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HEALTH AND WELFARE IN CANADA

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PART I -- HEALTH SERVICES

Responsibility for the administration of health-care services in Canada is a direct concern of provincial governments, with municipalities often exercising considerable authority over matters delegated to them by provincial legislatures. The Federal Government has jurisdiction over a number of health matters of national scope and provides important financial assistance to provincial health and hospital services. All levels of government are aided by a network of voluntary agencies in different health fields.

The Department of National Health and Welfare is the chief federal agency in health matters. The health side of the Department is organized into four branches -- Food and Drugs, Medical Services, Health Insurance and Resources, and Health Services. Through the Food and Drug Branch the Department is responsible for protecting the Canadian public from hazards to health of the foods, drugs, cosmetics, and medical devices sold to the public. The Medical Services Branch operates quarantine and immigration medical services and provides health services to Indians and Eskimos and other special groups. The Health Services Branch advises and provides consultative services to provincial and local health agencies on numerous matters concerning the health of Canadians. Technical advisory services are also provided to the provinces through the Health Insurance and Resources Branch, which administers a number of shared-cost programs.

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

Other important measures to improve the health of Canadians include public education programs on smoking (to reduce the incidence of lung cancer and other diseases attributable to cigarette smoking), on maternal and child health (to reduce infant and maternal mortality), and on environmental health (to strive to eliminate harmful industrial and other chemical wastes from the environment). The Department has also developed a comprehensive program to protect the public from harmful radiation resulting from the use of radioactive materials. Pollution control in Canada has traditionally been a provincial responsibility, but the Department of National Health and Welfare gives consultative and technical assistance for the investigation and control of specific pollution problems in many parts of the country. It has established a national sampling network to provide useful information on the quality of the air in Canadian cities. The Department also has direct responsibility to assist the International Joint Commission in coping with air pollutants crossing the Canadian-American border.

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

Public Health

Public health comprises those institutions, services, and activities that concern the health of society, rather than health care for individuals. They include environmental sanitation, dealing with purity of air, water, and soil; occupational hazards to health, including protection from radiation, work and traffic safety, and noise abatement; the control of infectious diseases, such as tuberculosis and venereal disease; case-finding activities for diabetes, glaucoma, tuberculosis, and cancer; control of food standards, food contamination and food additives; drug control; maternal and child health; preventive activities concerning cancer; addiction to alcohol and drugs, mental illness, and mental retardation; poison-control centres; quarantine; and health education. They also include vital statistics and statistics on contagious diseases.

Tuberculosis

Since 1956 the incidence of new active cases of tuberculosis decreased from 49 in 100,000 to 21 in 100,000 of the population in 1969, and the death-rate fell from 7.8 to 2.5 in 100,000.

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

Cancer

The standardized cancer death-rate has been rising steadily for many years; it was 141 in 100,000 of the population in 1969. Public and voluntary agencies engage in detection, treatment, public education and research. Free diagnostic and treatment services are now available in many provinces, supported by the federal Cancer Control Grant and by hospital-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 defective. Facilities include out-patient departments and psychiatric units of general hospitals, which provide short-term in-patient treatment. The large mental hospitals admit those patients who need long-term care, and the hospitals for the mentally defective care for the more severely retarded.

Diagnostic and treatment services for emotionally-disturbed children, for the mentally retarded, for alcoholics and for court offenders have been established in larger cities.

Since 1960 the number of in-patients in all psychiatric institutions has decreased by 17 per cent on account of the introduction of chemotherapy and the consequent shift from in-patient to out-patient treatment.

Hospital Insurance

Insured Services

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

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

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

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

British Columbia insures out-patient cytology and cancer therapy at specified facilities operated by the British Columbia Cancer Foundation; day-care surgical services; emergency services for accident victims; minor surgery; psychiatric services, including psychiatric day-care or night-care; and rehabilitation day-care services. An authorized charge of $1 or $2 daily applies to out-patient services depending upon type.

Coverage

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

Residence in the province is the major eligibility determinant under federal-provincial hospital-insurance programs. Most provinces require a three-month waiting period, but interprovincial arrangements provide for continuity of coverage when insured persons move from one province to another. Persons coming from outside Canada may qualify for immediate coverage in Alberta, Saskatchewan, and Newfoundland.

