MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE WITHIN THE FRAMEWORK OF SOCIAL SECURITY IN CANADA

Dr. J.E.F. HASTINGS

Professor of Public Health and Preventive Medicine and Professor of Medical Care, School of Hygiene, University of Toronto

Prepared for the International Labour Office

I.L.O.
Geneva
1968

This series of monographs, which was prepared in connection with a study of the organisation of medical care within the framework of social security, undertaken by the International Labour Office, with the assistance of external collaborators, covers the following countries:

Belgium	(Soc. Sec. 1968/D.5)
Canada	(Soc. Sec. 1968/D.8)
Ecuador	(Soc. Sec. 1968/D.6)
Federal Republic of Germany	(Soc. Sec. 1968/D.7)
India	(Soc. Sec. 1968/D.1)
Poland	(Soc. Sec. 1968/D.2)
Tunisia	(Soc. Sec. 1968/D.4)
United Kingdom	(Soc. Sec. 1968/D.3)

TABLE OF CONTENTS

PREFACE

Canada is a parliamentary democracy with a constitutional monarchy. It is a federal State with the dominion or federal Government located in Ottawa and with provincial governments in each of the ten provinces. There are also two territories in the north. Although largely federally administered, they are moving toward some degree of self-government. In the health field, as in many other areas of activity, there is a division of powers between the federal and provincial governments. The federal Government has direct responsibility for the health services for certain specified groups of people in Canada and otherwise for matters of a national or international character. As well, it provides extensive consultative, financial, laboratory, statistical, research and standard-setting services to the provinces. However, by a combination of legal interpretations of the British North America Act, Canada's constitution, and of gradual evolution, the major responsibility for direct health services for most of the population rests with the provinces. In turn, they may delegate certain of these responsibilities, such as public health, to some form of regional or local government. The essential participation of the health professions and related personnel and of voluntary health and social welfare agencies in the provision of health services in Canada should be emphasised also. More recently, various types of government and non-government prepayment and insurance organisations have come to play important roles in the financing of personal health care in particular. Finally, it should be noted that even within the government domain, a variety of agencies other than health departments are involved in various aspects of the health services field.

It is, therefore, not surprising to find that in a country, such as Canada, there are a considerable number of statutory and non-government schemes concerned with the provision of medical care and other personal health services. Nor is the distinction between the roles of government and of private agencies consistent one throughout the nation. Although there is an over-all general pattern of health services across the country, there is also much variety in detail, a reflection not only of constitutional factors but also of geography and of regional traditions and attitudes. Finally, the reader will note that the picture presented in the monograph is one of change, active change which has been occurring even as the writing has been done and much of which is not yet completed.

John E. F. Hastings
Toronto, Ontario, Canada
May, 1967

MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE UNDER SOCIAL SECURITY SCHEMES IN CANADA

A. Methods by which Members of the Population of Canada May Obtain Medical Care and Other Personal Health Services

1. Statutory Schemes

(1) Dominion Government Programmes

The Department of National Health and Welfare is the main federal agency in health matters. Other important public health and personal health care programmes are administered by the Department of Agriculture, Veterans Affairs and National Defence and by the Dominion Bureau of Statistics, the Medical Research Council and the Defence Research Board. Only programmes involving the provision of direct personal health services within a social security system of medical care, will be described in this monograph. Therefore, a wide variety of regulatory, statistical standard-setting, laboratory, consultative, advisory planning, research and public health functions of a national and international nature will not be discussed specifically. Personal health care programmes for the Indians and Eskimos, the armed forces, veterans, immigrants, the Royal Canadian Mounted Police, mariners and the federal Civil Service will also not be discussed in this monograph.

(2) Dominion-Provincial Programmes

(a) Hospital Insurance and Diagnostic Services

The Hospital Insurance and Diagnostic Services Programme now established in all provinces and territories covered 99.3 per cent. of the eligible population of Canada, as of 31 March 1966.[1] The Programme was introduced under the federal Hospital Insurance and Diagnostic Services Act of 1957, by which the dominion Government will share with the provinces the costs of providing specified hospital services to insured patients. The choice of methods of financing and administering the plan at the provincial level and the choice of the types of services offered beyond the basic services stipulated in the federal Act remains with the provinces. Federal legislation covers services in institutions approved to provide acute, chronic, and convalescent care, but excludes tuberculosis and mental hospitals[2], and institutions providing custodial care from the dominion-provincial cost sharing arrangement. Psychiatric and

---

[1] 98.7 per cent. of the entire Canadian population are covered. Those who are ineligible because of coverage under other government programmes include the armed forces, Royal Canadian Mounted Police, etc.

[2] For practical purposes free mental hospital and tuberculosis care have been provided by all provinces for a number of years.

tuberculosis units of general hospitals are, however, included within the cost sharing arrangements. Benefits must be universally available on uniform terms and conditions to all residents of a participating province, except for those already covered for hospitalisation under other federal or provincial programmes. There must be no limitation on the length of stay in hospital except that determined by medical need. Reciprocal arrangements among the provinces have been made to cover people hospitalised outside their home province and for those changing their residence to another province. Provision has also been made for out-of-country care in an emergency.

All participating provinces must agree to provide specified in-patient services listed in the dominion Act. Out-patients' care, although authorised for assistance under the federal legislation, is not mandatory upon provincial plans.[1]

The provinces use different methods for administering and financing their plans and in establishing eligibility for benefits. In some the hospital insurance programme is administered by the provincial department of health, whereas in others it is by a separate hospital services commission. Money raised through general revenues, provincial sales tax, and personal premiums is used separately and in combination for financing the provincial share of costs in different provinces. In the provinces where no premium is used residence in the province is the determining factor for eligibility for benefits, whereas in provinces with a premium system, eligibility for benefits is dependent upon payment of the premium as well as fulfilment of any residence requirements. Coverage is universal in provinces where no premium is levied and is either automatic or compulsory in all provinces except Ontario where participation in the insurance programme is voluntary for certain groups of people. However, even in Ontario the number of eligible people who are not covered is considerably less than 2 per cent. Under the cost-sharing formula in the Hospital Insurance and Diagnostic Services Act, the dominion Government pays each province 25 per cent. of the per capita cost of in-patient services in Canada as a whole plus 25 per cent. of the per capita cost of in-patient services in the particular province, multiplied by the average for the year of the number of insured persons in the province. On a national basis the federal contribution therefore amounts to approximately 50 per cent. of the shareable costs. However, for individual provinces the formula means that the proportion of shareable costs met by the federal Government will vary, with a higher proportion being met for provinces with low cost programmes than provinces with high cost programmes.

