

Medical Services Insurance is a non-premium plan covering all eligible residents and funded from provincial general revenues. All residents are required to be registered with the provincial plan but eligibility for benefits does not depend on prior registration, as provision is made for unregistered persons to be registered retroactively, if they are *bona fide* residents, on receipt of claims for insured services. No special provisions are required, therefore, for the coverage of those with limited incomes. Entitlement to insured services depends on an otherwise eligible resident's having been a resident of the province for a minimum waiting-period, lasting until the first day of the third month following establishment of residence in the province, immediately before the insured services are received. New residents who arrive from outside Canada are able to obtain coverage from the day of establishing residence.

Patients have free choice of physician and physicians may opt out of participation in the plan without their patients losing entitlement to benefits. A non-participating physician is not entitled to charge an insured resident for an insured service unless the resident is informed in advance that the physician is not participating in the plan. Any physician may charge an insured resident more than the tariff payable by the

commission for his services if the resident is given reasonable notice of his intention to charge a greater amount and the resident, or some other person acting on his behalf, consents in writing to the extra charge. The amount of the extra charge must be made known to the commission.

The insured services of Medical Services Insurance in Nova Scotia are those of the national program plus a limited optometric benefit. The coverage of the provincial plan also includes a Children's Dental Plan that provides a wide range of preventive, diagnostic and restorative procedures, including extractions and minor orthodontic services for children born after January 1, 1967. The dental coverage includes necessary services of dental specialists on referral. Eligible children do not require to be specially registered for the coverage of the dental plan. The MSI benefit package also includes a "Pharmacare" plan under which provincial residents 65 years of age and over are provided with coverage for prescription drugs, certain other drugs, and prescribed ostomy equipment. Residents who qualify for the Pharmacare benefit are issued with an identifying "Pharmacard".

The extra benefits described are administered by Maritime Medical Care as part of the MSI program.

The medical-care insurance plan in New Brunswick is officially known as "Medicare". The plan is funded from general provincial revenues and administered by the Medicare Division of the provincial Department of Health. The Minister of Health is the provincial authority.

Medicare is a non-premium plan that covers all eligible residents who have resided in the province for a minimum waiting-period lasting until the first day of the third month following the establishment of residence. No special provisions are required for the coverage of residents with limited incomes. Landed immigrants and certain other kinds of new resident are able to obtain immediate coverage effective the date of their arrival in Canada provided they will, in the opinion of the Director of the Medicare Division, establish residence within the province. Coverage is provided during periods of temporary absence and, on cessation of residence in the province, until the first day of the third month following arrival at a new residence elsewhere in Canada. Coverage ceases on the date of departure from Canada for residents who establish residence outside Canada.

Insured residents must register with the Medicare Division to become eligible to receive benefits. A hospital and medical identification card is then issued, which must be

shown to the professional concerned when obtaining an insured service.

Patients have free choice of physician and a physician may decide not to participate in the plan without his patients losing entitlement to benefits. However, he must advise his patients before providing insured services that he is a non-participant and provide an "opting-out notification". A participating practitioner also has the choice in the case of each patient of either billing the plan or billing the patient if he advises the patient of his intention in advance and provides an opting-out notification. Whether the patient is billed by a participating or non-participating physician, the amount of fee charged must be made known to the plan. The participating practitioner who bills the plan directly must accept the plan-payment for his services as payment in full. At his discretion, the plan's Director may accept accounts directly for insured services rendered by non-participating practitioners resident and practising outside the province. Reimbursement is paid for out-of-province services up to the amount that would have been paid to a participating doctor in New Brunswick for similar services. Elective care outside the province is not an insured benefit unless prior approval is received for related hospitalization or for Medicare benefit if hospitalization is not involved.

In addition to the comprehensive medical coverage and the dental coverage of the national program, the coverage of the provincial plan includes a drug-benefit program for insured residents 65 years of age and over and for those with cystic fibrosis. Qualified persons receive a Prescription Drug Program Identification Card; services are limited to those received in New Brunswick (except in certain border situations).

The Quebec Health Insurance Board is an agency of the Quebec government, which is responsible for the administration of the provincial Health Insurance Plan.

The plan insures all who qualify as residents of Quebec. No premium is required; financing is made up of contributions from individuals and employers in Quebec, participation by the Federal Government and a contribution from the Quebec Department of Social Affairs for certain services to welfare recipients.

The legislation providing for health-program financing has set the contribution of an individual at 1.5 per cent of his net income for the year, to a maximum of $235 for salaried employees and $375 for self-employed persons. This individual contribution must not reduce net income to a figure below either $5,600 or $3,700, depending on whether the individual is married or single. The employer's contribution is set at 1.5 per cent of the employee's salary.

Eight-fifteenths of the contributions thus collected are remitted to the Quebec Health Insurance Board and the remaining seven-fifteenths are turned over to the hospital services fund, which is used exclusively for the financing of hospital services in Quebec.

All residents of Quebec must be registered with the board. Landed immigrants and all dependents are deemed to be residents of Quebec from the time of their arrival. Foreign nationals and all dependents are considered residents of Quebec specifically if a foreign national holds an employment visa issued by the Federal Department of Employment and Immigration, stays in Quebec for the purpose of occupying a position or job for a period in excess of one year and contributes to the Health Insurance Plan.

New residents from another province become insured by the Quebec plan as soon as they lose their right to benefits under the plan in their previous province.

All persons registered with the Health Insurance Board receive a health-insurance card to present to the health professional when requiring insured services in Quebec.

Every health professional legally authorized to provide insured services in Quebec is also required to register with the board. The board provides for three categories of health professional in Quebec:

1. *"Opted-in" professional* – a professional who practises his profession under the plan and who is paid according to the rates set out in an agreement. The amount of these fees, including the price of drugs in the case of a pharmacist, is paid directly by the board.
2. *"Opted-out" professional* – a professional, other than a pharmacist, who practises his profession

outside the plan, but who agrees to payment according to the rates set out in an agreement. His fees are paid to his patients by the board.

3. *Non-participating professional* – a professional who practises his profession outside the plan and does not agree to payment according to the rates set out in an agreement. All his patients assume responsibility for paying his fees, which include the price of drugs in the case of a pharmacist.

Opted-out and non-participating professionals are required by law to notify any Quebec resident requiring their services in writing of their status. Such notice, however, is not required in emergency cases, since the professional is then paid by the board in accordance with the rates set out in an agreement.

The majority of health professionals providing insured services in Quebec have "opted-in".

Some health professionals practising outside Quebec have joined the Quebec Health Insurance Plan; these are mainly professionals living in areas near the Quebec border who have agreed to conform with the method of presenting claims and to accept the fees set out in agreements affecting Quebec professionals when they provide services to Quebec residents.

A Quebec resident is also entitled to reimbursement of the cost of insured services provided outside Quebec, provided that he presents the board with receipts for the fees he has paid or the statements of account for these services. Such a person, however, is entitled to claim only the amount he has actually paid for these services or the amount the board would have paid a Quebec health professional for these services under an agreement, whichever is the lesser.

Insured services under the health-insurance plan come under various programs:

Medical and surgical services
All residents of Quebec may benefit from this program, which is provided under the federal Medical Care Act. It covers all medically-necessary services provided by a physician.

Oral surgery and dental services
Oral surgery is provided under the Medical Care Act; in addition, Quebec residents may be covered for oral-surgery services specified by regulations and provided by a dentist in a hospital setting. Children under the age of ten (and under 12 from May 1, 1977) are covered for dental services specified by regulations and provided by a dentist in his office or in a hospital. Recipients of social aid are covered for dental services determined by regulations of the Social Aid Act. The Health Insurance Board

administers this program on behalf of the Department of Social Affairs, with the exclusion of dental prostheses.

Optometric services
All Quebec residents may be covered by this program, which covers optometrists' services specified by regulation, dispensed by an optometrist and required from an optometric point of view.

Prostheses, orthopaedic and other appliances
All residents are covered by this program, which includes purchase, adjustment, replacement or repair of prostheses, orthopaedic and other appliances specified by regulation that compensate for a physical deficiency or deformity and are supplied under prescribed conditions.

Drugs
The following kinds of person are covered by the drug program: all recipients of social aid and recipients of certain governmental social-aid measures; persons aged 65 and over in receipt of a monthly guaranteed-income supplement in addition to the Old Age Security Pension; persons between 60 and 64 years of age who are eligible for an allowance under the Old Age Security Act and who would otherwise, without that allowance, be eligible for social aid or certain governmental social-aid measures.

This program covers drugs supplied by a pharmacist on the prescription of a physician or a dental surgeon. These medications must be included in a drug list prepared by the Department of Social Affairs after consultation with the Advisory Council on Pharmacology.

The Ontario Health Insurance Plan (OHIP) is a combined hospital and medical-care insurance plan administered by the Ministry of Health. The Minister of Health is the responsible public authority.

The plan, which normally requires the payment of premiums by or on behalf of insured residents, is semi-voluntary, being compulsory in the case of employee groups of 15 or more persons who are residents of Ontario. Provision is made for the voluntary creation of a mandatory group in the case of six to 14 employees, and an organization of 15 or more persons may apply to become a "collector's group" or be designated as such by the plan. Registration and claims-processing are undertaken by 10 district offices that have been established in the following places: Hamilton, Kingston, London, Mississauga, Oshawa, Ottawa, Sudbury, Thunder Bay, Toronto and Windsor. Information offices are also located at Barrie, Kenora, Kitchener, Peterborough, St Catharines and Timmins.

Premiums for the combined plan must normally be paid three months in advance and coverage is subject to a comparable waiting-period for all residents, with certain specified exemptions. Landed immigrants may apply for the benefit coverage within three months of arrival without a waiting-period. Other kinds of new resident with no immediate previous entitlement to be covered by any provincial health-insurance plan can become insured persons without the usual waiting-period on payment of the appropriate premium within 30 days after arriving in Ontario. On a yearly basis, the premium rates for hospital and medical-care insurance coverage are as follows:

	Yearly premium rates		
	Regular annual premiums	taxable income $1,680 or less (single) or under $2,000 (couples and families)	taxable income $2,000 or less (single) or $3,000 or less (couples and families)
Single	$192	Nil	$ 96
Couples and families	$384	Nil	$192

The plan makes provision for total or partial assistance in paying premiums for persons with limited incomes, as shown in the preceding table, eligibility being determined by an assessment of the current year's taxable income. Eligibility for such assistance is contingent on the applicant's having resided in Ontario for at least 12 consecutive months prior to making application for premium assistance. Social-assistance recipients automatically qualify for total premium assistance, and temporary assistance is available for any insured person who is unable to pay premiums owing to unemployment, illness, disability or financial hardship. Organized provisions have been incorporated in the plan for enrolment of residents receiving social assistance from municipalities and others who are considered indigent. Residents of Ontario who are 65 years of age or older and who have been ordinarily resident in the province for the previous 12 months are entitled to premium-exempt OHIP coverage for themselves and other members of their "premium unit". Uninsured residents may be insured retroactively if it is determined that they would have been entitled to premium-free coverage on account of age or limited income. Provision is made for payment of premium arrears in certain other cases of previously-insured residents.

