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## HEALTH AND WELFARE IN CANADA

(Prepared in the Department of National Health and Welfare)

### PART I -- HEALTH SERVICES

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

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



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

(2) The Branch pays health-insurance premiums on behalf of those native peoples for whom the Federal Government accepts responsibility.

Under the Medical Care Act, the Federal Government contributes, nationally, 50 per cent of the average costs for each person of provincial medical-insurance plans meeting specified conditions. The Hospital Insurance and Diagnostic Services Act provides for federal cost-sharing 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 and 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.

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

The Federal Government discharges its responsibilities in environmental health through the Environmental Health Directorate of the Department of National Health and Welfare by providing regulatory authorities with the most authoritative assessments of the effect of environmental factors on human health and carrying out its statutory activities in the related fields of radiation protection and occupational hygiene.

Seven of the ten provinces have agencies in their health departments to deal with occupational and environmental health problems. As with the Federal Government, there is a close liaison between the health officials and officials responsible for assessment and control of the environment. Co-ordination of the many activities within provinces and between the provinces and the Federal Government is usually provided by advisory boards and committees.

Health research is conducted or supported by a number of federal agencies: the Medical Research Council, the Defence Research Board, and the Departments of National Health and Welfare and 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 Directorate of the Department of National Health and Welfare, and, as a by-product of program activities, certain other units in the Department.

## Public Health

Public Health comprises those institutions, services and activities that are concerned with the health of the community as a whole, rather than health care for individuals. It includes environmental sanitation, 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; the safety of drugs; 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. Health indicators include not only vital statistics and statistics on contagious diseases but indices of hospital morbidity and utilization of medical services and drugs.

*Tuberculosis*

Since 1956, the incidence of new active cases of tuberculosis decreased from 49 in 100,000 to 18.3 in 100,000 of the population in 1971, while the death-rate fell from 7.8 to 2.5 in 100,000 of the population.

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

*Cancer*

The standardized cancer death-rate has been rising steadily for many years, to 137.5 in 1970. Public and voluntary agencies engage in detection, treatment, public education and research. Free diagnostic and treatment services are now available in all provinces, supported by hospital and medical-care insurance. The larger general hospitals operate special cancer clinics.

*Mental disorders*

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

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

## 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 ordinarily 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 on 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 provinces are defined as persons legally entitled to remain in Canada who make their homes, and are ordinarily present, in the provinces; tourists, transients or visitors to the province are specifically excluded. Members of the Armed Forces, the Royal Canadian Mounted Police, and inmates of penitentiaries are not covered, 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 immigrating from outside Canada may qualify for immediate coverage in Alberta, Saskatchewan, Newfoundland, Manitoba, the Northwest Territories and, under specified circumstances, Ontario and British Columbia.

*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 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 a part of its cost by a premium combined with medical insurance of $132 for single persons and $264 for couples and families. Manitoba finances part of its cost from combined hospital-medical annual premiums of $49.80 for single persons and $99.60 for families. Saskatchewan levies annual premiums or taxes of $24 for single persons and $48 for families. Alberta levies an annual premium of $69 for single persons and $138 for families under the Health Insurance Premiums Act, which includes both hospital and medical insurance. The trend in all premium provinces has been to combine hospital and medical insurance levies in the interests of administrative simplicity.

In Alberta, British Columbia and the Northwest Territories, part of the financing is derived from utilization or admission fees. These fees, designated in the regulations as "authorized charges", are payable by the patient at the time of service and are deductible from provincial payments to hospitals. Alberta charges $5 for the first day only of adult or child in-patient care in general hospitals; in auxiliary hospitals $2 is charged

for each day of care up to 120 days and $3 a day subsequently. British Columbia charges $1 a day for in-patient care (except for newborn infants) and $1 or $2 for out-patient services, as previously mentioned. The Northwest Territories charges $1.50 a day for in-patient care.

## Medical-Care Insurance

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

*Federal medicare legislation*

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

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

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

c) The plan must cover not fewer than 95 per cent of the total number of insurable residents of the province.

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

The Medical Care Act, 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; thus far, only dental surgery in a hospital is a benefit.