The cost of out-patient services provided under specific agreements between a province and the federal Government are also shared. The federal contribution amounts to the same proportion of the cost for these services in a province as is the federal contribution for in-patient service in the province.

---

[1] See pages 16 and 20.

Since 1 January 1965, payments are no longer being made by the dominion Government to the province of Quebec under the programme, but financial arrangements have been transferred to a system of tax abatement for that province. In all other cases sharing agreements are in effect.

(b) Medical Care Insurance

Under the federal Medical Care Act of 1966, the dominion Government has authorisation to make contributions toward the cost of insured medical care services incurred by provinces for provi cially operated medical care insurance programmes which meet four criteria established by the federal legislation. The provincial plans must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province, which must be subject in respect of the accounts and financial transactions to provincial audit. Secondly, insured services must be available upon uniform terms and conditions to all eligible residents[1] of the province. Payments of money in regard to the cost of insured services must be on a basis that gives reasonable compensation for these services as provided by medical practitioners and that does not impede in any way reasonable access to insured services. Thirdly, the initial number of insured residents of a province covered must not be less than 50 per cent. of the total number of eligible residents in the province and, after the third year of the programme, not less than 95 per cent. Fourthly, the plan must not impose any minimum period of residence or any waiting period in excess of three months before people who are residents are eligible for services. Furthermore, arrangements must be made to ensure coverage of people temporarily absent from the province and for those who cease to be insured under a particular provincial programme by having become residents of another participating province. Thus, services must be fully transferrable. Finally, any health services of a kind prescribed by the Minister of National Health and Welfare to be required health services rendered by a person lawfully entitled to give such services may be specified by the Governor-in-Council as additional health care services under the Act if the law of a province also specifies them. By decision of the federal Government the Act is to be implemented not later than 1 July 1968.

(c) Canada Assistance Plan

The Canada Assistance Plan Act of 1966, was passed as a comprehensive public assistance measure to complement the provisions of the Canada Pension Plan Act of 1966. The Plan provides a single administrative framework for federal sharing with the provinces in the costs of public assistance and welfare services, including for the first time, medical care services, for those covered. It is designed to replace four existing programmes of unemployment assistance, old-age assistance, blind persons' allowances and disabled persons' allowances. However, a province will have the option of continuing to administer these categorical programmes separately. Also a province may contract out of this shared programme as in the case of the four separate programmes and resolve a tax abatement as an equalisation payment instead.

---

[1] Those covered under other government programmes, such as the armed forces, etc., are excluded.

The Plan authorises the federal Government to enter into an agreement with any province to share 50 per cent. of the cost of assistance to persons in need. A 'needs' test is to be used which takes into account a person's budgetary requirements as well as his income and resources.

Excluded from the provisions of the Act are services included under the Hospital Insurance and Diagnostic Services Programme. When the provisions of the Medical Care Act come into effect in each province then sharing by the federal Government under the Canada Assistance Plan for the cost of physicians' services and any benefits later included under the Medical Care Act will terminate, since all residents will be included under the provincial universal medical care plans for these benefits. Payments are being made following agreement with the provinces retroactive to 1 April 1966.

(d) Other Joint Programmes

The Emergency Health Services Division assists provincial and local governments to organise a national and other health services in time of disaster.

As part of the disabled persons allowances programme, physicians who are federal appointees serve, together with provincial appointees, on the medical review boards that determine disability. Under the federal-provincial vocational rehabilitation programme, administered by the Department of Manpower, that makes available a wide range of medical and restorative services to disabled persons with a vocational potential, the Department is involved with the treatment aspects in co-operation with the provinces.

Finally, the disability provisions of the Canada Pension Plan will come into effect for disabled contributors in 1971. Besides the cash disability benefit, the Plan will pay the costs of any approved medical and rehabilitation services that will improve working capacity; the benefits of the Canada Pension Plan are administered by the Department of National Health and Welfare.

(3) Provincial Government Programmes

Local health services are included under this heading since a province may delegate responsibility for services to regional and local government bodies.

(a) Public Health

Major responsibility for public health services rests with the provinces. The details of personal preventive services provided under public health auspices vary from province to province but basic programmes are similar, covering maternal and child health, school health, health education, dental health, mental health, nutrition, accident prevention, and more recently chronic disease control, ageing, family planning, and the general co-ordination of official and voluntary services in the community.

(b) Public Medical Care Programmes

Provincial medical care insurance schemes[1] in Saskatchewan, Alberta, British Columbia, Ontario, and Newfoundland and Labrador show considerable differences in the extent of coverage and of benefits provided. Legislation is currently before the Legislature of the province of Manitoba and serious consideration is being given to programmes in most other provinces, some of which have established special commissions or committees to study the situation.

(i) Newfoundland Cottage Hospital Medical Care Plan

The Cottage Hospital Medical Care Plan, established in 1934 in Newfoundland and Labrador, provides pre-paid coverage for medical and surgical care in 18 medical care districts in the outport areas of the province, covering just over 40 per cent. of the population. Similar medical care plans operated by the International Grenfell Association, the Notre Dame Bay Memorial Hospital Association and M.J. Boylen Hospital, but receiving provincial subsidisation, cover another 10 per cent. of the provincial population. Services are provided by salaried physicians who also serve as medical health officers for their areas. All physicians are either based in cottage hospitals or in district medical practices within cottage hospital districts.

(ii) Newfoundland Children's Health Service

Since 1957 Newfoundland and Labrador has had a programme financed out of general revenues which covers all children under 16 years of age for in-hospital medical and surgical care, anaesthesia, and special consultations.

(iii) Saskatchewan Medical Care Insurance Plan

Only one province, Saskatchewan, has a universal coverage medical care plan. Since July 1962 every person who has resided in Saskatchewan for three months and is not entitled to medical services under other public programmes and has paid or has had paid on his behalf the required premiums is entitled to have payment made on his behalf from the Medical Care Insurance Fund for medical, surgical and obstetrical care without limit in his home, doctor's office, and in hospital from his physician of choice, including payment of specialist rates for referred specialist services. The plan is administered directly by the provincial government through the Medical Care Insurance Commission.

---

[1] Defined as involving some degree of regulation and financial support by a public authority.

(iv) Alberta Health Plan

The Alberta Medical Plan, a government regulated medical care insurance programme, came into effect on 1 October 1963. Enrolment is on a voluntary basis. All insuring carriers operating under the Plan must offer a standard contract that covers all treatment and care provided by or under the supervision and direction of a physician. The Government has set maximum premiums for the standard contract. Over-all regulation is carried out by the Alberta Minister of Health and a Co-ordinating Directorate made up of representatives of the Minister, the College of Physicians and Surgeons, the Canadian Health Insurance Association, and Medical Services (Alberta) Incorporated, the non-profit medically-sponsored plan. Upon application the premiums of certain persons meeting an income test of need are subsidised by the Department of Health through its Medical Services Division.