Financing

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

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

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

Each province and territory makes at least some use of general tax revenues to finance its program. Newfoundland, Prince Edward Island, New Brunswick, Quebec and the Yukon Territory finance entirely from this source. Nova Scotia and British Columbia, in addition, impose a general sales tax and use part of the proceeds to assist in the financing of hospital care. Ontario raises about 40 per cent of its cost by a premium of $66 a year for single persons and $132 for families. Manitoba finances part of its cost from annual premiums or taxes of $43.20 for single persons and $86.40 for families. Saskatchewan levies annual premiums or taxes of $24 for single persons and $48 for families, together with a general sales tax under the Education and Health Tax Act. Alberta levies an annual premium of $69 for single persons and $138 for families under the Health Insurance Premiums Act, which includes both hospital and medical-care insurance.

In Saskatchewan, Alberta, British Columbia, and the Northwest Territories, part of the financing is derived from co-insurance charges or utilization fees. These charges, designated in the regulations as "authorized charges", are payable by the patient at the time of service and are deductible from provincial payments to hospitals. Saskatchewan charges $2.50 a day for the first 30 days of adult or child in-patient care and $1.50 a day for the next 60 days. There is no charge after the ninetieth consecutive day of in-patient care. For out-patient physiotherapy services, $1.50 a visit is charged. Alberta charges $5 for the first day only of adult or child in-patient care in general hospitals; in auxiliary hospitals $2 is charged for each day of care. British Columbia charges $1 a day for in-patient care (except for newborn infants) and $1 or $2 for out-patient services, as previously mentioned. The Northwest Territories charges $1.50 a day for in-patient care.

Medical-Care Insurance

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

Federal Medicare Legislation

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

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

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

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

d) provide for "portability" -- that is, full coverage of services after three months of residence in a province, and out-of-province coverage during the periods of waiting while a person establishes residence in another province.

For a participating province to benefit from the federal program, its own plan must provide for the financing of comprehensive physicians' services for all eligible residents of the province without regard to their age, ability to pay, or other circumstances. The Medical Care Act, in addition, empowers the Federal Government to include additional health-care services provided by non-physician professional personnel, under terms and conditions specified by the Governor-in-Council.

There is provision in the Act for provincial authorities to designate non-governmental organizations as agencies permitted to undertake restricted functions in connection with the premium-collection or claims-payment administration of the provincial plan. Such agencies must be non-profit and the payment of claims must be subject to assessment and approval by the provincial authority.

Provinces can finance services in any manner they wish, but the Act contains a proviso the intent of which is that no insured person shall be impeded in obtaining, or precluded from, reasonable access to insured services as a consequence of direct charges associated with the services received. A province may adopt any method it wishes of paying the providers of services, subject only to the proviso that the tariffs of authorized payments are on a basis that assures reasonable compensation for the services rendered.

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

Provincial Medical Care Plans

Before the establishment of government-administered medical insurance in most provinces over the last few years, prepayment arrangements to cover the cost of physicians' services, mainly voluntary as regards enrolment, had developed rapidly in both the public and the private sectors.

By the end of 1968, basic medical or surgical coverage, or both, were being provided to about 17.2 million Canadians, representing 82 per cent of the total population. Of these, the voluntary plans operating purely in the private sector provided coverage for about 10.9 million persons, or 52 per cent, and public plans of various kinds covered 6.3 million persons, or 30 per cent.

Early in 1971, with public medical-care programs implemented in all ten provinces and the Northwest Territories, insurance for physicians' services covered in most provinces virtually the entire eligible population, or slightly over 21 million persons.

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

In addition to the comprehensive physicians' services which must be provided as insured benefits by participating provinces, most plans also make provision for other health-care benefits that are part of the basic contract but towards the cost of which the Federal Government does not contribute. Refraction services by optometrists are included in the majority of provincial plans. A restricted volume of services provided by such practitioners as chiropractors, podiatrists, osteopaths, and naturopaths is also insured by some provinces. Residents may, if they wish, continue to seek insurance protection, generally from private voluntary agencies, for such additional services as dental care, special duty nursing, and prescribed drugs.