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

Provinces can finance services in any manner they wish, but the Act contains a proviso 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. The significance of this requirement is that extra charges, if imposed, must be not more than nominal. A province may adopt any method it wishes of paying the providers of services, subject only to the proviso that the 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 are assisted by something more than half their provincial costs. In general terms, the federal contribution to a participating province is an amount equal to (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 makes 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 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.

By early 1972, with public medical-care programs implemented in all ten provinces and the two sparsely-settled northern territories, insurance for physicians' services covered virtually the entire eligible population, or slightly over 21.7 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 is financed -- e.g., through premiums, sales tax, other provincial revenues or by a combination of methods.

In addition to the comprehensive physicians' services that must be provided as insured benefits by participating provinces, most plans also make provision for other health-care benefits that are part of the basic contract but 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 12 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. Six 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 12 plans in operation is described briefly in the paragraphs that follow, in chronological order of entry into the national program. The Saskatchewan plan is described in somewhat greater detail, since it has served as a prototype for most of the other plans. 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 and $12 a year for a single person. These premiums cover only a small part of the costs of the program. Welfare recipients are automatically covered, and no premium payment is required of them, or of any family head 65 years of age or over.

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

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 per cent of most non-visit fees listed in the physicians' fee schedule. The basis of payment for most office and home fees is also 85 per cent. Utilization charges, initially imposed in 1968, were abolished August 1, 1971.

Physicians may choose to receive payment in three ways. First, the physician may receive directly from the public authority payment of 85 per cent of the tariff in the current fee-schedule of the medical association, and accept this payment as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also, the physician receives the agreed percentage of the tariff. Thirdly, a physician may choose to submit his bill directly to the patient, who pays him either before or after seeking reimbursement from the public authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. No physician is compelled to confine himself to one or the other of these modes of payment. Physicians may also be paid through clinics which are financed by *per capita* contributions from the provincial authority.

British Columbia

This province became a participant under the federal Medical Care Act on July 1, 1968. The plan is governed by a public commission 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.

Participation in the program is voluntary. Premiums are $5 a month for single persons, $10 a month for 2-person families and $12.50 a month for families of three or more. For eligible residents (they must have resided in the province the preceding 12 consecutive months), the government offers subsidies totalling 90 per cent of the premium for persons with no taxable income and 50 per cent of the premium for persons with taxable income from $1 to $1,000. There are no special waivers as in Alberta, Saskatchewan and Ontario for persons 65 years and over.

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, 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.

The reduction formula applies whenever monthly payments exceed $6,000 for surgical specialists, $5,500 for medical specialists, and $4,500 for doctors who are not specialists. Excess payments are reduced to (a) 75 per cent of all sums up to and including $1,000 above the basic amount and (b) 50 per cent of all sums in excess of $1,000 above the basic amount. There is provision for averaging relatively low-income and high-income months if the doctor so wishes.

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, accepting 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 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. The combined hospital-medical premium is $49.80 a year for single persons and $99.60 a year for couples and families. Coverage of welfare recipients is automatic without premium payment. There are no premium subsidies because the premiums themselves are considered to be low. Persons and families eligible to receive the maximum guaranteed-income supplement allowance are not required to pay the premium. Those marginally below this maximum would be eligible for premium waiver if they were receiving assistance under social-allowance legislation.

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

Physicians may choose to participate in the plan, and to accept all payments from public authority, or they may elect to receive payments direct from all their patients. In the former case, the amount received (85 per cent of the 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. Premium payments are waived for household heads 65 years of age or over. The levy is also waived if it is the spouse only who is 65 years or over.

Registration and payment of applicable premiums are compulsory. Failure to comply makes residents liable to a waiting period of three months following registration before becoming eligible for insured services.

In addition to the benefits of physicians' services and a limited range of oral surgery, 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.

Payments to physicians are made at 100 per cent of the 1972 fee-schedule. Doctors may elect to bill patients for fees beyond those paid by the plan. In such cases, doctors are required to notify patients beforehand, and must indicate to patients the total amount and also the amount that will be paid by the plan.

Ontario

Ontario began participating on October 1, 1969. Enrolment is compulsory for employee groups of 15 or more persons and provision is made for the voluntary creation of a mandatory group in the case of five to 14 employees. An organization of five or more persons may apply to become a collectors' group. The insured benefits cover all medically-required services of medical practitioners and of oral surgeons in specified hospital settings, refractions by optometrists and, with limitations, certain paramedical services offered by chiropractors, osteopaths and podiatrists.