The new Alberta Health Plan, which came into effect on 1 July 1966 consists of the Alberta Medical Plan and an Extended Health Benefits Plan. The Extended Health Benefits Plan provides additional services to those under the Alberta Medical Plan, subject to an annual deductible amount and a co-insurance charge on certain services. Subsidisation at the same rates and for the same classes of persons is available for the Extended Health Benefits Plan.

Further changes in April 1962 have led to the establishment of a provincial agency which would write individual contracts for basic and optional benefits. Group contracts will be left to private carriers. Basic benefits in addition to physicians' services will include certain dental optometric, and podiatric services. Optional additional programmes include one for drugs and ambulance benefits, and another for chiropractic and naturopathic benefits. The new programme is to become effective as of 1 July 1967.

(v) British Columbia Medical Plan

The Plan came into effect on 1 September 1965 under the Medical Grants Act. It makes available medical insurance to all residents of the province not covered by another provincial or federal medical care scheme and subsidises the premiums of low income persons as in Alberta and Ontario. The British Columbia Medical Plan is an independent agency administered by a board appointed by the Government which is representative of the Government and the British Columbia Medical Association. Legislation presently before the British Columbia Legislature would establish a Medical Services Commission directly responsible to the province as the administrative body.

(vi) Ontario Medical Services Insurance Plan

The Plan began on 1 July 1966 and offers to all Ontario residents an insurance plan covering most physician services. It is open on a voluntary and individual enrolment basis to all residents and their dependants. Coverage is automatically provided to recipients of public assistance and to old-age pensionsers declared eligible. Premium subsidisation is provided by the Government for low income families and full premiums are paid for those with no taxable income. The Plan is administered by the Medical Services Insurance Division of the Ontario Department of Health. Persons who are members of existing non-private or private insurance programmes are not eligible for membership in the Ontario Plan so long as they retain these former types of coverage. Legislature presently before the Ontario Legislature would establish a provincial Health Insurance Registration Board which would eventually combine registration and premium collection for the province's hospitalisation and medical care plans.

(vii) Manitoba Medical Plan

Legislation is currently before the Manitoba Legislature to establish the Manitoba Medical Insurance Corporation which would collect compulsory premiums from all residents. Welfare recipients would have their premiums paid by the province. The final details of this Plan are not yet set. The programme will not be discussed in detail in this monograph for the latter reason.

(viii) Municipal Doctor Plans

These plans began as early as 1916 and in the decade after the First World War expanded rapidly in rural municipalities on the Canadian Prairies, especially in Saskatchewan, in which there was a situation of small population, low cash income, and therefore an inability to attract physicians on a straight private practice basis. The local government hired physicians on salary to care for municipal residents without charge at the time of service. Contracts usually permitted extra fees for certain procedures. These plans have either been superseded by government programmes, as in the case of Saskatchewan and pending in Manitoba, or in the interim period by other types of non-government insuring plans where the insuring agency has been able to insure most residents in certain communities. They will not be described further in this monograph.

(c) Programmes for Public Assistance Recipients

For a number of years Nova Scotia, Ontario, Saskatchewan, Alberta, British Columbia and Manitoba have operated plans providing certain personal health care services for specified categories of welfare recipients. In 1966 Quebec began a programme of comprehensive physician services for recipients of public assistance.

Recently New Brunswick and Prince Edward Island have also begun provincial schemes for the provision of certain personal health care services to public assistance recipients. Newfoundland recipients of public assistance who are individually certified by the welfare officer in their area as indigent for health care purposes are given free services. In areas covered under the Cottage Hospital Medical Care Plan, public assistance recipients are expected to pay the premium unless undue hardship would result.

Physicians' benefits for recipients of assistance in Saskatchewan and Ontario are now administered through the public medical care scheme set up in these provinces. Hospitalisation benefits in all provinces are available under the Dominion-Provincial Hospital Insurance and Diagnostic Services Plans. Thus, although basis of eligibility for population coverage is the same in all provinces, the precise groups of people covered vary somewhat as do the precise benefits from province to province.

(d) Workmen's Compensation

A Workmen's Compensation Act in each province protects workers affected by work-connected disabilities and diseases in industries covered by the legislation and is administered by a provincial board. While there is some variation by province, the legislation applies to most industries and occupations. Major groups of workers not covered are farm workers (except in Ontario), domestic servants, casual workers, employees of most financial, insurance and professional undertakings, and employees of certain service industries in some provinces. Compensation benefits include cash awards, all necessary medical aid, hospital care and physical restoration services, and vocational services to re-establish the injured worker in gainful employment. Costs are met from employer contributions to accident funds at rates fixed by the Workmen's Compensation Boards according to the hazard involved in each class of industry.

(e) Services for Specific Conditions, Diseases or Disabilities

The major part of the cost of care in mental institutions is borne by provincial governments. In five provinces institutional care is free while in the remaining five provinces relatives may be charged for patients' care, usually at a rate lower than the actual costs. The cost of short-term mental treatment provided in psychiatric units of general hospitals is covered under the provincial hospital insurance plans.

All provinces conduct tuberculosis control programmes that include case-finding through tuberculin-testing and X-ray surveys, and free treatment[1] at out-patient clinics in sanatoria. Most programme activities are decentralised to the local health units and city health departments which are usually assisted by voluntary tuberculosis associations in case-finding and health education.

---

[1] Except in British Columbia where sanatoria patients may be asked to pay a nominal charge.

In cancer control, three provinces have extensive cancer detection, treatment, medical services, and hospital services, under the provincial health department[1] and in four others provincial cancer commissions provide services.[2] In the remainder there is no specific cancer agency but the health department gives financial support to tumour clinics.[3] All provincial hospital insurance plans cover in-patient hospitalisation but not medical and surgical services except by interns and residents. However, payment is made in Saskatchewan and Alberta for approved medical care and surgery, both in-patient and out-patient; in New Brunswick for in-patient; in Prince Edward Island for diagnostic, medical and surgical services; in Newfoundland and Labrador for certain treatment under the Cottage Hospital Medical Care Programme.

Free diagnostic and treatment services are provided for venereal disease in all provinces but the operation of public clinics is being increasingly superseded by supplying free drugs to private physicians who are also reimbursed for the treatment of indigents.