Freedom of choice is provided for patients and for physicians. A physician may opt out of the plan without his patients losing their entitlement to benefits. If he bills the plan directly, he must accept the plan-payment for his services as payment in full. If a physician has opted out and intends to charge the patient more than the current provincial medical-association fee schedule, he is required to provide the patient with prior notification of the amount of his fee in excess of the schedule. Physicians who have opted out may still bill the plan directly under certain specified circumstances – for example, for insured services rendered to Indians or war veterans and insured services rendered as a member of an associate group in a hospital affiliated with a faculty of medicine. An opted-out physician who is a member of an associate medical group that is registered with the plan may bill the plan directly for insured services provided at the emergency department of a public hospital or in a nursing home, home for the aged, etc. Payment of such direct billings by opted-out physicians must be accepted as payment in full.

All private medical laboratories are required to be licensed. Each licensee is required to participate in

the provincial plan and accept the plan-payment for insured laboratory services as payment in full.

In addition to the insured services of the national Hospital Insurance and Medical Care Programs, OHIP provides the following extra benefits. The coverage of the provincial plan includes care in nursing homes and homes for the aged when regular nursing service and medical supervision are required, subject to a co-payment charge for patients over 16 years of age of $7.40 a day, with the plan paying the balance of the home's approved daily cost for medically-required services in standard-ward accommodation, for the cost of drugs ordered by a physician or dentist, and for the cost of specified devices ordered by a physician. This extended-care benefit is normally only available as an insured service to those who have been ordinarily resident in Ontario for the 12 months preceeding application for the benefit. Persons receiving benefits under the General Welfare Assistance Act or the Family Benefits Act who require extended care do not receive this as an insured service under OHIP but through the provincial social-assistance programs.

The benefit coverage of the Ontario plan also includes certain optometric benefits and coverage for the services of chiropractors, osteopaths and podiatrists on a limited basis, as well as other non-hospital benefits towards the costs of physiotherapy and ambulance services and also home-care services provided through organized home-care programs. Home renal-dialysis and home hyperalimentation equipment, supplies and medication are also insured benefits where available in a hospital in Ontario and prescribed by a physician on the medical staff of that hospital.

The Ministry of Health administers the Drug Benefit Plan, which provides approved drugs free of charge when prescribed by medical or dental practitioners for all residents over 65 years of age who are Canadian citizens or landed immigrants who have lived in the province for the previous 12 months. Ontario recipients of Guaranteed Annual Income and Provincial Family Benefits Allowance are also covered by the drug plan. Eligible residents are sent a drug-benefit eligibility card each month (the drug benefit is automatic for those eligible for the monthly financial allowances). Residents of nursing homes and homes for special care who are entitled to receive extended-care, chronic-care or special-care benefits are also covered by the Drug Benefit Plan. All prescriptions under this plan must be filled in Ontario.

Manitoba

The Manitoba Health Services Insurance Plan is a combined provincial hospital and medical-care insurance plan administered by a single public authority, the Manitoba Health Services Commission. The commission is responsible to the provincial Minister of Health and Social Development for administration of the plan.

The Manitoba plan is a non-premium plan that is funded from provincial general revenues. Each resident is an insured person, subject to the usual waiting-period of up to three months immediately following arrival in Manitoba if the new resident is from another participating province or territory. If the applicant previously lived outside Canada, benefits are available on the date of his arrival in Manitoba. All residents are required to be registered under the provincial plan.

Each patient has a free choice of physician. Physicians may decide not to participate in the plan without their patients losing entitlement to benefits. Participating physicians accept plan-payment as payment in full for their services and are not permitted to charge or to collect fees from insured residents in excess of the benefits payable by the plan. A non-participating physician must provide an insured person with reasonable notice that his fees will be collected directly rather than through the plan.

Normally, out-of-province benefits are payable at a rate of payment no greater than that for similar services rendered in Manitoba, though the commission, subject to regulations, may pay at higher rates for necessary out-of-province care.

An insured person who leaves Manitoba to live elsewhere should obtain an out-of-province certificate from the commission showing that coverage is available for up to three months following arrival in the new place of residence.

The benefit coverage of the provincial plan includes the comprehensive medical coverage and the limited dental coverage of the national program (and insured hospital services), plus limited optometric, chiropractic and other benefits. Extra benefits include limb prosthetic devices and services, and, with prior approval of the Health Services Commission, limb and spinal orthotic devices and services, when prescribed by a medical practitioner. The benefit package includes the initial fitting of a contact lens following congenital-cataract surgery, the fee including the cost of the lens and service for the first year following the fitting, and artificial eyes. Ante-natal Rh-immune globulin is available on an insured-service basis.

The benefit coverage of the provincial plan includes personal care in designated personal-care homes (nursing homes and hostels) in

Manitoba. Eligibility for the benefits of the personal health-care program is normally contingent upon the applicant's having lived in Manitoba for 24 consecutive months. However, if a person has been a resident for an aggregate of 30 years, or was resident in a personal-care home and receiving personal care as a benefit under the plan on April 1, 1974, he or she is also entitled to benefits without being subject to the 24-month waiting-period. There is an authorized charge of $5.75 a day payable by an insured person in a personal-care home.

The commission administers a prescription-drug program for residents of Manitoba. Under this program, it reimburses 80 per cent of the costs of defined drugs over an initial "yearly deductible" of $50 for single persons or families. Virtually all drugs prescribed by a physician or dentist are covered. Oxygen, needles and syringes are included in the coverage of the drug program. Social-assistance recipients or other residents entitled to free prescription drugs under other government programs, federal or provincial, are excluded from the plan.

The public authority responsible for the administration of the Saskatchewan plan consists of: the provincial Minister of Health, Board of Health Region Number 1, Swift Current; the Saskatchewan Tuberculosis and Respiratory Disease Association;the Saskatchewan Cancer Commission; and the Saskatchewan Medical Care Insurance Commission. All the agencies represented in the public authority administer their respective benefit programs in such a way as to conform with the requirements of federal legislation.

The Medical-Care Insurance Plan is administered by the Saskatchewan Medical-Care Insurance Commission, which is responsible to the Minister of Health. The Swift Current Health Region, which comprises an area of 15,000 square miles in the southwest corner of Saskatchewan, administers its own medical-care plan. Under the present agreement, the commission provides the region with a basic *per capita* grant related to the *per capita* amount spent on behalf of other residents of the province. The commission assumes payment responsibility for residents of the region who are 65 years of age and over.

The provincial plan is a non-premium one funded from general provincial revenues. Registration is required to establish eligibility for coverage, and health-services identification cards valid for six months

are posted by the Saskatchewan Hospital Services Plan, on a semi-annual basis, to all heads of families, including residents of the Swift Current Health Region. New provincial residents are also required to register in order to establish their entitlement to coverage.

A patient has free choice of physician, and a physician may decide not to participate in the plan without his patients losing entitlement to benefits. The benefits payable for insured services received outside the province are normally limited to the benefits payable for comparable services rendered in Saskatchewan. However, the costs of medical services that are not available in Saskatchewan, but are provided in another province, are paid in full.

A Saskatchewan physician may bill the plan direct, bill the plan indirectly through one of the two approved health agencies, or bill the patient direct. Under the first two alternatives, he must accept the plan-payment as payment in full. The approved health agencies usually act as a "post office" in the processing of claims only where the physician is affiliated with the agency and the patient is a subscriber to it; but there are exceptions, as in the case of social-assistance recipients and out-of-province services received by agency subscribers. The approved health agencies are permitted to provide their subscribers with coverage for a range of extended benefits.

The provincial plan includes an optometric benefit, coverage for referred orthodontic service by a dentist, particularly for care of cleft palate, and coverage for chiropractic services. The chiropractic benefit is unique in that it is the only one of its kind provided by a public medical-care insurance plan in Canada that does not have a limit on the number of necessary services, or dollar volume, an individual or family can receive. X-rays by chiropractors outside the province are not covered.

With certain exceptions, Saskatchewan residents holding valid health-services cards are eligible for the benefits of other health plans administered by the provincial Department of Health. These include the following provincial plans:

The Saskatchewan Hearing Aid Plan makes it possible for insured residents to purchase at cost any required hearing aids. The cost charged to the patient for a hearing aid excludes any overhead costs. Batteries and other hearing-aid accessories are also provided at cost. Related services, which include hearing-evaluation and the sale, fitting, repair and servicing of hearing aids, are provided through permanent and mobile regional clinics at public expense.

Prosthetic and orthotic devices are provided free of charge to

insured residents, under the Saskatchewan Aids to Independent Living Program. Wheel-chairs, walkers, respiratory equipment, commodes and similar appliances may be obtained through local health offices under this program. All re-usable aids are provided on a free-loan basis. An equipment-maintenance and -repair service is also provided. This program is administered by the provincial Department of Health.

The Saskatchewan dental plan for children was implemented by the provincial Department of Health on September 1, 1974. It is intended to phase the plan in over a five-year period so that by 1978 all children aged three to 12 years will be eligible for care if they are registered with the Saskatchewan hospital and medical-care insurance plans. Children born between 1967 and 1971 were eligible in 1976 to be enrolled in the plan. In northern Saskatchewan, children aged three to 16 years are at present covered by the plan. The coverage of the dental plan includes diagnostic, preventive, restorative and surgical services, which are provided by dental teams working out of regional centres and mainly in school and mobile clinics. (The Swift Current Region continues to administer its own dental-care program.)