Five of the 11 provincial and territorial medical plans finance their portion of total costs from general taxation revenues only and there is thus virtually no direct cost to families apart from additional billing that doctors may in some instances impose. Five of the plans employ premium levies to help finance their share of costs, and one employs a payroll tax. Typically, premiums are paid for welfare recipients, and various devices are used to keep the financial burden low for families that are poor but just above the poverty-line entitling them to welfare assistance.

Each of the 11 plans in operation is described briefly in the paragraphs that follow, in chronological order of entry into the national program. It must be noted that, although most doctors are paid on a fee-for-service basis, alternative or additional arrangements include salary, sessional payments, contract service, capitation, and incentive pay.

Saskatchewan

This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory and amount to $24 a year for a family, or $12 a year for a single person. These premiums cover only a small portion of the costs of the program. Welfare recipients are automatically covered, and no premium payment is required for them.

The Medical Care Insurance Commission, which is the principal administering agency, makes payments to doctors for the bulk of the services provided under the Plan. About 5 percent of the population obtains its insured services under terms and conditions identical to those by the Commission, by way of the separate administering agency known as the Swift Current Health Region. Also, the provincial authority arranges for payment for physicians' services in mental and tuberculosis institutions and for cancer control.

Medical benefits include home, office, and hospital visits, surgery, obstetrics, psychiatric care outside mental hospitals, anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions. Refractions by optometrists are also an insured benefit.

The Medical Care Insurance Commission pays for approved services on the basis of 85 percent of the fees listed in the physicians' fee schedule*, apart from certain classes of service where a utilization charge applies. These utilization charges are $1.50 for each office visit and $2.00 for each home and out-patient call and are payable by the patient to the attending physician. In such instances, the financial responsibility of the public authority is reduced by the amount of the applicable fee. To avoid financial hardship to patients in exceptional cases there is provision for a family maximum on the total amount of such fees that must be paid. Welfare recipients are not required to pay utilization fees.

Physicians may choose to receive payment in three ways. First, the physician may receive directly from the public authority payment of the agreed-on percentage of the tariff in the current fee-schedule of the medical association, less the utilization fee, and accept this payment, along with the utilization fee payable by the patient, as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also the physician receives the agreed-on percentage of the tariff, less the utilization fee. Thirdly, a physician may choose to submit his bill directly to the patient, who pays him either before or after seeking reimbursement from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. No physician is compelled to confine himself to one or the other of these modes of payment.

British Columbia

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

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* Except that the basis of payment is 100 per cent of the fee-schedule for most visits.

Participation in the program is voluntary. Premiums are $5.00 a month for single persons, $10.00 a month for 2-person families, and $12.50 a month for families of three or more. For eligible residents, the government offers subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. Welfare recipients are automatically covered without payment of premium.

Payment to physicians is made at 90 per cent of the current fee-schedule. Physicians either bill patients for services rendered, or accept payment directly from a licensed carrier. In the former case, the physician has to notify the patient in writing, before rendering a service, that he is a non-participating physician, and the patient has to agree in writing that he is prepared to pay more than the amount of reimbursement that he may receive from the public authority. In the latter case, the physician may also charge a fee in excess of the tariff, provided the patient has been duly notified, he agrees in writing to the extra charge, and the amount of the extra charge is made known to the Commission.

Newfoundland

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

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

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

Early in 1971, the medical profession and the provincial government reached agreement on a formula that reduces the percentage payment on the fee-schedule beyond a monthly maximum limit on aggregate payments.

Customarily, large numbers of doctors in Newfoundland have contracted with the provincial government and with certain voluntary agencies to receive salaries for service in outlying areas. These arrangements were continued after April 1, 1969.

Nova Scotia

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

The insured services include all medically necessary procedures by practitioners, plus a limited range of oral surgery procedures in hospitals. Refractions by optometrists are not a benefit.

Benefit payments by the Plan are made at 85 per cent of the current fee-schedule. Physicians must choose either to participate, that is accept all payments directly from the plan, or not to participate. In either case, physicians may "extra-bill", but they must obtain written consent from the patient before rendering the service, and the amount of the extra charge has to be made known to the Commission.