All provinces have established alchoholism programmes, of which seven offer patient services of varying scope and all engage in public education on alcoholism. The provinces of Ontario, Manitoba and British Columbia have created separate agencies or "foundations" which operate treatment clinics, conduct public and professional education and engage in research. The health departments in Quebec and Alberta carry out programmes of broad scope and in Saskatchewan and New Brunswick they are developing counselling treatment services for alcoholics.

Services for persons with various chronic disabilities such as heart disease, arthritis, diabetes, visual and auditory impairment, paraplegia, poliomyelitis, etc., have been developed largely by voluntary agencies, assisted by federal and provincial funds.

2. Schemes Based on Collective Agreements

The provision of plans to cover the costs of medical care, hospitalisation and loss of income through illness have been subjects of collective bargaining in Canada for a number of years. In general as a result of collective bargaining agreements industry participates, either in part or in full, in the payment of premiums for employees in the provincial hospitalisation programmes and in medical care plans of varying comprehensiveness provided either under non-profit or private insurance auspices. Hospitalisation coverage at the standard ward level is now provided for all Canadians under provincial government programmes but additional semi-private accommodation and other hospital benefits may be purchased through the Blue Cross non-profit plans, and through private insuring agencies. In most provinces and in some industries those additional benefits have been part of collective bargaining. In the

---

[1] Alberta, New Brunswick and Prince Edward Island.

[2] Saskatchewan, British Columbia, Manitoba and Ontario.

[3] Newfoundland and Labrador, Nova Scotia and Quebec.

medical care field a wide variety of carriers are active selling group contracts to industry, these are often the basis of major fringe benefits and collective bargaining. These programmes will be described in the next section on Private Arrangements.

3. Private Arrangements

(1) Non-Government Insurance

One of the most interesting developments in the provision of medical care in Canada in recent years has been the growth in the number of persons covered by non-government insurance plans, both of the professionally and independently sponsored non-profit types and the private insurance company type. The Department of National Health and Welfare estimated that at the end of 1965 12,007,118 Canadians, 61.4 per cent. of the population, including dependants of insured people, had voluntary coverage for expenses entailed in physician services. This figure represents a substantial increase over the 1955 figure of 39.6 per cent. It should be pointed out that these figures indicate only that some degree of coverage was provided. It is known that contracts vary widely and their benefits range from extremely comprehensive to limited scope. Thus, some 1,569,184 of 6,527,518 insured persons who were covered under non-profit auspices had limited and not comprehensive protection. The coverage figures vary widely from province to province depending upon the extent of government activity in this field. The 1965 estimate is made up of 6,527,518 people covered by non-profit plans and 5,479,000 covered by private company insurance plans, less and unknown but likely degree of duplication in coverage.

It should also be noted in each province and in the territories the government hospital plans are the sole insuring bodies for basic hospitalisation expenses and the role of non-government plans is in offering coverage for semi-private accommodation and other additional hospital benefits.

Non-government insurance plans for medical care have two basic methods of enrolment, group and non-group. In general to obtain a group contract a certain specified percentage of the total group, usually an employee group, must join the plan. Group plans are on the whole able to offer more comprehensive benefits at lower premium rates than non-group plans. Under non-group enrolment, which is available to individuals without group affiliation, premium rates are higher in general than for comparable group contracts. In certain cases conditions may be attached to individual contracts such as age limitations, limitations because of pre-existing illnesses, etc. Contracts for industrial employee groups commonly include a degree of employer sharing in premium payments. As a result of economically dictated enrolment procedures, people covered by non-government insurance plans tend to be selected more from those employed in industry and business, those who are self-employed, those in the middle and upper-income groups, those in younger and middle-age groups and those living in urban areas than from other groups in the population. In particular rural groups and older people have been difficult to cover under this type of procedure.

Enrolment statistics by themselves are not a true indication of the proportion of total costs being insured and budgeted for on a predictable premium basis because contracts vary widely. Also a proportion of the population have some coverage under more than one contract.

Benefits may be provided in one of two basic forms, the service benefit in which the subscriber is guaranteed certain services specified in the contract. A service plan is essentially a contract with those providing care, doctors, hospitals and others under which the providers agree to accept payment from the plan for services they provide rather than from the member directly. The usual implication is that, for the basic service, this payment represents discharge of the financial obligation in full, i.e., there would be no additional charge incurred by the patient at the time of recurring service. In the cash benefit type of plan there is no contract between the plan and those providing care. The plan agrees to pay the lesser of the actual billed cost for service rendered or a specified amount for any particular service, either to the member or the provider of the service. Any additional costs are paid directly by the member concerned. Some service benefit plans providing doctors' services have a type of payment that is really a hybrid of the two methods, this is the "open end" service plan which provides a full service benefit for those below a specified income level but permits extra billing for those with incomes above this level. Others provide full general practitioners' service benefits but permit extra billing by specialists. In general, service plans do not pay the full medical association provincial fee schedule but prorate accounts, the reasoning being that the provider is saved the overhead costs of collection. In instances where extra billing is permitted the physician then charges the patient directly an additional sum.

There are a variety of types of non-government medical care insurance plans:

(a) Producer-Sponsored, Non-Profit, Insurance Plans

These are plans set up by and administered by agencies controlled by those providing benefits.

Blue Cross plans are sponsored by the voluntary hospital associations. Until the start of the Dominion-Provincial Hospital Insurance Plan they offered fairly comprehensive in-hospital service benefit contracts. With the introduction of the government hospitalisation programmes, the plans ceased operation in Manitoba, Saskatchewan and British Columbia. Elsewhere they have confined their activities in the hospital field to offering coverage for additional benefits such as semi-private, special nursing care, etc., not offered under provincial government plans. In the Maritimes and Quebec the plans also offer contracts covering general surgical, obstetrical benefits, and calls in the home, office, or hospital, and certain diagnostic services. In Ontario an extended benefit scheme, including drugs in some instances, has been recently introduced.

Physician-sponsored plans, called Blue Shield Plans in the United States but rarely in Canada, are sponsored or approved by provincial medical associations. Most of them are members of a common clearing house and partial central co-ordinating body known as Trans Canada Medical Plans. There are two plans in the Maritimes, two in Quebec, two in Ontario, one in Manitoba, two in Saskatchewan, one in Alberta, and two under one administrative agency in British Columbia. Ten of these offer services or partial "open end" service benefit contracts, and several others offer cash benefit contracts of varying comprehensiveness. Comprehensive benefit contracts generally cover medical, surgical, obstetrical care, home, office and hospital diagnostic procedures, and other services, whereas limited benefit contracts generally cover surgical and obstetrical benefits in home, office and hospital, usually non-surgical care at the hospital, and certain diagnostic services. In Saskatchewan the essential role of the two medically-sponsored plans there is to act as the intermediary fiscal agency between the subscriber, physician and Saskatchewan Medical Care Insurance Commission for the settlement of medical claims. People may purchase membership in the non-profit carriers at nominal cost. It is important to recall that under the Saskatchewan Plan collection of premiums related to medical care services is solely a function of the public authority.