The plan makes extensive use of dental nurses and dental assistants working under the supervision of full-time dental officers. The dental nurses have been specially trained to do fillings, baby-teeth extractions and other simple procedures. No premiums are charged for enrolment in the plan and no charges are made for services provided by staff employed by the plan. If a child enrolled in the plan requires services provided by the plan that are beyond the competence of the dental nurses, the child is referred to a dentist in private practice. The dental plan reimburses the dentist for these services at an accepted rate. Major orthodontic services, gold restorations and charges in excess of the rate agreed to are not covered by the plan.

Under the nearly universal, non-premium Prescription Drug Plan, eligible insured residents who are covered by the provincial medical-care and hospital insurance plans can receive prescription drugs listed in a governmental formulary. There is no direct cost to the beneficiary other than the payment of a standard dispensing fee that is payable to the pharmacist. The drug plan will pay only for drugs purchased from participating pharmacies in Saskatchewan and a few border communities in Alberta and Manitoba.

Alberta

The Health Care Insurance Plan in Alberta is administered by the Alberta Health Care Insurance Commission, which is responsible to the Minister of Hospitals and Medical Care. Eligibility for provincial hospital insurance depends on the medical-care insurance status of the applicant.

All eligible residents are required to be registered with the commission. If a resident is not registered within the prescribed time-limits, eligibility for coverage normally cannot be effected until the first day of the third month after the date of application for registration. The commission is required to register an unregistered resident effective from the date on which he becomes a recipient of a social allowance under the Social Development Act, is admitted to a provincial mental-health institution, becomes a ward of the government, or enters a provincial jail or correctional institution, as the case may be.

A conjoint premium is charged for medical-care and hospital insurance. Premiums are collected on a monthly, quarterly or annual basis, but under employment and other group arrangements they are payable monthly. Social-assistance recipients are not required to pay premiums and scaled subsidies are available for other persons with limited incomes. If a resident not eligible for subsidy finds himself unable to pay his premiums owing to financial hardship, the Health Care Insurance Commission is authorized to waive his premiums temporarily when the Department of Social Services and Community Health has verified his need.

The following premiums are charged to insured persons:

	Regular yearly premiums	Social-assistance recipients	Subsidized annual premiums when taxable income is				
			Nil	or	$500 or less (single)	or	$1,000 or less (family)
Single	$ 76.80	Nil	Nil		$39.60		
Family of two or more	$153.60	Nil	Nil		$79.20		

New residents from outside Canada are not eligible for subsidy during the first 12 consecutive months of residence in Alberta. A resident who is 65 years of age or over, or whose spouse is 65 years of age or over, is entitled to exemption from premium payment for the basic hospital and medical-care insurance coverage on behalf of himself and any dependants in the family unit. (Other benefits available to this group of residents are described at the end of this section.)

The plan permits a resident who is not a dependant and who is registered and is not in default of premiums to opt out of the plan and the provincial Hospitalization Benefits Plan on a yearly basis if his application is received before July 1. An approved application is valid for the year July 1 – June 30, and during this period the resident is not liable for premiums and is responsible for the cost of his (and his dependants') hospital and health-care services. Only a very small number have opted out.

In regard to remuneration, practitioners are not required to make a choice of dealing directly with the provincial plan for all of their insured patients or opting out for all of their patients. In this respect the plan is quite different from those of other participating provinces, with the exception of New Brunswick. The patient has a free choice of practitioner but, if the practitioner intends to charge an amount greater than the plan benefit, he must have the patient's agreement to that effect before the services are rendered. The practitioner is thus free to deal with the plan or the patient or both regarding the remuneration for his services. Osteopaths are registered under the provincial Medical Profession Act and their services are thus eligible as insured services under the Medical Care Program.

Under the Alberta Health Care Emergency Financial Assistance Regulations, insured residents may receive additional benefits for the cost of necessary health and hospital services yet to be incurred or already incurred outside Alberta beyond the usual level of payment in respect of similar services rendered in Alberta. These extra benefits can be obtained on application to the commission and are subject to certain stipulations such as: prior approval (where applicable); the existence of an emergency situation; services not being available in Alberta – but only where the cost of the services rendered places an undue burden on the financial resources of the applicant.

If a registered resident leaves Alberta temporarily for a period expected to exceed six months, he is required to notify the commission of the relevant details. Where basic health services are being received

outside Alberta and lasting more than three months, the commission must be notified before the end of the three-month period why continuation of out-of-province care is necessary. Under such circumstances, the commission may continue payment of benefits, prescribe the period in which benefits will continue to be paid, or terminate benefits. Where notification is not undertaken and no arrangements have been made to return the patient to Alberta as soon as practical, the commission may terminate benefits at any time after three months have elapsed from the date the first of the services was received.

A resident of Alberta leaving Alberta to live permanently elsewhere is required to obtain a certificate of continuing coverage in order to be assured of benefits following his departure, and until the coverage of the next provincial plan can be obtained, where applicable. The certificate must be applied for before leaving or within one month of leaving, and will only be issued if the applicant is not in arrears in premium payments. Such certificates are normally limited to a maximum period of three months following the date of departure from Alberta (plus up to one month's travel time if the applicant plans to live permanently elsewhere in Canada). Where a registrant or dependant requires coverage while *en route* from Alberta to establish permanent residence outside Canada, the commission may, in any case in which it finds that unforeseen and extenuating circumstances warrant, extend the duration of the certificate for a further period not exceeding 12 months.

Additional benefits include some office dental services and limited optometric, chiropractic and podiatric services and appliances provided by podiatrists. The commission also makes available to paid-up, registered residents who are unable to obtain Blue Cross coverage on a group-subscriber plan an optional health-services contract (for hospital-differential charges for preferred accommodation, ambulance services, prescription drugs, appliances, home-nursing care, naturopathic services, clinical psychological services, dental care needed because of accident or injury, additional cost of hospital and medical-care services outside Canada and mastectomy prostheses) at subsidized rates of $2.25 a month for a single subscriber and $4.50 a month for a family of two or more persons. The optional coverage is available at reduced premiums for those with limited incomes. Residents who are 65 years of age or over are entitled to this coverage without premium payments on the same basis as for the basic hospital and medical-care coverage.

Further additional benefits are included for registered residents who are 65 years of age or over through an Extended Health Benefits Program. Where a registrant is 65 years of age or over, or the spouse of a registrant is 65 years of age or over, the registrant, spouse and any dependants in the family unit are entitled to the coverage of the Extended Health Benefits Program. This program is administered by the commission and by the Department of Social Services and Community Health under the Treatment Services Act.

The benefits of the Extended Health Benefits Program for which the commission is responsible include dental goods and services, including restorative, surgical and prosthetic dental care and repairs to dentures (but excluding otherwise-insured benefits of the Alberta plan and the Blue Cross plan) and specified optical goods and services prescribed following an eye-examination. The benefits of the Extended Health Benefits Program for which the Department of Social Services and Community Health has assumed responsibility include hearing aids and approved surgical and medical equipment, supplies and appliances, major equipment being provided on loan from the government. These latter items are not intended to replace those normally provided by a hospital or nursing home.

The Medical Services Plan of British Columbia is administered by a commission within the Medical and Hospital Programs Division of the Ministry of Health. The Medical Services Commission functions as the public authority responsible to the deputy minister of the division for the operation of the provincial medical-care insurance plan. The commission administers the provincial plan from a centralized administration in Victoria.

The Medical Services Plan of British Columbia is a premium-supported voluntary plan. Generally, new residents are subject to a waiting-period of up to three months before becoming eligible for coverage. Coverage is contingent on the required monthly premiums having been paid, with coverage normally ceasing when the premium is 15 days in default. Subsidies of 50 per cent or 90 per cent are available towards the cost of the premiums for persons in specified low-income brackets if they have been permanent residents of the province for the 12 months prior to application.

The following premiums are charged to insured persons:

	Regular yearly premiums	Yearly premiums when taxable income nil	Yearly premiums when taxable income less than $1,000
Single	$ 90.00	$ 9.00	$ 45.00
Two persons	$180.00	$18.00	$ 90.00
Family of 3 or more	$225.00	$22.44	$112.44

Full premiums are paid on behalf of persons who qualify for social assistance. Temporary premium assistance amounting to 90 per cent of premiums may be granted to subscribers who have resided in the province for the preceding 12 months if they are unable to pay the premiums otherwise required to obtain the coverage of the provincial plan on account of unemployment, illness, disability or financial hardship. Such temporary assistance may be granted for a period of up to three months and there is provision for further three-month extensions.

The patient has free choice of physician and a physician may opt out of participation in the plan without his patient losing entitlement to benefits. Osteopaths are registered under the provincial Medical Act and their services are eligible as insured services under the Medical Care Program. Physicians are responsible for ensuring that referrals for insured pathological, radiological and electrodiagnostic services (other than electrocardiograms) are to laboratories approved by the Medical Services Commission, preference being given to the use of available approved hospital and public laboratories unless the patient agrees in advance in writing to accept liability. Regulations specify which laboratory services are insured when provided in a practitioner's office.

Physicians are not permitted to charge patients in excess of the plan benefit payable in respect of their services unless an insured person requests unusual time-consuming service above and beyond ordinarily-required care, and if the attending physician has given prior notice of his intention to charge a greater amount, consent to the extra charge is agreed to in writing by the insured person, and the amount of the extra charge is made known to the commission.

When an insured person is temporarily absent from the province, the provincial plan restricts the insured services to those resulting from unexpected illness or injury. Prior authorization must be obtained from the commission where an insured person elects to seek medical attention outside the province, except in certain situations where the nearest convenient location for the insured service is outside the province but within Canada.

Additional benefits in the British Columbia plan include the services of optometrists, chiropractors, naturopaths, physiotherapists, podiatrists, Red Cross nurses, special nurses and VON nurses, and orthoptic treatment. Orthodontic service provided by a dental surgeon to an insured person 20 years of age or under in the care of a hare-lip and/or cleft palate is also included in the additional-benefit package, but only where the service arose as part of or following plastic-surgery repair performed by a medical practitioner. The extra benefits are provided mostly on a limited basis and are only available within British Columbia.

The Department of Human Resources administers a free prescription-drug program, known as "Pharmacare", for residents 65 years and over who have been residents of the province for at least 90 days and a universal Pharmacare plan, effective June 1, 1977, that protects individuals from financial hardship as a result of high prescription drug expenses. The plan pays 80 per cent of the cost after the first $100, which must be met by the family.