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

Manitoba

Manitoba began participating under the federal Medical Care Act on April 1, 1969. Enrolment is compulsory for all eligible residents but failure to pay the required premiums is not a barrier to receipt of insured services. Premium levies are 55 cents a month for single persons and $1.10 a month for families. Coverage of welfare recipients is automatic without premium payment. There are no premium subsidies because the premiums themselves are nominal.

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

Physicians may choose to participate in the Plan, and to accept all payments from the public authority, or they may elect to receive payments direct from all their patients. In the former case, the amount received (85 per cent of the fee-schedule) must be accepted as payment in full. A non-participating physician must give a patient "reasonable notice" if he intends to "extra-bill".

Alberta

Alberta became a participating province under the federal Medical Care Act on July 1, 1969, with administration by a Health Care Insurance Commission. A combined annual premium of $69 for single persons and $138 for families covers both medical and hospital insurance. Subsidies reduce the premiums to $24 for single persons and to $48 for families with no taxable

income in the previous year; to $36 for single persons whose taxable income does not exceed $500; and to $72 for families whose combined taxable income does not exceed $1,000.

Registration and payment of applicable premiums are compulsory. Failure to comply makes householders liable, at time of seeking services, for payments of back premium levies, plus a penalty of 10 per cent of the unpaid premium, in order to ensure payment of the doctor's claim.

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

Residents objecting in principle to claiming benefits under the new combined hospital and medical program can choose to remain outside the program (i.e., to "opt out") and not to be liable for premium payment. For hospital and related care, they are at liberty to obtain private insurance coverage but application of the federal Medical Care Act prevents private carriers from offering insurance for physicians' services.

The plan also offers subscribers the option of purchasing insurance for additional health services (again, with subsidy provisions) from the voluntary Alberta Blue Cross agency. The optional membership offers coverage for hospital differential charges for semi-private and private ward care, ambulance services, drugs, appliances, home-nursing care, naturopathic services, clinical psychological services, and dental care needed because of accidental injury. Since July 1, 1970, payments to physicians have been made at 100 per cent of the 1969 fee-schedule.

Doctors may elect to bill patients for fees beyond those paid by the plan, provided that the patient is notified before service is rendered and providing that the plan is notified of the total amount.

Ontario

Ontario began participating on October 1, 1969. Enrolment is compulsory for persons in specified employed groups and voluntary for others. The insured benefits currently cover all medically-required services of medical practitioners and of oral surgeons in specified hospital settings, and refractions by optometrists. Provision was made after July 1, 1970, for coverage, with limitations, of certain paramedical services offered by chiropractors, osteopaths, and podiatrists.

Payments are made at 90 per cent of the current fee-schedule. Physicians may choose various modes of payments, but they are not required to enter into a formal commitment to confine themselves to any given mode. Regardless of the mode of payment selected, a physician is required to advise the patient of any intention to charge more than is provided under the Plan.

Premiums are $5.90 a month for single persons, $11.80 a month for two-person families, and $14.75 a month for families of three or more. Coverage is automatic for welfare recipients and no premium payment is required for them. Subsidies for low-income families modify premiums as follows:

a) No taxable income in the previous year -- full premium assistance (i.e., 100 percent subsidy);

b) Some taxable income -

$2.95 a month (i.e., 50 percent subsidy) for single persons if taxable income in previous year was $500 or less;

$5.90 a month (i.e., 50 percent subsidy) for two-person families if combined taxable income in previous year was $1,000 or less;

$5.90 a month (i.e., 60 percent subsidy) for families of three persons or more if combined taxable income in previous year was $1,300 or less.

There are two additional provisions relating to financial aid. Three months' coverage is paid for families qualifying for temporary assistance, and recipients of Old Age Security pensions are entitled to full subsidy of premiums at permissible income levels higher than the ceilings set under the general subsidy program.

As in British Columbia, the public authority in Ontario makes use of administering agencies. In Ontario these agencies can be non-profit agencies or commercial insurance companies handling this component of their activities on a non-profit basis. Agencies can be "designated" or "participating", depending on the degree of their involvement in enrolment and claims-processing functions. Most of their enrolment is of employee and other groups. In addition, the Ontario Health Services Insurance Plan itself enrols members and processes claims and covers the majority of non-group and subsidized beneficiaries.

By early 1971, the activities of many of the private carriers was being phased-out and their functions were being absorbed into the program of the public carrier.