(b) Consumer-Sponsored, Non-Profit Insurance Plans

Plans of the cash benefit and limited benefit type are operated by co-operatives. Like Blue Cross they were once active in the hospitalisation field but are now chiefly in the surgical and medical expense field. Some offer additional benefit to those provided by provincial hospital insurance plans. Those plans are generally small and based on rural areas. Some of the plans have cash-deductible and major medical expense benefit contracts.

Group practice, prepayment plans are common in the United States and offer service benefits which are proved by panels of general physicians and/or specialists on a prepaid basis. The plans stress preventive medicine and the absence of any deterrent to seeking care. Typically the patient on joining a plan may choose one of the group panels as the one from which he wishes to receive care. The doctors receive payment on a salary basis or capitation basis, and in general contract with the plan for a lump sum of money to provide care to its members, and divide the money among themselves on an agreed basis. These plans have received a good deal of labour support in the United States. Only one such plan is presently in operation in Canada, the Sault Ste. Marie and District Group Health Association, covering some 25,000 people in Sault Ste. Marie, an Ontario steel manufacturing town. A second plan is being prepared for St. Catherines, Ontario, also a large manufacturing town.

At the time of disagreement in Saskatchewan between the College of Physicians and Surgeons representing the bulk of physicians, and the government of Saskatchewan, when the Medical Care Act was passed in 1962, groups of people in several communities favouring the government programme built clinic facilities in which doctors willing to work directly with the government plan provided services. In general, the clinics in small communities have either closed or

rented their facilities to private doctors. But, in several larger communities, such as Regina and Saskatoon, community-sponsored clinics have continued to flourish. The doctors in them work directly with the government plan. The clinic facilities are owned and operated by the community groups sponsoring them. In addition they encourage the provision of additional preventive and health educational services.

A few non-profit plans other than those included under the above descriptions are also in operation with cash benefit contracts of varying comprehensiveness.

(c) Private Insurance Company Plans

A large number of private insurance companies are active in the field. Because of the numbers and varieties of contracts available it is difficult to outline benefits more precisely than to say that they vary all the way from very comprehensive ones which provide a wide range of medical and ancillary services to limited cash benefit ones for any one of a combination of medical, surgical and hospital expenses, beyond those provided by government hospital plans. One type of relatively common contract sold by private insurance carriers is the contract with an initial deductible amount which is paid by the subscriber before the benefits come into effect. This allows for a lower premium. Also there are plans which provide a major medical or catastrophic benefit, which covers most or all expenses over an initial amount and up to a set amount.

(2) Care Provided by Employers

Most large employers and many smaller ones provide occupational health services which provide pre-employment and other examinations, first aid, health counselling and supervision of working conditions. In isolated communities, chiefly mining and lumber towns, some large companies employ physicians either on a full or part salary and may build hospitals, so that medical and hospital services may be assured to their employees and families. The medical services are available usually on a fee-for-service basis but sometimes are free of charge to employees or at reduced cost. Other residents may use the services on a fee basis. Approved hospitals are included in provincial hospitalisation plans.

4. Combination of Statutory Schemes and Private Arrangements

In the hospitalisation field it is permissible for non-government plans to sell additional benefits of varying kinds beyond those offered by the provincial government plans. They may not, however, provide contracts providing services of the same type as those provided under the provincial plans. In the medical care field the situation varies depending on whether a province has a provincially operated medical care plan and on the nature of the provincial plan. In British Columbia, non-government carriers are free to operate along with the government-sponsored plan in providing similar basic and additional benefits. In Alberta the non-government plans by providing a variety of standard contracts are open to subsidisation for the premiums of certain categories of people in the low income groups. In order to provide these they must also guarantee that any citizen of Alberta may join for a

specified premium. In Saskatchewan two non-profit, medically-sponsored plans are the only non-government ones remaining in the field. As noted in essence they act as intermediary agencies between the public, physicians and the Medical Care Insurance Commission. In Ontario non-government plans may continue at the present time to sell contracts in competition with the Ontario Medical Services Insurance Plan, and to provide contracts with additional benefits not included in O.M.S.I.P. In Newfoundland the non-government plans may operate in areas where the Cottage Hospital Medical Care Programme is not in effect. They may not of course provide benefits, such as physicians' services for hospitalised patients, provided under the Children's Health Programme.

It would appear likely that with the establishment of universal provincial programmes in the future that the role of non-government plans will become limited to the provision of benefits not provided under the government schemes. Since the government plans initially appear to be limited largely to physician services, a wide area of insuring for additional services, drugs and other benefits, remains open for private insurance coverage.

B. Summary of the Provisions of Statutory Schemes

1. Provincial Hospital Insurance Plans

Scope and Qualifying Conditions

In all provincial and territorial plans hospital care benefits are provided as medically necessary to all eligible persons unless provided under other government schemes such as those for workmen's compensation cases and for veterans for service-connected illness. (see table 1.)

Range of Benefits

(a) In-Patient Benefits

It is mandatory for all provinces entering into an agreement with the dominion Government under the Hospital Insurance and Diagnostic Services Act to provide, on uniform terms and conditions, the following standard in-patient services, as specified in the Act.[1]

Benefits are provided through any provincially licensed and approved hospital or other designated facility providing acute, chronic and convalescent care.[2] In-patient benefits, under the hospital plan, are provided as long as medically necessary. This is subject to medical review and decision on individual cases by provincial hospital authorities. In general, once patients require essentially only custodial care they are no longer covered. Most provinces have other legislation providing some financial support for nursing home and custodial care of public assistance recipients.

---

[1] As of 1965, Quebec has received federal contributions through tax abatement and not under the act, but in-patient benefits are similar to those in other provinces.

[2] Tuberculosis and mental hospitals are excluded from federal cost sharing as are nursing homes and custodial institutions. Care in them is covered by provinces separately although a charge, based on ability to pay, may be made in some provinces for mental hospital care. Income from this source accounts for less than 10 per cent. of operating revenues in provinces where charges are made. In Ontario and Prince Edward Island mental and tuberculosis hospital care is provided free of charge by the province to persons covered under their hospital plans. Care in psychiatric and tubercular wards in general hospitals is included as a federal shareable cost. Most provinces provide some financial assistance under other legislation for care to social assistance recipients in nursing homes and custodial institutions.