Yukon Territory

The Yukon Health Care Insurance Plan is administered directly by the territorial government with the assistance of a non-profit health-insurance agency acting as an agent in the assessment and processing of claims. The territorial government is responsible for the final assessment and approval of claims submitted to the agent.

The plan is a compulsory premium plan but eligibility for coverage depends on residency status rather than on premium-payment. A resident is a person who has lived in the Yukon Territory for three consecutive months, and each resident is an insured person entitled to benefits, subject to a waiting-period lasting until the first day of the third month following arrival in the case of new residents or those who re-establish residence. Landed immigrants who move directly to the Yukon on entering Canada to establish residence are entitled to benefits from the day of their arrival in the territory. Residents leaving the Yukon to reside elsewhere continue to be insured for a period of up to three months following departure, or until they become eligible to obtain coverage from the plan of their new province of residence (i.e. first day of third month of residency in the new province), whichever is the shorter period. This period may be extended by one month's travelling time.

The premiums charged by the territorial plan on a yearly basis are as follows:

	Regular yearly premiums	No taxable income	Yearly premiums when taxable income was $500 (single), $1,000 (couple), $1,300 (family of 3 or more), or less
Single	$ 57.00	Nil	$28.50
Family of 2 persons	$111.00	Nil	$55.50
Family of 3 or more	$132.00	Nil	$66.00

Every resident is required to register himself and his dependants with the plan or to be registered by a person acting on his behalf. The plan makes provision to pay in whole or in part the cost of the premiums for those with limited incomes who qualify for assistance on a yearly basis (April 1 – March 31), based on taxable income for the previous calendar year as shown in the table. Premium assistance is conditional upon the individual's having resided in the Yukon for a period of 12 months prior to applying for premium assistance. Persons 65 years and over are exempt from paying premiums. Registered residents receive plastic registration cards, which are used by participating doctors in the preparation of claims.

The patient has a free choice of physician and each physician may decide not to participate in the plan without his insured patients losing their entitlement to benefits. The maximum level of benefits payable for insured services received outside the territory but in Canada is established at the prescribed rate payable for these services by the host province. The benefit payable in respect of insured services received in other jurisdictions is at a level determined by the administrator of the plan as being fair having regard to the nature of the services rendered but not in excess of the benefit payable for comparable services provided in the Yukon.

The benefit coverage of the territorial plan is limited to the insured services of the national program.

Northwest Territories

The medical-care insurance plan for the Northwest Territories is administered by the Health Care Plan, a section of the Department of Social Development. The Director of the Department of Social Development has been designated by the Commissioner of the Northwest Territories as responsible to him for plan administration.

The plan covers all eligible residents and is funded on a non-premium basis from general territorial revenues. New residents arriving to establish residence in the Northwest Territories from elsewhere in Canada become eligible for coverage from the first day of the third month after becoming a resident. New residents who have had no immediate previous opportunity to acquire coverage anywhere in Canada are eligible for coverage from the first day of arrival in the N.W.T. Insured residents are required to register with the plan before receiving insured benefits. Each person registered receives a registration card that must be presented when receiving an insured service. Residents moving out of the Northwest Territories to reside elsewhere in Canada may claim benefits for up to three months following departure, or until they become eligible to obtain coverage from the provincial plan in the province where they now reside (i.e. from the first day of the third month following establishment of residence in the province), whichever is the shorter period.

Physicians must choose to participate in the plan for all their insured patients or to practise completely outside the plan for all their patients. Patients have free choice of physician, however, and a physician may decide not to participate in the plan without his patients losing entitlement to benefits. Where insured services are provided outside the Northwest Territories, the benefit payable is in accordance with the tariff established by the medical-care plan of the province in which the service was rendered; in the case of insured services received in another country, the benefit payable will be in accordance with the benefit payable for a comparable service rendered in the Northwest Territories.

The benefit coverage of the territorial plan is limited to the insured services of the national program. If the required treatment is not available at the point of original consultation and diagnosis in the Territories, the territorial government will reimburse the amount spent on air-transportation required from any point in the Territories in excess of the regular corresponding fare (return or one-way, as the case may be) between Yellowknife and Edmonton.

Health-Care Programs for Social-Assistance Recipients

Provincial programs providing certain medical-care and other health-care benefits to recipients of social assistance were in operation in each province before the introduction of province-wide hospital and medical-care insurance. The total number of persons eligible for benefits under such plans is estimated to be from 5 to 7 per cent of the Canadian population.

Since 1966, the Federal Government has, under the Canada Assistance Plan, paid half the cost incurred by provincial social-assistance plans for needy persons of personal health-care services not insured under the hospital and medical-care insurance legislation or, generally, if the benefit is universally available to insured residents. Since April 1, 1977, the services of the Extended Health Care Services Program have been excluded from cost-sharing under the Canada Assistance Plan, as the Federal Government is now contributing towards the costs of these services under other arrangements (see Appendix). The coverage at present for the principal services is as follows:

Physicians' services
Following the implementation of the provincial medical-care insurance plans, provincial welfare recipients automatically became enrolled for insured services. Premium assistance, partial or complete, is available for residents with limited means in the premium provinces. Under the provincial plans, welfare recipients are covered on the same basis, so far as benefits are concerned, as the general population. Social-assistance recipients may also receive broader benefits, including such generally non-insured items as travel allowances and telephoned advice, the cost of these additional items being ordinarily shared under the Canada Assistance Plan. Any extra billing by physicians, where practised, is usually waived.

Hospital care
Hospital-insurance programs in every province provide coverage for social-assistance recipients without payment of premiums or direct charges at the time of service.

Prescribed-drug benefits
As already noted in the descriptions of provincial health-insurance plans, some provinces cover virtually their entire populations, or such categories as those 65 years of age and over, for a drug benefit. In British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Quebec and Newfoundland, virtually all provincial social-aid recipients are enrolled under schemes providing prescribed-drug benefits. In Quebec, persons 65 years and over in receipt of a guaranteed income supplement to the Old Age Security pension are

entitled to the same benefits as other social-assistance recipients. Drug benefits consist of practically all approved prescription drugs and some unprescribed medications. Payment-rates to pharmacies or dispensing physicians are negotiated by the provincial governments. In some provinces certain patients may be required to pay a portion of the retail charge.

The Ontario and Nova Scotia governments provide a comprehensive drug benefit, at no direct cost to the recipient, for all residents 65 years of age and over (and for other family members in Ontario). These two governments subsidize the cost of drugs beyond this benefit provided by municipalities operating welfare programs for those in need. Under provincial auspices direct supplemental drug allowances are also available to the needy. Ontario also provides patients in nursing homes, homes for special care, persons receiving assistance under the government's family-benefits program, and recipients of the provincial guaranteed-income supplement, with prescribed drugs from a formulary under the provincial Drug Benefit Plan.

Most provinces supply, through their health departments, certain drugs that are important in the prevention of infections and for certain conditions requiring lengthy treatment where therapy costs can be very high – for example, venereal disease, rheumatic fever and tuberculosis.

Dental benefits

As already noted, some provinces operate universal, or nearly-universal, dental programs covering all children within specified ages or all residents 65 years of age and over. Dental-benefit plans are operated for selected social-assistance recipients 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 to others at municipal discretion for essential dental services. All provincial public-assistance recipients qualify for the dental benefits of schemes operated in Alberta and Saskatchewan, and selected categories qualify in Manitoba.

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 under each of these plans are at negotiated fixed rates. The patient is required to pay a co-charge of approximately 50 per cent of the cost of dentures in Alberta and Saskatchewan.

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

Optical benefits

Health-benefit schemes for social-assistance recipients in the four most westerly provinces include certain optical services and eye-glasses.

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

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 embellished frames.

Other health-care benefits

Other health benefits provided under programs in some provinces include, when not otherwise available to all residents under special programs, home nursing, appliances, physiotherapy, podiatry, chiropractic and emergency transportation, usually at the discretion of the provincial authority. Some of these services are shareable under the Canada Assistance Plan.

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, when moving from another, is up to three months after establishing residence.

All provinces provide first-day coverage on arrival, discharge or release, as applicable, to *bona fide* residents who have had 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) taking up residence in Canada for the first time, members of the Canadian Forces, members of the Royal Canadian Mounted Police, and prisoners in federal penitentiaries (on discharge or release);

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

In most plans, eligibility for coverage depends on whether any registration or premium-payment requirements have been met; sometimes both requirements must first be met. It is important when moving residence to maintain any pre-existing coverage until the waiting-period in the new province of residence has been fulfilled.

In no provincial or territorial plan can there be exclusions or limitations of membership or of benefits by reason of age, economic status or previous medical condition. The basic insured benefits are hospital care and physicians' services, but some plans also insure, sometimes as an added option, such benefits as prescribed drugs and the services of optometrists, 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 but do not qualify for provincial health services.

Health Insurance for Canadians Travelling Abroad

In recognition of the mobility of Canadians, federal legislation requires that the benefits of provincial hospital and medical-care insurance plans be portable when the insured person is temporarily absent from his or her province of residence, for fairly extended periods, anywhere in the world. In addition, the coverage must be portable when the individual moves to another province, for at least three months during the waiting-period normally imposed before a new resident from another province can obtain coverage.

Although there is a high degree of conformity in out-of-province benefits within Canada, payments for insured services (especially hospital care) received outside Canada are not standardized. Generally, for emergency and out-patient hospital services, payments tend to approximate the charges in the host country. In-patient services (i.e., for persons occupying hospital beds) are as a rule paid for at the rates prevailing in the province where the individual is resident and insured. 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. 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. The extent of coverage for hospital and physician care outside the home province of the resident may be circumscribed if the condition is of a non-emergency nature or if prior authorization has not been sought and received from the provincial insurance-administrating authority.

Residents who are absent for more than a year can in some provinces continue their insured status if the insuring authority is satisfied with reasons for absence and of intention to return to the home province.

Many provinces insure their residents for a wide range of services in addition to the basic hospital and medical-care insurance programs mentioned above. These benefits are seldom extended to coverage of the service when the resident is outside the province or country. As the cost of health services in some countries may be far in excess of the benefits payable by the provincial plans, Canadians travelling abroad are generally advised to take out additional supplementary health insurance for travellers, which is available through private insurance companies.