Quebec

This province entered the national program on November 1, 1970. Registration of all eligible residents is compulsory and, as with other plans, the benefits include all medically-required physicians' services and also refractions by optometrists, and a limited range of dental services. The medical services are provided for the most part by doctors engaged in private fee practice, and they are paid for on the basis of claims submitted. Doctors

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

For financing of part of the provincial share of costs a tax on earnings is used. Each tax-payer whose net income in a year is $4,000 or more if married, or $2,000 or more if single, contributes 0.8 per cent of such income up to a maximum of $125 as regards employees who get at least three-quarters of their income from wages and salaries and up to $200 in other cases. Employers also contribute 0.8 per cent of their entire payroll.

Prince Edward Island

The province began participating on December 1, 1970. Benefits are comparable to those in other provinces. Registration is required but is not a condition of eligibility. All funds required to meet the provincial share of costs are obtained from general revenue sources. Doctors who decide to collect directly from patients can extra-bill but only up to the amount for the service as listed in the medical association fee-schedule, and only after they have told the patient their intention, obtained the patient's written consent, and notified the provincial agency of the amount. Doctors who elect, alternatively, to bill the provincial agency directly are paid by the agency 85 per cent of the fee-schedule amount. This they must accept as payment in full unless, again, they notify the patient of their intention to extra-bill for the additional 15 per cent, and obtain the patient's written consent.

New Brunswick

The province began participating on January 1, 1971. Registration is by family head and is required, although it is not an eligibility requirement. Doctors must indicate whether or not they intend to participate in the plan; if they so decide, they are obliged to accept 87 per cent of the current fee-schedule as payment in full (except for inclusive obstetrical services provided by a specialist, for which they can bill the patient an extra $43.50). Those doctors who elect to deal directly with particular patients as regards payment may "extra-bill" beyond amounts indicated at the 87 percent rate (the arrangement is similar to that in Saskatchewan), provided the patient is informed beforehand.

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

Northwest Territories

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

Because of isolated conditions in this far northern area, it is common, as in the outport areas of Newfoundland, for many doctors to work on a salary rather than a fee-for-service basis.

Health-Care Programs for Welfare Recipients

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

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

Physicians' Services

Following the implementation of public medical-care insurance plans in the provinces, as already described, provincial welfare recipients became automatically enrolled without premium payment. Under such programs for recipients of welfare, benefits and payment-rates to physicians are identical to those applicable to the general population. Co-charges and extra-billing are usually waived.

Hospital Care

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

Prescribed-Drug Benefits

In British Columbia, Alberta, Saskatchewan, New Brunswick, and Newfoundland virtually all provincial public-assistance recipients are enrolled

under schemes providing prescribed-drug benefits. In Manitoba a drug program covers persons designated as aged and infirm, recipients of mothers' allowances and their dependents, government wards, and indigent persons in unorganized territory. A variety of systems of drug benefit and non-benefit lists are employed and payment rates to pharmacies or dispensing physicians are negotiated by provincial governments. Under several schemes co-charges are levied on patients.

Drugs provided at local initiative in Ontario, Nova Scotia, and Quebec are sharable under provincial legislation, as well as under the Canada Assistance Plan.

Dental Care Benefits

Dental benefit plans are operated for selected recipients of welfare in the four Western provinces and in Ontario. 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 their children under the age of 18. All provincial public-assistance recipients qualify for dental benefits of schemes operated in Alberta and Saskatchewan.

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

All dental-care expenditures by municipalities in Ontario in respect to welfare recipients are shared by the province and through the Canada Assistance Plan.

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

Optical Care Benefits

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

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

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

Other Health-Care Benefits

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

Federal Programs

The Federal Government has customarily provided a range of health benefits to needy war veterans, Indians and Eskimos.

These groups are now covered under provincial or territorial public hospital and medical-insurance plans, the Federal Government paying premiums and utilization fees in most instances. The Federal Government continues to provide such extended health care as is necessary where it is not among benefits of provincial health-insurance programs.

Canada Assistance Plan

The cost of health-care services provided to welfare recipients is shared with the Federal Government under the Canada Assistance Plan on the same basis as financial aid and welfare services (*see section on Social Assistance*).