TABLE 1

Scope and Qualifying Conditions for Benefit Under the Provincial Hospital Insurance Plans

Province	Scope[1]	Initial Qualifying Period	No. of Ins. Persons as of 31 Mar. 1966	Perc. of Elig. Population Insured as of 31 Mar. 1966[1]
Newfoundland and Labrador	All residents automatically.	Three months for immigrants from other provinces; none for those from other countries.	504,000	100
Prince Edward Island	All residents automatically.	Three months residence.	107,000	100
Nova Scotia	All residents automatically.	Three months residence.	742,000	100
New Brunswick	All residents automatically.	Three months residence.	620,000	100
Quebec	All residents automatically.	Three months residence.	5,744,000	100
Ontario	Compulsory premium for all residents and families employed by firms with 15 or more employees; voluntary for all others.[2]	Third month after month in which premium is due and paid (effective waiting period is from two to three months).	6,763,996	98.4[5]
Manitoba	Compulsory premiums all residents.[3]	Three months residence or one month from date of legislation whichever is later.	935,790	98.3
Saskatchewan	Compulsory premium all residents.[4]	New residents, in general, qualifying period is three months from establishment of residence; spouses of new residents who also become new residents but who arrive during	941.956	99.2

Province	Scope[1]	Initial Qualifying Period	No. of Ins. Persons as of 31 Mar. 1966	Perc. of Elig. Population Insured as of 31 Mar. 1966[1]
		three-month qualifying period applicable to their spouses, their own qualifying period is the remainder of the same three-month period. For newly landed immigrants coverage may be obtained without any qualifying period at all by paying the special rate of $2.00 per month and in such a case the coverage begins immediately on payment of a special rate, but the special rate itself is collected from the beginning of the following calendar month.		
Alberta	All residents automatically.	There is no qualifying period, but if a person becomes a resident following being a resident elsewhere in Canada where he was eligible for insured services and if the jurisdiction where he was a resident imposes a qualifying period upon its own new residents, Alberta imposes a qualifying period the length of which is the lesser of three months or the other jurisdiction qualifying period.	1,447,000	100
British Columbia	All residents automatically.	Three months residence.	1,862,000	100

Province	Scope[1]	Initial Waiting Period	No. of Ins. Persons as of 31 Mar. 1966	Perc. of Elig. Population Insured as of 31 Mar. 1966[1]
Yukon Territory	All residents automatically.	Three months residence.	15,000	100
Northwest Territories	All residents automatically.	Three months residence.	25,000	100
Canada			19,707,742	99.3[5]

[1] For the most part, those excluded from enrolment are members of the Canadian Armed Forces, the Royal Canadian Mounted Police, and inmates of federal penitentiaries, all of whom have special programmes of their own. The Dominion Bureau of Statistics estimates these people to represent some 0.6 per cent. of the total population. (Annual Report of the Minister of National Health and Welfare on the Operation of Agreements with the Provinces under the Hospital Insurance and Diagnostic Services Act for the Fiscal Year Ended 31 March 1966, p. 10.)

[2] The Department of Public Welfare pays premiums for provincial public assistance recipients and municipalities may pay premiums for indigent residents. Other uninsured indigents who become hospitalised have such costs paid by the responsible municipal or provincial authority.

[3] Public assistance recipients are covered by the province without premium payments on their behalf.

[4] Public assistance recipients have their premium paid either by the province or municipality.

[5] As of March 1967, the Ontario Hospital Services Commission estimates 99.2 per cent. coverage. This would increase Canadian coverage to over 99.5 per cent. of all eligible population.

(b) Out-Patient Benefits

The trend has been towards a growing list of hospital out-patient benefits. Provinces are free to choose which, if any, out-patient services they wish to provide as benefits. Only those specified in dominion-provincial agreements are included in federal cost sharing. All provinces provide some insured out-patient services under the Programme. The pattern varies from province to province but among the services offered are emergency care following accidents, diagnostic services, and therapeutic services, including minor surgical and medical procedures. Some provinces provide certain psychiatric out-patient services as well.

Cessation of Benefits

In provinces where benefit is related to contributions, coverage may be suspended if premiums are not kept up to date. When a protected person moves from one participating province to another, coverage is generally extended so as to take into account travelling time, and the waiting period of the Hospital Insurance Plan of the new province. All schemes include a provision concerning the suspension of benefit for persons moving out of Canada.

Provincial Financing and Cost Sharing by Beneficiaries

Data on the provincial financing and cost sharing by beneficiaries is outlined in table 2. It should be noted that the federal share of cases is obtained from general tax revenue. In the case of Quebec, a federal tax abatement has been agreed on rather than a grant under the Hospital Insurance and Diagnostic Services Act.

Table 2

Provincial Financing and Cost Sharing by Beneficiaries

Province	Provincial Financing	Cost Sharing by Beneficiary
Newfoundland and Labrador	Consolidated revenue.	Nil
Prince Edward Island	Consolidated revenue.	Nil
Nova Scotia	Five per cent. sales tax and consolidated revenue.	Nil
New Brunswick	Consolidated revenue.	Nil
Quebec	Consolidated revenue.	Nil
Ontario	Premium of $39.00 per year for a single person and $78.00 per year for a family. (Includes	Nil

Province	Provincial Financing	Cost Sharing by Beneficiary
Ontario (cont'd.)	dependent spouse and dependent children under 21 years.) Also consolidated revenue. Ontario Department of Public Welfare pays premiums for categorical public allowance recipients. Municipalities may pay premiums for resident public assistance recipients. Other uninsured hospitalised indigents may have their charges paid by the responsible provincial or municipal authority.	
Manitoba	Premium of $24.00 per year for a single person and $48.00 per year for a family (including dependent spouse and dependent children under 19 years). Also special charge on personal income tax and corporation taxable income. The province pays the premiums for categorical public allowance recipients. Municipalities pay premiums for resident public assistance recipients.	Nil
Saskatchewan	Premium of $24.00 per year for a single person and $48.00 per year for a family (includes dependent spouse and dependent children under 18 years). Also consolidated revenue. The province pays the premiums for categorical public allowance recipients. Municipalities pay the premiums for resident indigents.	Nil
Alberta	Consolidated revenue and a municipal contribution from a levy based on the equalised assessment on property.	In-patient: adult $5.00 first day and $2.50 each subsequent day. Newborn $1.00 per day. Auxiliary hospitals $1.50 per day. The province pays these charges for

Province	Provincial Financing	Cost Sharing by Beneficiary
Alberta (Cont'd.)		public assistance recipients, rheumatoid arthritic patients for authorised treatment, cancer patients for up to seven days for diagnosis, and poliomyelitis patients. Out-patient: 20 per cent. of charge for services provided as per a schedule. The province pays the charges for the above groups and also for out-patient services at auxiliary hospitals and multiple handicapped children's units.
British Columbia	Consolidated revenue.	In-patient: $1.00 per day except newborns. Out-patient: $2.00 per treatment. The province pays these charges for public assistance recipients.
Yukon Territory	Yukon Consolidated Revenue Fund.	Nil
North-west Territories	North-west Territories Revenue Account in the Consolidated Revenue Fund of Canada.	In-patient: $1.50 per day. The federal authorities pay the charge for indigent registered Indians and Eskimos, and the territorial authorities for other indigents.