Doctors are confined to two modes of receiving payment for insured services. Those billing directly to the medical plan are paid directly by the plan at a rate of 90 per cent of the approved fee for the service rendered, and cannot bill the patient for the balance. Doctors electing alternatively to bill patients directly cannot be paid by the plan. Patients must pay the doctor for his billed amount and can recover from the plan 90 per cent of the approved fee for the service rendered.

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

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

Quebec

This province entered the national program on November 1, 1970. Registration of all eligible residents is compulsory and, as with other plans,

the benefits include all medically-required physicians' services and also refractions by optometrists, and a limited range of dental services. The medical services are provided for the most part by doctors engaged in private fee practice and 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. Welfare recipients, and others who happen to have earnings below the income thresholds, are covered without payment of the tax on earnings.

Prince Edward Island

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 the family head and is required, although it is not an eligibility requirement. Doctors must indicate whether or not they intend to participate in the plan; if they so decide, they are obliged to accept 87 per cent of the current fee-schedule as payment in full (except for inclusive obstetrical services provided by a specialist, for which the doctor can bill the patient a specified extra amount).(3) Those doctors who elect to deal directly with particular patients as regards payment may "extra-bill" beyond amounts indicated at the 87 percent rate.

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(3) The actual amount that may be extra-billed is specified in legislation in New Brunswick, but other provinces permit specialists to extra-bill for non-referred care if the specialist rate is higher than the rate the plan will pay for such service.

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

Northwest Territories

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

Because of isolated conditions in this far northern area, it is common, as in the outport areas of Newfoundland, for many doctors to work as salaried employees of third-party institutions and agencies, even though payments made by the insuring authority to these agencies, as to self-employed doctors, are on a fee-for-service basis.

Yukon Territory

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

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

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

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

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

## Health-Care Programs for Welfare Recipients

Provincial programs providing certain medical-care and other health-care benefits to recipients of welfare allowances were in operation in each province before the introduction of province-wide medical-care insurance. Organized provincial schemes providing stipulated health services were introduced in Ontario in 1942, Saskatchewan in 1945, Alberta in 1947, British Columbia in 1949, Nova Scotia in 1950, Manitoba in 1960, Quebec in 1966, Prince Edward Island in 1966, and New Brunswick in 1967. Newfoundland has for many years operated a plan that 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, payment-rates to physicians are identical to those applicable to the general population. Benefits may be a little broader and include such ordinarily non-insured items as travelling allowance and telephoned advice. 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 charges by them.

*Prescribed-drug benefits*

In British Columbia, Alberta, Saskatchewan, New Brunswick, Quebec 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 mother's 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 and Nova Scotia are sharable under provincial legislation, as well as under the Canada Assistance Plan.

In some provinces, certain non-prescription drugs such as antacids, dandruff shampoos and aspirin for treatment of arthritis are a benefit in varying degree. There is also a custom of supplying, through health department auspices, certain drugs of continuing treatment that are essential for life-saving or maintenance of minimum health.

*Dental-care benefits*

Dental benefit plans are operated for selected recipients of welfare in most provinces. In British Columbia, special means tests are applied to public-assistance recipients in order to qualify them for enrolment. A separate program is operated in that province for the children under 13 years of age of all welfare recipients. The Ontario program provides dental benefits to persons in receipt of mothers' allowances and dependent fathers' allowances. This includes parents and their children under the age of 18. Provincial assistance is also available for essential dental services for others at municipal discretion. All provincial public-assistance recipients qualify for dental benefits of schemes operated in Alberta, Saskatchewan, and selected categories in Manitoba. Quebec has introduced a program that emphasizes care among lower age categories.

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.

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 that will be paid for frames -- e.g., for cosmetic purposes.

*Other health-care benefits*

Other health benefits 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 usually provided a range of health benefits to needy war veterans, Indians and Eskimos.

These groups are now covered under provincial or territorial public hospital and medical-insurance plans, the Federal Government 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 entitled "Social assistance")*.

## Immigrants

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 the patients' home, in the doctor's office, or in hospital. The insured services include surgery and diagnostic tests. The normal waiting period for a new resident in a province is three months after establishing residence there. Some provinces, however, have arrangements for waiving this period. As an example, in Saskatchewan a landed immigrant may receive immediate coverage upon registration and payment of the premium.