Rehabilitation Services

Public and voluntary agencies provide rehabilitation services to disabled and chronically-ill people in order to further their social and economic independence. Provincial health and welfare departments administer vocational rehabilitation programs for disabled adults. The Federal Government provides rehabilitation services for veterans and, in co-operation with the provinces, services to native Indians and Eskimos. Special programs exist for handicapped children, for the blind, the mentally defective, and for people suffering from tuberculosis, psychiatric disorders, arthritis, paraplegia and cystic fibrosis.

Medical rehabilitation is provided under the hospital and medical-care insurance in 29 special units of hospitals, five centres for hospital out-patients and 12 independent facilities. Workmen's compensation boards operate five rehabilitation centres for people who have been injured while at work. Two children's rehabilitation hospitals are privately financed. Moreover, the Department of National Health and Welfare administers 12 prosthetic service centres and gives special grants for the rehabilitation of crippled children as well as for training and research. Universities offer courses in physiotherapy, occupational therapy, audiology, speech therapy and prosthetics.

The Department of Manpower and Immigration shares with the provinces the costs of providing vocational rehabilitation services to disabled people.

The services include assessment, counselling, training and job-placement. Some local committees and voluntary agencies engage in finding jobs for the handicapped.

Provincial health departments in co-operation with community agencies provide rehabilitation services to former patients of psychiatric institutions, to people with tuberculosis and to other handicapped people.

Voluntary Health Agencies

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

Many are organized to serve people with specific afflictions -- for instance, blindness, cystic fibrosis, cerebral palsy, deafness, epilepsy, diabetes, mental disorders, haemophilia and paraplegia. Two of the largest, which care for crippled children and for disabled adults, are affiliated with the Canadian Rehabilitation Council.

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 gives courses in first aid to the injured, in home-nursing of the sick, and in child-care, and operates first-aid stations for mass gatherings. Voluntary agencies operate about 250 workshops for the disabled, which provide vocational rehabilitation and paid employment.

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

PART II -- INCOME MAINTENANCE

Family Allowances

Every child under 16 years of age who was born in Canada or who has resided here for at least one year, or whose father or mother was domiciled in Canada for three years immediately before his birth, is eligible for family allowances. The allowances, which were established in 1945, are paid from general revenue by the Department of National Health and Welfare. They are not considered income for income-tax purposes. However, the income-tax exemption allowed for dependent children under 16 is less than that for older dependents. Allowances are $6 a month for children under ten years of age and then $8 a month up to the age of 16. The Department pays family assistance at the same rates for each child under 16 supported by an immigrant who has landed for permanent residence in Canada or by a Canadian returning to Canada to reside permanently. This assistance is paid until the child is eligible for family allowances.

The Province of Quebec introduced a supplementary family-allowances program for dependent children under the age of 16. These allowances are based on family size and the ages of the children and are paid twice yearly. Newfoundland also pays supplementary schooling allowances with twice-yearly payments to school children.

Youth Allowances

This program, which is administered by the Department of National Health and Welfare, became effective in September 1964. It provides monthly allowances of $10 in respect of all dependent youths aged 16 and 17 receiving full-time educational training or precluded from doing so by reason of physical or mental infirmity. Youth allowances are paid from general revenue and are not considered income for income-tax purposes. A higher income-tax exemption is allowed for dependents 16 years old and over than for those under 16. Eligibility is determined by the residence of a child's parents. A child may be temporarily absent from the country, at school, or absent and receiving care if disabled, and still be considered eligible. Quebec has its own system of youth allowances under special financial arrangements with the Federal Government.

Canada Pension Plan

The Canada Pension Plan is a contributory social-insurance program for members of the Canadian labour force. It was enacted in 1965 and the first contributions were collected in January 1966. Each contributor builds up a right to a retirement pension, the amount of which is related to his previous earnings patterns. Benefits are also provided thereunder to a disabled contributor and his dependent children. At the contributor's death, his widow and children receive a lump-sum death benefit, as well as monthly benefits. Quebec operates its own plan, the Quebec Pension Plan, which is closely co-ordinated with the Canada Pension Plan, so that both operate as one. Together they cover about 92 per cent of the labour force in Canada. There are certain minor exemptions from coverage. The largest of the exempted groups are employees who earn $600 or less a year and self-employed persons who earn less than $800 a year.