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 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 a large number of hospital rehabilitation units and separate in-patient rehabilitation centres. In addition, there are out-patient rehabilitation centres for children, supported by voluntary agencies and provincial health departments. Twelve prosthetic-service centres are operated by the Department of National Health and Welfare in the larger cities across the country. Universities offer courses in physiotherapy, occupational therapy, audiology and speech therapy, and prosthetics and orthotics.

Under a federal-provincial vocational-rehabilitation program, provincial welfare departments arrange assessment, counselling, vocational training and job-placement for handicapped persons. In some areas, local committees and voluntary agencies help the Canada Manpower Centres (national employment offices) find jobs for the handicapped.

In Canada, workers' compensation laws are within the competence of the provincial legislatures and are applicable to the majority of employers in each province. Compensation is provided for workers in most types of industry for injuries suffered on the job, unless the disablement is for fewer than a stated number of days or unless the injury is attributable solely to the worker's misconduct and does not result in death or serious disablement. Compensation is also payable for specified industrial diseases. A worker entitled to receive compensation under a workers' compensation act generally has no right of action against his employer for injury from an accident occurring in the course of employment or for an industrial disease. One of the primary objectives of

the compensation process in Canada is the rehabilitation of the injured worker. The boards may adopt any means considered expedient to aid in getting workers back to work and in lessening any handicap.

It is important to note that workers' compensation boards, not hospital- and medical-insurance plans, pay the costs of hospital, physician and other health-care services when these expenses are for care of work-related illnesses, injuries and conditions that are judged to be compensable.

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 for 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 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.

Canadian carriers providing health-insurance coverage for visitors

Visitors to Canada may obtain health-insurance coverage from the Ontario Blue Cross or from the Blue Cross of Atlantic Canada. These are non-profit carriers. Details of the plans, and application forms, may be obtained directly. The addresses are:

Ontario Blue Cross,
150 Ferrand Drive,
Don Mills, Ontario.
M3C 1H6

Blue Cross of Atlantic Canada,
P.O. Box 220,
Moncton, New Brunswick.
E1C 8L3

The completed application and premium must be submitted prior to arrival in Canada or within 21 days after arrival.

A person visiting Manitoba may obtain health-insurance coverage from the United Health Services Corporation (Manitoba Blue Cross) 100A Polo Park, P.O. Box 1046, Winnipeg, Manitoba, R3C 2X7, which is another non-profit carrier. An application form and further details may be obtained by writing to the plan. *A completed application and premium must be submitted prior to arrival in Manitoba or within 21 days after arrival.*

Visitors to Atlantic Canada (Nova Scotia, Newfoundland, New Brunswick and Prince Edward Island) may wish to obtain health-insurance protection from Maritime Medical Care Incorporated, a non-profit health association. An application form and further details may be obtained by writing to the company at 5675 Spring Garden Road, Halifax, Nova Scotia, B3J 1H2. *The completed application form and premium must be submitted prior to arrival in Canada or within 21 days after arrival.*

A person visiting Ontario may obtain health-insurance coverage from CUMBA Co-operative Health Services, 562 Eglinton Avenue East, Toronto, Ontario, M4P 1B9. An application form and further information may be obtained by writing to the plan. *Coverage is effective from the date an application and premium are received by the plan or from the date of the visitor's arrival in Canada, if the application and premium are received before arrival.*

A commercial carrier, Hospital Medical Care Plan, 710 Bay Street, Toronto, Ontario, also offers coverage for visitors to Canada.

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 include 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, Guaranteed Income Supplement and Spouse's Allowance programs, and Family Allowances. Through the Canada Assistance Plan, the Federal Government shares in the financing of provincial social-assistance and social-services programs.

During the course of a joint federal-provincial review of social security in Canada, which took place between 1973 and 1976, major improvements were made to the Family Allowances program, the Old Age Security/Guaranteed Income Supplement/Spouse's Allowance program and the Canada/Quebec Pension Plans.

The Federal-Provincial Social-Security Review undertook an extensive examination of current social-assistance and social-services programs that were cost-shared by the Federal Government under the Canada Assistance Plan. As a result of this review, the Federal Government is planning this year to introduce new legislation for the cost-sharing of provincial social-services programs, which will extend the range of services that are now cost-shared under the Canada Assistance Plan and the Vocational Rehabilitation of Disabled Persons Act. The emphasis of the new act will be on rehabilitation services and support services for the aged and disabled.

The Federal Government has proposed, and has agreement in principle from the provinces for, a system of income support and supplementation. This proposal is currently being studied as to the techniques of implementing such a program.

Family Allowances

The Family Allowances Act, 1973, was approved by Parliament in December 1973 and became effective on January 1, 1974. The new program replaced the Family Allowances, Youth Allowances and Family Assistance programs formerly in effect.

Family Allowances are paid on behalf of children under 18 years of age who are resident in Canada and are maintained by parents or guardians. At least one of the parents or guardians must be either a Canadian citizen, a landed immigrant or a non-immigrant who has been admitted to Canada for a period of at least one year (during which time the parent's income must be subject to Canadian income tax). Family Allowances are increased in January of each year if there is an increase in the cost of living.

A provincial government may ask the Federal Government to vary the rates on the federal payments made in that province on the basis of the age of the child or the number of children in the family or both. The monthly payment in an individual province must not, however, be less than 60 per cent of the federal monthly rate and the payments made in respect of all the children in a province must average the federal monthly rate for a child. The provinces of Alberta and Quebec have taken this option.

OAS/GIS/Spouse's Allowance

The Old Age Security pension is a monthly benefit paid to all persons who can meet the age and residence requirements. The age requirement is 65 years. The pension is earned by residence in Canada at the rate of one-fortieth of the full pension for each year of residence in Canada after reaching the age of 18. This means that residence in Canada for 40 years after the age of 18 would qualify a person for the full Old Age Security pension and residence in Canada for less than 40 years after 18 would qualify a person for a portion of the full pension. The minimum partial pension is ten-fortieths of the full pension, based on a required minimum residence in Canada of ten years after the age of 18.

The residence rules apply to all persons who are not residents of Canada as of July 1, 1977, and have not had prior residence in Canada after reaching 18. In addition, these rules apply to residents of Canada under the age of 25. All other persons have the opportunity of qualifying for a full Old Age Security pension in one of three ways:

(1) by having resided in Canada after attaining the age of 18 for periods that total at least 40 years;
(2) by having resided in Canada for the ten years immediately preceding the approval of the application;

(3) by having been present in Canada, after reaching 18 and prior to the ten years mentioned above, for periods that, when totalled, equal at least three times the length of the absences during the ten-year period, and by having resided in Canada for at least one year immediately preceding the approval of the application.

It should be emphasized, however, that failure to fulfil these requirements for a full pension does not mean that a person may not qualify for a partial pension.

Residence in Canada for 20 years after reaching 18 is necessary before payment of the Old Age Security pension may be made outside of Canada for an indefinite period.

The Guaranteed Income Supplement is a supplementary payment added to the basic pension on the basis of an income test. It was introduced in 1967 to help those pensioners who had been unable to make adequate provision for later life and who were not in a position to benefit fully, or at all, from the Canada Pension Plan or the Quebec Pension Plan, under which benefits are paid in direct relation to contributions made from earnings over a qualifying period. The supplement was originally intended as a transitional measure while the retirement-pension programs of these two plans were maturing. The Guaranteed Income Supplement is only payable outside Canada for a maximum of six months, in addition to the month of departure.

The Government is aware of the difficult circumstances facing many couples in Canada when they have to live on one pension. This situation can occur when one spouse is over 65 and qualifies for Old Age Security payments while the other spouse is under 65.

Under the Spouse's Allowance program, which was introduced effective October 1975, the spouse of an Old Age Security pensioner may be eligible for a Spouse's Allowance if that spouse is between 60 and 65 years of age and meets the Old Age Security residence requirements. Eligibility for the Spouse's Allowance, like the Guaranteed Income Supplement, is based on an income test. In this case, the combined yearly income of the couple is considered.

The Old Age Security, Guaranteed Income Supplement and Spouse's Allowance programs are escalated quarterly to reflect increases in the cost of living as measured by the Consumer Price Index. If the cost of living does not increase or if it declines, the level of benefit in pay will not decrease.

Canada Pension Plan – Quebec Pension Plan

The Canada Pension Plan (CPP) is a compulsory, contributory, earnings-related plan that, with the Quebec Pension Plan, 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, which consist of pensions for disabled contributors and benefits for their dependent children.

Employees contribute 1.8 per cent of contributory earnings, which is matched by the employer, whereas self-employed persons contribute at the rate of 3.6 per cent. In 1977, contributory earnings are earnings from $900 to $9,300 inclusive.

The Canada Pension Plan effectively applies in all provinces except Quebec, which has the Quebec Pension Plan. These two statutory plans, designed to operate virtually as one, became operative on January 1, 1966. Pension credits acquired under both plans are taken into account for purposes of calculating benefits under either plan.

Persons generally exempt from contributing to these plans are those who are earning in 1977 $900 or less. These are also some classes of workers to whom the mandatory contributory requirement does not apply, for example:

(1) persons employed outside Canada by a Canadian employer (including the Federal Government), when the employer has not agreed to cover the employment;
(2) persons employed in Canada by the government of another country or by an international organization, if the employer has not agreed to cover the employment;
(3) persons working in Canada for an employer who is not resident in Canada, if the employer has not undertaken to cover the employment in Canada;
(4) persons employed in international transportation, partly in and partly outside Canada, when the employment is not otherwise covered by regulation.

Such persons may elect to contribute at the self-employed rate of 3.6 per cent by completing a prescribed form and attaching it to their income-tax returns.

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 number of years contributions were required. Pensionable earnings are earnings from the first dollar up, including the

year's maximum pensionable earnings. In 1977, the year's maximum pensionable earnings are set at $9,300.

Although a retirement pension is payable upon application as early as the age of 65, persons between the ages of 65 and 69 who are employed can defer applying in order to continue to contribute to the Canada (or Quebec) Pension Plan if they think this is to their advantage. Once a retirement pension has become payable to a person, that person can no longer contribute under the plan. At the age of 70 persons should apply, since they can no longer contribute.

Disability benefits –
are payable to contributors who had contributed for at least five whole or part calendar years in the ten years preceding the onset of disability and are found to be suffering from a severe and prolonged mental or physical disability. This benefit, which is payable each month beginning three months after the month in which a person is found to be disabled, consists of a fixed monthly amount ($44.84 in 1977) and 75 per cent of the contributor's imputed retirement pension.