Present practices of provincial hospital and medical-care plans vary, as regards waiting periods for landed immigrants of civilian status.

Generally, three categories of "immigrants" can be delineated. These are:

(1) Landed immigrants with clearly-established residence in a specific province;
(2) repatriated Canadians, returning Canadians, returning landed immigrants, and Canadian citizens establishing residence for the first time;
(3) non-Canadian spouses (of Canadian residents) assuming residence in a province for the first time.

The appended table on waiting periods is not exhaustive since many irregular types of situation can be envisaged that do not fit the indicated parameters. The listing is intended to reflect general usage.(4)

In all provincial and territorial plans there can be no exclusions or limitations of membership or of benefits for reason of age, economic status or previous medical condition. The basic insured benefit is hospital care and physicians' services but some plans also insure, sometimes as an added option, such benefits as the services of optometrists, druggists for prescribed medicaments, physiotherapists, podiatrists (chiropodists), chiropractors, osteopaths and naturopaths.

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

## Rehabilitation Services

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

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

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

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(4) See Appendix following Page 24.

## Voluntary Health Agencies

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

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

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

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

## PART II -- INCOME MAINTENANCE

*Family allowances*

Every child under 16 years of age who was born in Canada or who has resided there 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 dependants. 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.

In 1967, Quebec introduced a supplementary family allowances program for dependent children under the age of 16. The rates of allowance are based on family size and the ages of the children and are paid twice yearly.

*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 dependants 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, attending school outside Canada, or absent and receiving care if disabled, and still be considered eligible. Quebec has its own system equivalent to youth allowances, for which it is compensated under special financial arrangements with the Federal Government.

*Canada Pension Plan*

The Canada Pension Plan is a contributory social-insurance program for eligible 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 monthly benefits as well as a lump-sum death benefit. Quebec operates its own plan, the Quebec Pension Plan, which is closely co-ordinated with the Canada Pension Plan, so that both operate virtually as one. Together they cover most 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. A pension index and an earnings index are used to make adjustments to this Plan so as to keep benefits and contributory limits in line with 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 until retirement pension becomes payable at the full rate. Payment of a retirement pension to contributors from 65 to 70 years of age is subject to a retirement test and also 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.

To obtain coverage under the Plan, all eligible persons must obtain a social insurance number to identify and maintain their 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*

Under this program, the Federal Government pays a monthly pension to all eligible persons who are 65 years of age or older. In 1972, the pension payable is $82.88 a month. To be eligible, the claimant must have lived 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 lived 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 lived 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 65 are eligible for the old-age pension. A pensioner who leaves Canada for permanent residence abroad but has had 20 years of residence in Canada since attaining the age of 18 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 and is then suspended until the pensioner returns to Canada.

The 1972 pension was adjusted by the percentage increase in the consumer price index during the fiscal year 1971-72 over that for the fiscal year 1970-71. Beginning in 1973, the OAS pension will be adjusted on April 1 of each year to reflect the full rise in the cost of living during the previous calendar year.

The Department of National Health and Welfare administers the program through regional offices located in each provincial capital, to which application is made for the pension.

*Guaranteed income supplement*

This program, which started in January 1967, is designed to provide a guaranteed minimum income to old-age pensioners. Beginning January 1, 1972, the new maximum for the combined pension and supplement is $150 a month for a single person or a married person whose husband or wife is not a pensioner, made up of the old-age security pension of $82.88 and a supplement of $67.12, and $285 a month for a married couple where both are pensioners, made up of the pension of $82.88 and supplement of $59.62 for each spouse. The supplement is subject to an income test and 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. In

1972, pensioners with only the old-age security pension receive a guaranteed annual income of $1,800 for single persons, and of $3,420 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. Beginning in 1973, the GIS will be adjusted on April 1 of each year to reflect the full rise in the cost of living during the previous calendar year.

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, regional offices, and local offices across the country. Unemployment insurance is compulsory for all persons in the labour force who work under the direction and control of an employer. Self-employed fishermen are covered as an interim measure pending new legislation for that industry. Persons earning less than $30 a week or 20 times the provincial minimum wage, whichever is less, and all other self-employed workers are excluded from unemployment insurance.