The Plan is financed by contributions from employees, employers and self-employed persons, and by interest earned by the fund. The Plan provides a pension index and an earnings index, which are used to make adjustments thereto for changing economic conditions. The pension index reflects upward changes in the consumer price index from 1 per cent up to a limit of 2 per cent and is principally used to adjust benefits in pay. The earnings index, on the other hand, is based on a long-term moving average of national wages and salaries and will be used from 1976 on to adjust the contributory limits under the Plan. Retirement pensions were first payable in January 1967 to retired contributors 68 years of age and over. Each year thereafter, the retirement age has been reduced by one year, so that from 1970 on any contributor aged 65 or over who has retired is able to claim his retirement pension.

The Plan has a ten-year transitional period during which partial retirement pensions are payable and during which the retirement pension will be payable at its full rate. Payment of a retirement pension to contributors from 65 to 70 years of age is subject to a retirement test and applies to those taking up new employment after starting to draw a retirement pension. At 70 the retirement test no longer applies. Survivors' benefits, including pensions for widows, disabled widowers, orphans' benefits, and the death benefit, became payable in 1968. Pensions for disabled contributors and their dependent children became payable in the spring of 1970.

Everyone covered by the Plan must obtain a social insurance number to identify and maintain his individual record of earnings. Provision is made under the Plan for appeals with respect to coverage, contributions and benefits. The Department of National Health and Welfare administers the payments of benefits; the Department of National Revenue is responsible for coverage and contributions.

Old-Age Security

A pension of $80 a month is payable by the Federal Government to all persons who meet the age requirements and have been resident in Canada for at least ten years immediately preceding application for the pension. Any gaps in the ten-year period may be offset if the applicant, after the age of 18, had resided in Canada in earlier years for periods equal in total to three times the length of the gaps; but in this case the applicant must have resided in Canada for one year immediately before application. Persons who have had 40 years of residence in Canada since 18 years of age, and who left Canada before reaching the qualifying age, are eligible for the old-age pension. The qualifying age is 65 years or over. A pensioner who resides outside Canada permanently but has 25 years of residence in Canada since attaining the age of 21 may continue to receive his pension indefinitely. Otherwise, payment of the pension to pensioners absent from Canada is continued for six months in addition to the month of departure. It is then suspended until the pensioner returns to Canada. The program is financed through a 3-percent sales tax, a 3-percent tax on corporation income and, subject to a maximum of $240 a year, a 4-percent tax on taxable personal income. The Department of National Health and Welfare administers the program.

Guaranteed Income Supplement

This program, which started in January 1967, is designed to provide a guaranteed minimum income to old-age security pensioners. Beginning in April 1971, the new maximum for the combined pension and supplement will be $135 a month, made up of the pension of $80 and a supplement of $55, for a single person or a married person whose husband or wife is not a pensioner, and $255 a month altogether, made up of the pension of $80 and supplement of $47.50 for each member, for a married couple where both are pensioners. The benefit payment is subject to an income test. The benefit depends on the amount of income an applicant has in addition to his old-age security pension. For purposes of the program, income is determined in the same way as under

the Canada Income Tax Act. Pensioners with only the old-age security pension receive a guaranteed annual income of $1,620 for single persons, and of $3,060 for a married couple both of whom are pensioners. Pensioners with income in addition to their old-age pension receive partial benefits. The rule used to determine the amount of the partial benefit is that the maximum monthly supplement is reduced by $1 for every full $2 of monthly income a pensioner has in addition to his old-age security pension and any supplement he may have received. Payments will be made outside Canada in the same way as under the old-age security program, but cover only temporary absence from the country. The program is administered by the Department of National Health and Welfare. The Department of National Revenue checks income information received on returns made under this program against information received under the Income Tax Act.

Unemployment Insurance

The Unemployment Insurance Act provides for a program of unemployment insurance administered by the Unemployment Insurance Commission through its head office, five regional offices, and local offices across the country. Unemployment insurance is compulsory for all employees, irrespective of length of residence, except salaried personnel earning more than $7,800 a year, people working in certain occupations, such as teaching and domestic service, and those employed in charitable institutions and non-profit hospitals. Employment in agriculture and horticulture became insurable April 1, 1967.