Surviving-spouse benefits –
are payable to the widow or widower of a person who, by 1977, had made the required contributions to the plan for at least four years. A survivor's benefit is payable to a disabled spouse, a spouse with dependent children, and a spouse 45 years of age or older. A reduced survivor's pension is payable to a spouse between the ages of 35 and 45 who is disabled or a spouse with dependent children. The survivor's pension for a spouse under the age of 65 includes a flat-rate component ($44.84 in 1977) 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 payable on behalf of unmarried dependent children up to the age of 18, or up to the age of 25 if the orphan continues to attend school or university full-time. The same monthly benefits are payable, under the same conditions, 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 – $44.84 in 1977. 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 for only one deceased contributor.

Death benefit –
a lump sum, 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 ($930 in 1977), is paid to the estate of a deceased contributor who, by 1977, had made the required contributions to the plan for at least four years.

Benefits in pay are adjusted annually to reflect the full increase in the cost of living.

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

Purpose
The Canadian Unemployment Insurance Program was established in 1940. Its general purpose is to facilitate the matching of unemployed workers with available jobs. In particular, it provides temporary income-replacement to unemployed workers while they are searching for suitable jobs. At the same time, it provides immediate access to training, mobility and placement services for those requiring these services in order to obtain suitable and permanent employment.

Coverage
Participation in the program is compulsory for nearly all paid workers in Canada, approximately 98 per cent of whom are covered under the program. While coverage is generally restricted to paid employees, self-employed fishermen are covered under special provisions of the legislation.

Types of benefit
Regular benefits are paid to insured persons who become unemployed as a result of a temporary or permanent lay-off and who are capable of work and are available for and looking for work.

Special benefits are paid to those insured persons who are not working because of sickness, injury or pregnancy; a special retirement benefit

is also payable to insured persons upon reaching the age of 65.

Conditions for receipt of benefits
Eligibility for regular benefits is restricted to insured individuals who had at least eight weeks of insured employment in the previous year. Information regarding the number of insured weeks and the amount of insured earnings, and evidence that the person is unemployed, are contained in records of employment provided by employers.

The conditions for continuing eligibility to regular benefits are that the claimant is capable of working and available for work. Persons in receipt of regular benefits are generally required to demonstrate their availability by searching actively for suitable employment while they are receiving benefits.

Special benefits (such as maternity and sickness benefits) are available to workers who have accumulated at least 20 weeks of insured employment in the previous year, provided the particular conditions related to the establishment of a claim to special benefits are met.

Administration of program
The staff administering the Unemployment Insurance Program in offices located in all major towns and cities across Canada aim to provide prompt payment of benefits to claimants. They also assist claimants in becoming re-employed as quickly as possible by referring them to the nearest Canada Manpower Centre and its specialized staff. The unemployment-insurance staff also make regular checks to detect and prevent the defrauding of the program (for instance, by collecting benefits while working at a full-time job) and to ensure that claimants are living up to the obligations on which the continued receipt of benefits depends.

Duration of benefits
(a) *Regular benefits;* the maximum time a person may collect regular benefits varies from 18 to 51 weeks. The number of weeks of regular benefit to which the claimant is entitled depends on the number of weeks he or she worked in the previous year, the prevailing national unemployment rate and the rate of unemployment in that part of the country in which the claimant resides.
(b) *Special benefits;* a person who becomes unemployed owing to illness may receive up to 15 weeks' benefits. Pregnant women taking maternity leave are eligible to draw up to 15 weeks' benefits during a period including the expected date of

confinement. A three-week lump-sum benefit is available to insured workers on reaching the age of 65.

Rate of benefit

The rate of benefit (whether regular or special) is equal to two-thirds of average insurable earnings over the previous 20 weeks of insurable employment, or over the actual number of insured weeks for persons who had less than 20 weeks of insurable employment during the previous year. In 1977, the maximum weekly benefit payable is $147; the minimum is $29. Benefits received are considered as taxable income and contributions to the program are an allowable deduction for income-tax purposes.

Financing the program

The program is financed by an arrangement involving employees and employers (the private sector), and the Federal Government (the public sector). The private sector pays for the total cost of special benefits. Private-sector contributions also cover the cost of administration of the program, and that portion of the regular benefits paid during the initial-benefit phases of the plan, up to a pre-determined national rate of unemployment. Currently (1977), the employee rate of contribution is $1.50 for $100 of earnings, up to a maximum contribution of $3.30 a week; the employer rate of contribution is $2.10 for $100 of salary or wages paid to employees, up to a maximum of $4.62 a week for each employee. The public sector absorbs the remaining costs of regular benefits in the initial-benefit phases and the full cost of benefits paid in the extended-benefit phases of the plan.

New legislation

At the time of this report, legislation (Bill C-27), which proposes the establishment of the Canada Employment and Immigration Commission, is before a Standing Committee of the House of Commons. The Commission will administer the Unemployment Insurance Program and the various programs of the Department of Manpower and Immigration. It will report to Parliament through the minister of the new Department of Employment and Immigration.

Bill C-27 also contains proposals to amend the Unemployment Insurance Program legislation, which, if adopted, would require alterations to the description of certain of the qualifying conditions and the duration of benefits described earlier.

The Canada Employment and Immigration Commission will provide for integration of the various services of Canada Manpower Centres and unemployment-insurance offices. These services will be available in the same local office, thus allowing the individual claiming unemployment-insurance benefits to receive, at the same time, counselling and other assistance to facilitate his or her re-employment and a better matching of skills with available jobs. This "one-stop" co-ordinated approach will provide more effective services to the unemployed and should thereby contribute to a more effective functioning of the labour market.

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

The range of industries covered by workers' 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 (except 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 workers' compensation boards according to the hazards in each class of industry.

Employees of the Federal Government have the same coverage as that provided by the Government Employees Compensation Act, which is administered by Labour Canada. 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 Labour Canada.

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

Under the Canada Assistance Plan (CAP), the Federal Government reimburses the provinces for 50 per cent of the cost of assistance 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 help recipients achieve self-support.

"Assistance" means 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 homes for special care such as homes for the aged, nursing homes, or welfare institutions for children; travel and transportation; funerals and burials; certain health-care services not covered by provincial hospital and medical-care insurance plans, or by the extended health-care services program; 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 by 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 resided in a province for ten years and must meet certain income requirements. Most provinces no longer accept applications under these categorical programs, but aid the blind and disabled by means of their general assistance programs, the costs of which are shared under the CAP.

Several provinces operate independent income-support programs that 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 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 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 these funds are eligible for 50 percent reimbursement from the Federal Government under the Canada Assistance Plan.

New Horizons Program

The New Horizons Program was established to provide an opportunity for retired Canadians to participate more actively in the life of the community. Grants are made available to groups of ten or more retired seniors to assist them in organizing projects of their own choosing that will make use of their skills and experience to the benefit of themselves and other members of their community.

A wide range of projects has been funded, including physical recreation, publications, information services, historical research, art and crafts, personal-care services, culture and education, restoration of artefacts, and activity centres.

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, with federal reimbursement for half the costs of assistance and of certain welfare services offered 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 the elderly.

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 being placed on preventive services to children in their own homes. Subsidized day-care services for the children of working mothers are available under voluntary and public auspices. At present, these services are established mainly in the larger centres.

Family-welfare agencies or combined family-and-child welfare agencies offer a wide range of services to individuals and families in need of guidance on such problems as marital relations, parent-child relations and credit-debt counselling. A number of voluntary agencies provide information and referral services designed to ensure a link with the network of social services in the community. Homemaker services intended to maintain families in emergencies, or as an aid to fostering independent living in the community for the elderly and disabled, are being developed by many provinces. Social-integration centres such as Golden Age Clubs for the elderly, Friendship Centres for *métis* and Indians, and "drop-in" centres for troubled youth, are made available to meet the special needs of persons in danger of being isolated from community life.

Activity centres for the mentally-retarded and the physically-disabled provide training in life and vocational skills and expand their social boundaries further into the community.

Summary of Provincial Health Insurance Plans (January 1, 1978)

NOTE: This summary does not include many health services provided by provincial health departments on a universal basis (e.g. health unit services, institutional care for tuberculosis and mental patients, venereal disease control, home-care programs).

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Children's Dental Health Program available to children up to 11 years of age. This program is administered by the Department of Health.

Premium per month – none

Hospital Insurance Standard benefits[c]:

In-patient: Standard ward and all approved available services.

Out-patient: Laboratory, radiological, and other diagnostic procedures, including the necessary interpretations; radiotherapy and physiotherapy where available, occupational therapy, where available, out-patient visits, emergency visits, operating room facilities including supplies, plaster casts, drugs and medical and surgical supplies administered in hospital.

Out-of-province benefits[c]:
Same benefits as provided in the province.

Authorized charges – none

(Effective April 1, 1978, there will be a standard ward charge of $3 a day, up to a maximum of 15 days per admission. Re-admission within 60 days of discharge in connection with the same illness or condition will be limited to the $45 maximum charge. Patients aged 65 years and over and patients certified by the Department of Social Services as being unable to pay will not be subject to the $3 ward charge.)

Medical Care Insurance
Benefits
Standard benefits[a]: All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Premium per month – none

Hospital Insurance
Standard benefits[c]:
In-patient: Standard ward and all approved available services.

Out-patient: Laboratory procedures as specified, radiological procedures as specified, including use of radioactive isotopes; drugs, biologicals and related preparations for emergency diagnosis and treatment; all other services specified as in-patient services.

Out-of-province benefits[c]:
Within Canada: Standard ward rate or rate authorized for out-patient services of host province in case of: 1) emergency, 2) referral with prior approval of Commission for conditions that cannot be treated adequately in P.E.I. Otherwise, daily rates established by Commission based on the average of the three major hospital *per diem* rates in effect at time service rendered.

Outside Canada: In-patient services only to maximum of:
1) emergency – up to $100 a day towards costs of hospital room

charges and 75% of balance of cost of insured services.
2) referral with prior approval of Commission for conditions that cannot be adequately treated in Canada – standard- ward rate for hospital and all necessary essential services. Otherwise, daily rates established by Commission based on the average of the three major hospital *per diem* rates in effect at time service rendered.