Insured workers and employers each make contributions to the unemployment insurance fund. All workers pay a like contribution rate on their first $150 of weekly earnings in 1972 (the earnings ceiling escalates annually). The large employer pays between 100 per cent and 200 per cent of the insured person's contribution rate, depending on his three-year moving average layoff factor. Small employers, with insurable payrolls of less than $78,000 (in 1972), pay 140 per cent of the insured person's contribution rate. The Federal Government covers the extra cost of benefits when the unemployment rate rises above 4 per cent plus the cost for extension of benefit period to claimants with long periods of unemployment.

To qualify for unemployment benefit, a person must have at least eight weeks of labour-force attachment in the previous 52 weeks for minimum benefits and 20 or more weeks for full benefits (including sickness and maternity benefits). A person must be capable, willing and available for work, but unable to obtain suitable employment, or unable to work because of sickness or maternity, and registered.

Unemployment benefits amount to 66 2/3 per cent of previous weekly-insured earnings (maximum of $100 a week in 1972) and 75 per cent for low-income claimants with dependants, or claimants with dependants whose duration of unemployment is prolonged. Benefits are payable after a two-week waiting

period for up to 51 weeks; up to 15 weeks for sickness and maternity; and three weeks without the two-week waiting period for persons retiring from the labour force.

*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 widows or dependants in case of fatal accidents or disease. Benefits for disability are based on 75 per cent of average weekly earnings, subject to an annual ceiling. 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 income from other sources is 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 disabled persons' allowances and blind 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 a ten-years' residence requirement and the income requirements. Seven provinces have now merged disabled-persons' allowances with their general social-assistance programs; four 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.

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. Subsidized day-care services for the children of working mothers are operated under voluntary and public auspices. These services are established mainly in the larger centres but, with increased federal and provincial funds made available in 1972, it is expected that facilities will be enlarged and extended to areas now without such services.

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.

## APPENDIX

### Waiting Periods for Health Insurance Eligibility, by Province, Canada 1972

| Province | Category | Hospital Insurance | Medicare |
|---|---|---|---|
| Newfoundland | 1 | Nil | Nil |
| | 2 | Nil | Nil |
| | 3 | Nil | Nil |
| Prince Edward Island | 1 | Upon registration | Upon registration |
| | 2 | 3 months | 3 months |
| | 3 | 3 months | 3 months |
| Nova Scotia | 1 | 3 months | 3 months |
| | 2 | 3 months | 3 months |
| | 3 | 3 months | 3 months |
| New Brunswick | 1 | 3 months | 3 months |
| | 2 | 3 months | 3 months |
| | 3 | 3 months | 3 months |
| Quebec | 1 | 3 months | Nil |
| | 2 | 3 months | Nil |
| | 3 | 3 months | Nil |
| Ontario | 1 | 1st day of 3rd month after application | Immediate coverage upon application prior to normal waiting period expiring. |
| | 2 | 1st day of 3rd month after application | 1st of 3rd month after application |
| | 3 | 1st day of 3rd month after application | 1st of 3rd month after application |
| | (But 1st of 1st month if member of a group) | | |
| Manitoba | 1 | Nil | Nil |
| | 2 | Nil | Nil |
| | 3 | Nil | Nil |
| Saskatchewan | 1 | Immediate from date of premium payment if normal waiting period not yet expired | Same |
| | 2 | 3 months | 3 months |
| | 3 | 3 months | 3 months |
| Alberta | 1 | Nil | Nil |
| | 2 | Nil | Nil |
| | 3 | Nil | Nil |

| Province | Category | Hospital Insurance | Medicare |
|---|---|---|---|
| British Columbia | 1 | 3 months | 1st day of 2nd month following month in which application is accepted |
| | 2 | 3 months | Same as above |
| | 3 | 3 months | Same as above |
| | (But under certain circumstances immigrants may obtain immediate coverage upon arrival if application is made immediately to plan and if applicant is coming off similar coverage elsewhere.) | | |
| Yukon Territory | 1 | 3 months | Nil |
| | 2 | 3 months | Nil |
| | 3 | 3 months | Nil |
| Northwest Territories | 1 | Nil | Nil |
| | 2 | 3 months | Nil |
| | 3 | 3 months | Nil |



RP/A