Administration

The administrative authorities responsible for the management of Provincial Hospital Insurance Plans in individual provinces are listed hereunder:

Newfoundland and Labrador	Health Insurance Division, Department of Health.
Prince Edward Island	Hospital Services Commission, reporting through Minister of Health.
Nova Scotia	Hospital Insurance Commission, reporting to Minister of Health.
New Brunswick	Division of Hospital Services, Department of Health.
Quebec	Hospital Insurance Service, Department of Health.
Ontario	Hospital Services Commission, reporting through Minister of Health.
Manitoba	Hospital Commission, reporting to Minister of Health.
Saskatchewan	Hospital Services Branch, Department of Health.
Alberta	Hospitals Division, Department of Health.
British Columbia	British Columbia Hospital Insurance Service, with own deputy minister.
	Department of Health Services and Hospital Insurance.
Yukon Territory	Yukon Hospital Insurance Commissioner, reporting to the Commission of the Yukon Territory.
North-west Territories	Territorial Hospital Insurance Services Board, reporting to the Commissioner of the north-west territories.

Right of Appeal

Appeals in relation to eligibility for benefits and payment are made through the administrative authority in each province. Appeals in relation to the quality or quantity of care may be made to the administrative authority and to the courts if deemed necessary.

2. Provincial Medical Care Plans

(1) Newfoundland and Labrador Programmes

(a) Cottage Hospital Medical Care Plan

Scope and Qualifying Conditions

Any resident in the 18 cottage hospital districts in rural Newfoundland and Labrador is eligible for benefits for himself and

his dependants[1] on payment of or on commitment to pay an annual subscription fee. There is no waiting period for new residents of cottage hospital districts to become subscribers and immediately eligible for benefits provided that they make a payment on the annual fee within three months after taking up residence in a cottage hospital district.

Range of Benefits

Benefits, which are continued as long as medically necessary, are provided by salaried doctors who also serve as medical health officers for their districts, and by district nurses. In 1965 some 74 doctors were employed, including 49 in cottage hospitals and 21 in district medical practices within cottage hospital districts. In some districts only a district nursing service exists.

In association with the cottage hospital district services the province operates a motor vessel equipped as a floating clinic and serving out of Placentia Bay. Small cabin cruisers stationed at Belleoram, Hermitage Bay and Burgeo, provide accommodation for medical clinics and emergency transport of patients.

The province also operates an air ambulance service, using aircraft under contract to the provincial government.

Similar benefits in the three additional areas are provided by a further 24 related doctors, based on five hospitals.[2] A fleet of motor vessels is maintained by the International Grenfell Association. There is reciprocity between these plans and the Cottage Hospital Medical Care Plan.

Benefits include services of the local doctor and district nurse in the home, office and out-patient clinic or cottage hospital and specialist care, not available in the local area, which is provided in St. John's, Grand Falls, or Cornerbrook, on referral by the local doctor or nurse. Professional service fees are charged for deliveries and dental extractions and are reclaimed by the province. Care for an acute affect of illness and for referrals is provided in other cottage hospital districts.

Exclusions include drugs[3], dressings, appliances, eye refraction tests and dental plates. Care for an injury from an accident for

---

[1] Anyone dependent on the subscriber except single persons not attending school and able to work. The latter are responsible for their own fees.

[2] International Grenfell Association - three hospitals and 16 doctors; Notre Dame Bay Memorial Hospital Association - one hospital and five doctors; M.J. Boylen Hospital - three doctors.

[3] Drugs are, however, available at cost from personnel and facilities in the districts.

which another person is responsible is not usually paid for by the Plan. Care by doctors outside cottage hospital districts are not benefits except on explicit referral, or if treatment is needed for acute attack of illness. Care provided under other provincial and federal programmes is also excluded. Travel costs of the patient or doctor are excluded. Those unable to pay may make special arrangements with the local welfare officer.

Cessation of Protection

Subscribers who change residence from a cottage hospital district to an area of the province not covered by the Plan (apart from the parallel plans already mentioned) cease to be eligible for benefits.

Financing Arrangements

Premiums charged to subscribers vary according to the district and are based on the per capita income in the district as determined by the province. They account for about 50 per cent. of the total costs of the Plan. The remainder comes from general provincial revenue.

Annual premium rates are

Town of Gander:

Single person	$12.00
Family	24.00

Towns of Botwood, Bishop's Falls:

Single person	$ 8.00
Family	16.00

Other cottage hospital districts:

Single person	$ 5.00
Family	10.00

Nursing districts served by general hospitals:

Single person	$ 4.50
Family	9.00

Nursing districts not served by cottage and general hospitals:

Single person	$ 3.00
Family	6.00

Premiums for residents of the three additional areas are:

Single person	$ 5.00
Family	10.00

Non-subscribers pay fees according to their ability to pay. Annual grants to cover deficits of the plans are negotiated with the province.

Cost Sharing by Beneficiary

The service fees for deliveries and extractions are as follows:

	Delivery	Dental Extraction
Gander, Botwood, Bishop's Falls, and Channel Port aux Basques	$20.00	$1.00
Other cottage hospital districts	10.00	.50

Administration

The Cottage Hospital Medical Care Plan is operated by the provincial Department of Health which employs the personnel and owns the facilities. The three additional programmes are operated by the non-government associations noted which employ the personnel and own the facilities.

Right of Appeal

Matters related to eligibility and payment of premiums are handled by the Department of Health, together with the local welfare officer in certain cases. Appeals about the quality or quantity of care may be made to the Department, the provincial College of Physicians and Surgeons as the provincial medical licensing authority, and to the courts if deemed necessary.

(b) Children's Health Plan[1]

(2) Saskatchewan Medical Care Insurance Plan

Scope and Qualifying Conditions

All eligible residents after three months of residence are required to register and become insured[2] and become eligible on so doing for coverage. There is no waiting period for landed immigrants. The premium is paid in conjunction with the hospital insurance premium. In 1966, 96.4 per cent. of the estimated provincial population, including those covered by the province under the Saskatchewan Assistance Act 1966, were covered and the remainder were covered under other federal and provincial programmes.