Authorized charges – none

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Optometric visual analysis; Dental plan for children born after January 1, 1967, or for students registered with the School for the Blind; Pharmacare plan for residents 65 years and over; cystic fibrosis program; diabetes insipidus drug program, effective April 1, 1978; hare lip/cleft palate dental program.

Premium per month – none

Hospital Insurance
Standard benefits[c]**:**

In-patient: Standard ward and all approved available services.

Out-patient: Broad range of essential services as approved by regulation including: medically necessary laboratory, electro-encephalographic and radiological examinations, radiotherapy for malignant and non-malignant conditions, electro-cardiograms, physiotherapy facilities where available, various drugs, hospital services including meals for day patient care for diabetes, hemodialysis, ultrasonic diagnostic procedures and interpretations and electro-cardiograms and interpretations, as well as specified

hospital services when required for emergency diagnoses and treatment within 48 hours of an accident and specified hospital services in connection with various minor medical and surgical procedures.

Out-of-province benefits[c]:
Within Canada: In-patient only for (a) emergencies and (b) with prior approval of Commission of a medically-necessary referral outside Nova Scotia from a Nova Scotia physician.

Outside Canada: Ward rate up to $100 a day plus 75% of the remainder except for infants less than 15 days old, then up to $11 a day. (Effective May 1, 1978, out-of-province out-patient services covered at specified rates.)

Authorized charges – none

Medical Care Insurance
Benefits
Standard benefits[a]: All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]: Prescription Drug Program for beneficiaries who are 65 years and over, for those with cystic fibrosis and for those who are social service benefit recipients.

Premium per month – none

Hospital Insurance
Standard benefits[c]:
In-patient: Standard ward and all approved available services.

Out-patient: All approved available services.

Out-of-province benefits[c]:
In Canada: Complete *in-patient* coverage at standard ward rate approved by hospital's provincial plan.

Out-patient: Total amount charged for entitled services at rates approved by hospital's provincial plan.

Outside Canada: In-patient coverage – All-inclusive rate not in excess of the average standard-ward rate, rounded to the nearest dollar, of the three largest New Brunswick hospitals.

Out-patient coverage – Entitled out-patient services at New Brunswick rates.

The rates for out-of-province benefits, both for medical care and hospital insurance, apply only in the case of: (a) emergency, (b) temporary absence from province for education, (c) referral by a New Brunswick physician with prior approval of the Department of Health, (d) special services not being available in New Brunswick, (e) the treatment being required up to the first day of the third month following the month of arrival at a new residence following a permanent move.

Authorized charges – none

Medical Care Insurance Benefits

Standard Benefits[a]: All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]: Optometry, oral surgery performed in a university establishment. Drugs and related professional services for recipients of social aid and recipients of certain governmental social aid measures; for persons aged 65 years and over; for persons between 60 and 64 years of age who are eligible for an allowance under the Old Age Security Act and would otherwise, without that allowance, be eligible for social aid or certain governmental social aid measures. Dental services for children under the age of 12 (and under the age of 14 from May 1, 1978). Prostheses, orthopaedic appliances or other appliances specified by regulation. Breast prostheses grant program following mastectomy. Functional aids program for the visually handicapped under 18 years of age.

Premium per month – none[g]

Hospital Insurance

Standard benefits[c]:

In-patient: Standard ward including all available services.

Out-patient: Clinical services of day or night psychiatric care, electroconvulsive therapy, insulin shock

therapy, behavioural therapy, emergency care, minor surgery, radiotherapy, diagnostic services, physiotherapy, occupational therapy and inhalation therapy services, orthoptic services, services or examinations necessary for a resident to obtain employment, or those required in the course of employment or on the demand of the employer, provided that such examination or service is required by a law of Quebec other than the Collective Agreement Decrees Act, hearing and speech services.

Out-of-province benefits[c]: *Within Canada: In-patient:* Approved standard ward rate.

Out-patient: Insured services at the prevailing rate of the hospital where these services are received.

Outside Canada: In-patient: Without prior approval, up to $25 a day. Emergency or sudden illness and referral cases receiving prior approval, room and board at the ward rate plus cost of other insured services.

Excluded: spas, psychiatric and tuberculosis hospitals.

Out-patient: at the prevailing rate of the hospital where the insured services are received provided that: (a) the services were received during the 24 hours following an accident; (b) the services became necessary due to sudden illness or emergency.

Authorized charges

The payments authorized are $7 a day in extended-care hospitals and in extended-care units in short-term-care hospitals. Children under the age of 18 are exempt. Low-income individuals may benefit from total or partial exemption depending on their family and financial situations.

Additional services offered to the Quebec population under special programs of the Department of Social Affairs include:

(a) the transportation of sick persons according to specified criteria;

(b) the supply of special drugs at reduced cost ($2 a prescription with a maximum of $100 annually) for ambulatory patients with cancer, glaucoma, cystic fibrosis, tuberculosis, hyperlipoprotinemia, diabetes insipidus or psychiatric illness;

(c) home-care services ordered by the attending physician to permit convalescence at home and reduce hospitalization (this program includes renal dialysis and parenteral nutrition);

(d) home-care services to encourage the maintenance at home and avoidance of family break-up or long-term institutionalization for elderly persons.

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Optometry, chiropractic, podiatry, osteopathy (also out-of-hospital benefit towards cost of physiotherapy and for ambulance services). Home Care Program Services; home renal-dialysis and home hyperalimentation equipment, supplies and medication. (The provincial Ministry of Health administers a free Drug Benefit Plan for persons 65 years and over who are Canadian citizens or landed immigrants and who have lived in the province for the past 12 months, disabled persons and persons with limited incomes.)

Premium per month[d]

Single – $16[e]. Family of 2 or more – $32[e]. (Effective August 1, 1978, premiums increased to $19 (single) and $38 (family of 2 or more).)

Hospital Insurance

Standard benefits[c]**:**

In-patient: Standard ward and all approved available services.

Out-patient: Broad range of essential services, physio-, speech, occupational, radio-and inhalation therapies, diet counselling services when prescribed by a physician, and other hospital services when medically necessary. Where available from a hospital, the provision of equipment, supplies and medications for use in the home by haemophiliac patients for the emergency treatment or the prevention of haemorrhage. The plan also provides an extensive nursing home benefit.

Out-of-province benefits[c]**:**

Full rate in other Canadian provinces less any co-insurance or capital charges made by province concerned. 75% of standard ward for non-emergency admissions in the United States including room, board and all extras. 100% of emergencies (except mental illness) anywhere in the world. 100% of standard ward care in all other cases (except mental illness) occurring outside Canada or the U.S.

Authorized charges – none

Medical Care Insurance Benefits

Standard benefits[a]: All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]: Certain optometric and chiropractic services, prosthetic devices and certain limb and spinal orthotic devices and services when prescribed by an M.D. Contact lens following congenital cataract surgery. Artificial eyes. Prescription drug program.

Premium per month – none

Hospital Insurance

Standard benefits[c]:

In-patient: Standard ward and all approved available services.

Out-patient: All services except drugs and dressings in certain cases.

Personal care homes: Standard ward and all approved available services.

Out-of-province benefits[c]:

In Canada: Rate approved by hospital's provincial plan.

Outside Canada: The greater of 75% of hospital's charges or a daily allowance if: (a) emergency, (b) adequate care not available in Manitoba, (c) during 3 months following permanent move, (d) temporary employment or education. The lesser of 75% of hospital's charges or a daily allowance for elective cases.

Authorized charges – none

(Effective May 1, 1978, $7 a day may be charged by hospitals in Manitoba to insured persons receiving hospital in-patient services that are not medically required but are provided after the need for placement in a personal care home has been established to the satisfaction of an assessment panel. A residential charge of $7 a day is made to insured persons receiving personal care in personal-care homes (previously $6.25).)

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Optometry, chiropractic, oral surgery by a dentist and referred services by dentist for care of cleft palate. With certain exceptions, Saskatchewan residents holding valid health-services cards are eligible for the benefits of other plans administered by the provincial Department of Health. These include a subsidized hearing-aid plan; the provision of prosthetic and orthotic devices; provision of wheelchairs, walkers, commodes and other aids to daily living; a dental plan for children; a prescription drug plan.

Premium per month – none

Hospital Insurance

Standard benefits[c]**:**

In-patient: Standard ward and all approved available services.

Out-patient: to the extent that a hospital is able to provide it.

Out-of-province benefits[c]**:**

In-patient:

Within Canada: Standard-ward rate less co-insurance charge where applicable.

Outside Canada: Maximums apply as to rate and number of days of care.

Out-patient:

Within Canada: Total amount charged.

Outside Canada: Total amount charged or a rate considered to be fair and reasonable.

Authorized charges – none

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Dental services rendered by dental surgeons as specified in regulations, optometric and chiropractic services and podiatric services and appliances. An optional health-services contract is available through the Commission, providing Alberta Blue Cross Plan membership at reduced rates to residents who are not members of a group. For residents 65 years and over and their dependants, the government provides a substantial portion of the cost of eyeglasses and a major portion of the cost of dentures and dental care, and assumes the cost of hearing-aids and medical and surgical equipment, supplies and appliances.

Premium per month[d]

Single – $7.05[f]. Family of 2 or more – $14.10[f]. (Effective July 1, 1978, premiums increased to $7.65 (single) and $15.30 (family of 2 or more).)

Hospital Insurance

Standard benefits[c]**:**

In-patient: Standard ward and all approved available services.

Out-patient: 100% of all out-patient procedures rendered by the hospital; 100% of all diagnostic and physiotherapy services rendered in approved facilities outside the hospital; 100% of all out-patient services provided by provincial cancer clinics; dietetic counselling services. The plan also provides an extensive nursing-home benefit.

Out-of-province benefits[c]**:**

In-patient: 100% of all approved in-patient charges in Canada. Outside Canada, at $50 a day or the actual cost, whichever is the lesser, minus the authorized charges. For newborn – $9 a day or the actual cost, whichever is the lesser.

Out-patient: 100% of all services rendered by hospitals in Canada, at their respective approved rates. Outside Canada, for out-patient service at an active treatment hospital, the lesser of the amount charged or the amount that would be paid for the same service in Alberta.

Authorized charges –

Adults (excluding residents 65 years and over and their dependants) and children (excluding newborn): $5 for the first day in active-treatment hospitals. Also excluded are: (a) inter-hospital transfers, (b) admissions approved by cancer clinics, (c) polio patients, (d) recipients of social assistance from Department of Social Services and Community Health. Auxiliary hospitals: $5 a day after 120 days ($5.50 a day, effective July 1, 1978).