Insured workers and employers each make contributions according to wages, ranging from 20 cents to $1.40 a week, and the Federal Government contributes a fifth of the combined employer and employee contributions. Rates of benefit are related to contributions and range from $14 to $46 a week for a person without dependents, and from $19 to $58 a week for a person with one or more dependents.

To qualify for regular benefit, a person must have at least 30 contribution weeks in insurable employment during the 104 weeks immediately preceding his claim, eight of which must fall in the immediately-preceding 52 weeks or since his last benefit period began, whichever is the shorter period. The period of regular benefit payments varies from 12 to 52 weeks. Claimants must be unemployed, and capable of and available for work.

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

Workmen's Compensation

In each province a workmen's compensation act protects workers who are affected by work-connected disabilities or diseases. While there is some

variation by province, the legislation applies to most industries and occupations. Major groups of workers not covered are farm-workers (except in Ontario), domestic servants, casual workers, employees of most financial, insurance and professional undertakings, and employees of certain service industries in some provinces. Compensation benefits include cash awards, all necessary medical aid, hospital care, physical restoration services, and vocational services, to re-establish the injured worker in gainful employment. Cash is paid for loss of wages during temporary disability, disability pensions for permanent disability, and survivors' benefits to widows or dependents in case of fatal accidents or disease. Benefits are 75 per cent of the worker's earnings subject to conditions of maximum annual earnings of from $6,000 to $7,600, as stipulated in the individual acts. Costs are met from employers' contributions to accident funds at rates that are established by the workmen's compensation board according to the hazards in each class of industry.

Social Assistance

Financial aid is provided through provincial or municipal departments of welfare to persons in need, including needy mothers with dependent children, disabled persons, elderly persons, widows, unemployed persons and persons whose benefits from other sources are not adequate to meet their needs. Aid is also provided through institutional care for the elderly or infirm who do not require hospital care but who are unable to care for themselves; these are operated under provincial, municipal or voluntary auspices. Counselling, homemaker and other services are provided as necessary.

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

The provinces also administer the federal-provincial blind persons' allowances and disabled persons' allowances. The federal contribution may not exceed 50 per cent of $75 a month or of the allowance paid, whichever is less, for disabled persons' allowances, or 75 per cent of $75 a month or of the allowance paid, whichever is less, for blind persons' allowances. To be eligible for an allowance under either of these programs, an applicant must meet the ten-years' residence requirement and the income requirements. Under the Disabled Persons Act, the total income, including the allowance, may not exceed $1,260 a year for an unmarried person, $2,220 a year for a married couple or $2,580 a year for a married couple when the spouse is blind within the meaning of the Blind Persons Act. Under the latter Act, the total income, including the allowance, may not exceed $1,500 a year for an unmarried person, $1,980 a year for a person with no spouse but with one dependent child or more, $2,580 for a married couple and $2,700 a year for a married couple when both are blind. Six provinces have now merged disabled-persons' allowances with their general social

assistance programs; three of these provinces have similarly merged blind persons' allowances. In these provinces, allowances to the needy blind or disabled are determined, as for other social assistance recipients, on the basis of need.

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

PART III -- WELFARE SERVICES

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 being made under the Canada Assistance Plan. Provincial administration of welfare is carried out through the department of public welfare or social development in each province. In some provinces municipalities administer assistance to persons with short-term need.

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

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

Child-welfare services, including protection, foster care and adoption services, are provided by 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. Day nurseries for the children of working mothers are established only in the larger centres, where they are chiefly under voluntary auspices, except in Ontario, where there are also municipally-sponsored day nurseries which receive provincial grants.

A number of voluntary agencies also contribute to community welfare, including the welfare of families and children and of groups with special needs, such as the aged, recent immigrants, youth groups and released prisoners. Family welfare agencies or combined family-and-child-welfare agencies in urban centres, for example, offer case-work services to families in need of

counselling on such problems as marital relations, parent-child relations and family budgeting. Counselling and recreational services for older or retired people are being developed by many agencies, and child and youth organizations with recreational and character-building programs offer group participation in physical education, camping, the development of special skills, and other opportunities for healthful activity. Welfare councils and community planning councils contribute to the planning and co-ordinating of local welfare services.

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

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