Medical Care Insurance Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]*:* Optometry, chiropractic, naturopathy, physiotherapy, podiatry, orthoptic treatment and services of Red Cross nurses, special nurses and VON, orthodontic services for hare lip and/or cleft palate. (Free prescription-drug program for residents 65 years and over, the handicapped and the chronically ill, and a universal Pharmacare plan which protects individuals from financial hardship as a result of high prescription-drug expenses. Further details may be obtained by writing Pharmacare, Ministry of Human Resources, Parliament Buildings, Victoria V8V 1X4.)

Premium per month[d]

Single – $7.50. Two persons – $15. Family of three or more persons – $18.75.

Hospital Insurance

Standard benefits[c]:

In-patient: Standard ward and all approved available services.

Out-patient: Emergency services, minor surgical procedures, day care surgical services, out-patient cancer therapy, psychiatric day-care and night-care services, day-care rehabilitation services, narcotic-addiction services, physiotherapy services, diabetic day-care, and specified out-patient psychiatric services (in designated hospitals), dietetic-counselling services; cytology services operated by B.C. Cancer Institute and renal-dialysis treatments for chronic renal failure (in designated hospitals); day-care services at the Arthritis Centre of British Columbia and psoriasis day-care services at Shaughnessy Hospital, Vancouver.

Out-of-province benefits[c]:

(a) *In-patient:* During a temporary period of absence that ends at midnight on the last day of the 12th month following the month of departure from province – maximum stay of 12 months unless otherwise approved.

(b) Referral, if approved by Deputy Minister.

(c) *Out-patient:* renal-dialysis treatment for chronic renal failure in designated hospitals in another province, less $1 authorized charge.

(d) *Out-of-Canada:* in-patient maximum $75 a day for adults and children. $12 a day for newborn. Lesser of charge or $75 for out-patient dialysis for chronic renal failure. (Canadian funds)

Authorized charges

(a) $4 a day in general hospitals, excluding newborn,

(b) $6.50 a day for adults and $1 a day for children under the age of 19 in extended-care hospitals,

(c) $2 for each emergency or minor surgical out-patient treatment,

(d) $2 for day-care surgical services,

(e) $1 for out-patient cancer therapy, psychiatric day-care or night-care and psychiatric out-patient services, out-patient physiotherapy services, diabetic day-care services, day-care rehabilitation services, each dietetic-counselling session, renal-dialysis treatment, day-care arthritic services and psoriasis day-care services.

Medical Care Insurance Benefits

Standard benefits[a]: All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Additional benefits[b]: Full travel coverage, plus iving expenses allowance, while away from home for treatment of cancer, cystic fibrosis, tuberculosis or mental illness. Also cost of drugs required to treat specific chronic diseases. Assistance towards travel costs to receive medical treatment away from home community.

Premium per month – none

Hospital Insurance

Standard benefits[c]:

In-patient: Standard ward and all approved available services.

Out-patient: Emergency and follow-up treatment of injuries; medically-necessary diagnostic radiological examinations with necessary interpretations; laboratory examinations; minor surgical procedures; physiotherapy and radiotherapy where available; and certain day-care surgical procedures.

Out-of-province benefits[c]:

In-patient: Rate approved for hospital by its own provincial plan.

Out-patient: Same benefits as in N.W.T.

Outside Canada: Up to a maximum specified rate.

Authorized charges – none

YUKON TERRITORY

Medical Care Insurance

Benefits

Standard benefits[a]*:* All medically-required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals.

Premium per month[d]

Single – $4.75. Couple – $9.25. Family – $11.

Coverage depends on residency status rather than on payment of premiums. Persons 65 years or more are premium-exempt.

Hospital Insurance

Standard benefits[c]**:**

In-patient: Standard-ward rate and all approved available services.

Out-patient: Laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the diagnosis and treatment of an injury, illness or disability excluding simple procedures which ordinarily form part of a physician's routine office examinations; day care surgical services.

Out-of-province benefits[c]**:**

In-patient: Rate approved for hospital by its own provincial plan.

Out-patient: Same benefits as in Territory.

Outside Canada: Maximum applied as to rate.

Authorized charges – none

Notes:

(a) These benefits are provided in accordance with the terms and conditions of the Medical Care Act (Canada).

(b) These additional benefits are generally provided on a limited basis. For specific details, information may be obtained from the provincial plan. The Federal Government is not contributing under federal health-insurance legislation towards the costs of these additional benefits. However, the Federal Government contributes towards the cost of certain health services under the Extended Health Care Services Program, such as nursing-home and adult residential care, home-care (health aspects) and ambulatory health-care services.

(c) These benefits are provided in accordance with the terms and conditions of the Hospital Insurance and Diagnostic Services Act (Canada), except for nursing-home benefits – see Note (b).

(d) The premiums are those for persons who do not qualify for premium assistance on account of limited income. The provisions for assistance vary from province to province.

(e) Rates are for combined medical-care and hospital-insurance coverage. Premium exemption if member of premium unit is 65

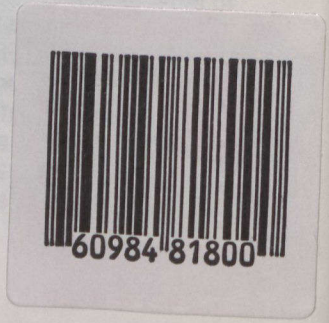
years or more and resided for at least the previous 12 months in province.

(f) Premium exemption for basic (and for optional) coverage if member of a premium unit is 65 years or more. Eligibility for hospital insurance depends on medical-care insurance status.

(g) The legislation providing for health-program financing has set the contribution of an individual at 1.5% of his net income for the year, to a maximum of $235 for salaried employees and $375 for self-employed persons. This individual contribution must not reduce net income to a figure below either $5,957 or $3,931, depending on whether the individual is married or single. The employer's contribution is set at 1.5% of an employee's salary. (Individual contributions ceased July 1, 1978, with effect retroactively to January 1, 1978.) Eight-fifteenths of the contributions thus collected are remitted to the Quebec Health Insurance Board and the remaining seven-fifteenths are turned over to the hospital-services fund, which is used exclusively for the financing of hospital services in Quebec. (The method of financing has been changed in 1978.)

Plan Addresses

	Medical Care	Hospital Insurance
Newfoundland	Newfoundland Medical Care Commission, Elizabeth Towers, Elizabeth Avenue, St. John's, Newfoundland. A1C 5J3	Hospital Services Division, Department of Health, Confederation Building, St. John's, Newfoundland. A1C 5T7
Prince Edward Island	Health Services Commission, P.O. Box 4500, Charlottetown, P.E.I. C1A 7P4	Hospital Services Commission of Prince Edward Island P.O. Box 4500, Charlottetown, P.E.I. C1A 7P4
Nova Scotia	Health Services and Insurance Commission, P.O. Box 760, Halifax, Nova Scotia. B3J 2V2	Department of Health, P.O. Box 488, Halifax, Nova Scotia. B3J 2R8
New Brunswick	Department of Health, Insured Services Division Box 5100, Fredericton, New Brunswick. E3B 5G8	Department of Health, Insured Services Division Box 5100, Fredericton, New Brunswick. E3B 5G8
Quebec	Quebec Health Insurance Board, P.O. Box 6600, Quebec, Quebec. G1K 7T3	Department of Social Affairs, Joffre Building, 1075 chemin Ste-Foy, Quebec, Quebec. G1A 1B9



Ontario

Ontario Health Insurance Plan — (Medical Care and Hospital Insurance)

HAMILTON
25 Main Street W.,
L8P 4P9

KINGSTON
1055 Princess Street,
K7L 5A9

LONDON
227 Queens Avenue,
N6A 5G6

MISSISSAUGA
55 City Centre Drive,
L5B 3M1

OSHAWA
44 Bond Street W.,
L1G 1A4

OTTAWA
75 Albert Street,
K1P 5Y9

SUDBURY
295 Bond Street,
P3B 2J8

THUNDER BAY
435 James Street S.,
P7C 5G6

TORONTO
2195 Yonge Street,
M5W 1A0

The above district offices undertake registration and claims processing. Information offices are also located at Barrie, Kenora, Kitchener, Peterborough, St. Catharines, Timmins and Windsor.

Manitoba

Manitoba Health Services Commission,
599 Empress Street,
Winnipeg, Manitoba.
R3C 2T6

Manitoba Health Services Commission,
599 Empress Street,
Winnipeg, Manitoba.
R3C 2T6

Saskatchewan

Saskatchewan Medical Care Insurance Commission,
Provincial Health Building,
3211 Albert Street,
Regina, Saskatchewan.
S4S 5W6

Saskatchewan Hospital Services Plan,
Provincial Health Building,
3211 Albert Street,
Regina, Saskatchewan.
S4S 5W6

Plan Addresses

Alberta	Alberta Health Care Insurance Commission, P.O. Box 1360, Edmonton, Alberta. T5J 2N3 or Alberta Health Care Insurance Commission, J.J. Bowlen Building, 620 - 7th Avenue S.W., Calgary, Alberta. T2P 0Y8	Alberta Department of Hospitals and medical Care, Hospital Services, P.O. Box 2222, 9945 - 108 Street, Edmonton, Alberta. T5J 2P4
British Columbia	Medical Services Commission, 1515 Blanshard Street, Victoria, B.C. V8W 3C8 (Insurance contract may be obtained from the Medical Services Plan of British Columbia, 1515 Blanshard Street, Victoria, B.C. Mailing Address: P.O. Box 1600, Victoria, British Columbia. V8W 2X9)	Hospital Programs, Ministry of Health, Parliament Buildings, Victoria, British Columbia. V8V 1X4
Northwest Territories	N.W.T. Health Care Plan Government of the N.W.T., Yellowknife, N.W.T. X1A 2L9	N.W.T. Health Care Plan, Government of the N.W.T., Yellowknife, N.W.T. X1A 2L9
Yukon	Yukon Health Care Insurance Plan, P.O. Box 2703, Whitehorse, Yukon. Y1A 2C6	Yukon Hospital Insurance Services, P.O. Box 2703, Whitehorse, Yukon. Y1A 2C6

External Affairs Canada
Affaires extérieures Canada