---

[1] See page 7.

[2] After this period coverage becomes effective one month after the premium is paid.

Range of Benefits

Benefits are provided without limit of time on a first dollar coverage basis for as long as medically necessary. They include:

Doctor's services	- medical, surgical, psychiatric, obstetrical and diagnostic procedures, and care in the office, home and hospital from the private physician of choice. Specialist service at specialist rates on referral by another physician or for services given only by specialists.
Anaesthesia	- in conjunction with diagnostic, surgical, obstetrical, certain dental and other procedures.
Laboratory	- all, including interpretations, by a specialist in pathology in a non-hospital facility; a list of procedures performed in their offices by physicians other than pathologists.
Radiology	- diagnostic X-ray services, including interpretation, performed by a specialist in radiology in a non-hospital facility.
Preventive medicine	- inoculations and vaccinations where not provided through a government agency and routine physical examinations when not for the purpose of marriage, employment insurance, nor at the request of any third party.
Dentistry	- performed by a dentist in support of a surgeon performing maxillo facial surgery.

Exclusions include plastic surgery for cosmetic purposes, refractions, drugs, appliances, special duty nursing, telephoned advice, travel expenses, medical examinations for a third party or judicial reasons, ambulance service, and services not provided by or under the direction of a qualified physician. Also excluded are services covered under other provincial legislation, such as the Mental Health Act, Cancer Control Act, Venereal Disease Act, Public Health Act, the Hospital Services Plan and the Workmen's Compensation Act and under federal legislation, such as for members of the Canadian Armed Forces, the Royal Mounted Police, inmates of federal penitentiaries, and registered Indians on reserves or living outside reserves for more than 12 months, or veterans allowance recipients.

Out-of-province benefits include all benefits covered under the Plan, at rates payable within Saskatchewan, on a reimbursement basis.

It should be noted that in the Swift Current Region, the Region Health Board in addition retains a full-time consultant radiologist and operates a dental service for children. These services began before the province-wide insurance plan went into effect and have been continued.

Cessation of Protection

Benefits cease three months after permanent change of residence provided that the premium has been paid for that period. If resident is in default on premium procedures are followed to collect the premium with or without a penalty depending upon the circumstances.

Financing Arrangements

There is an annual premium of $12.00 for a single person and $24.00 for a family (including dependent spouse, unmarried dependants under 18 years at the beginning of each year and under the age of 21 years if attending educational institutions or training at a school of nursing, and all sons and daughters at any age dependent by reason of physical or mental infirmity). The premium is collected jointly with the hospital insurance one by the Saskatchewan Hospital Services Plan through local municipalities or provincial offices and paid into the Medical Care Insurance Fund. In 1965, approximately 24 per cent. of the Fund came from premiums. The balance is appropriated by the Saskatchewan Legislature from the provincial Consolidated Revenue Fund.

Recipients of public assistance have their premiums paid by the provincial authority or, in certain cases, by the responsible municipal authorities.

Residents in the Swift Current Region pay their premiums to the Regional Board of Health. The province pays a per capita grant based on the per capita cost of medical case insurance outside the Region, less the per capita premium revenue and, thus provides revenue related to that spent elsewhere in Saskatchewan.

Cost Sharing by Beneficiary

Except in the Swift Current Region, there is no cost sharing at the time of receiving service. In the Swift Current Region, the Health Region Board levies utilisation fees which are paid directly by the patient to the physician. These are - $1.00 for office calls, $1.00 for minor surgery, $2.00 for home calls, and $3.00 for night, Sunday, holiday and emergency home calls.

Administration

Administration is by the Saskatchewan Medical Care Insurance Commission[1], which is responsible to the Minister of Public Health.

Approved health agencies (both existing ones are non-profit plans started some years ago under medical auspices) may act as intermediary agencies between the Commission, patients and doctors.

---

[1] Consists of nine members, including three nominated by the College of Physicians and Surgeons of Saskatchewan. The Deputy Minister of Public Health serves ex officio and has no vote.

Thus, a person may enrol with one of the agencies which will forward accounts on his behalf received from doctors affiliated with the agency to the Commission, and on receipt of payment for accounts sends these to the physicians concerned. A small annual administration charge of $1.50 for a single person and $3.00 for a family is made by the agencies to enrolees for the service.

In the Swift Current Region, which has had its own medical care insurance plan since 1946, the Health Region Board has been allowed to retain autonomy in collecting and administering premiums collected in the Region. In addition the province pays a per capita grant related to the amount spent per capita on behalf of the provincial indigents. The Health Region Board pays for all insured services to the Region beneficiaries except for Saskatchewan Assistance Plan beneficiaries.

Right of Appeal

Matters related to eligibility and premium payment are the responsibility of the Lieutenant Governor-in-Council (Provincial Cabinet), and those related to payment of accounts are the responsibility of the Medical Care Insurance Commission. Appeals related to the quality and quantity of service may be taken to the Commission, the Saskatchewan College of Physicians and Surgeons, as the provincial medical licensing authority, and to the courts if deemed necessary.

(3) Alberta Health Plan

As of the time of writing this monograph, the Alberta Health Programme consists of the Alberta Medical Plan for physicians' services, introduced in October 1963, and the Extended Health Benefits Plan for certain additional services, introduced in July 1966. Under the Alberta Health Plan Act of April 1967 which comes into effect on July 1, 1967, and supersedes the former Programme, a number of important changes will be made. Both the existing Programme and, to the extent that information is presently available, the new Plan will be described in this monograph.

Scope and Qualifying Conditions

(a) Existing Alberta Health Programme

(i) Alberta Medical Plan

Any resident is eligible on voluntary payment of a premium on behalf of himself and his dependants[1], either under an individual or group contract to an approved insuring agency. Benefit coverage begins at the start of the fourth month after the month of enrolment

---

[1] Dependants include spouse, dependent children under 21 years, dependent children 21-24 years who are unmarried and at an accredited educational institution, unmarried children over 21 years dependent because of mental or physical infirmity.

and payment of the premium.[1] This has been waived during certain "open enrolment periods" in the past. Special waiting periods after the effective benefit date apply to maternity services (nine months), annual routine physical examinations (two years), and psychiatry by private physicians (12 months for individual contract holders).

(ii) Extended Health Benefits Plan

Any resident is eligible on voluntary payment of a premium on behalf of himself and his dependants[1], either under a separate contract or under a rider to an Alberta Medical Plan contract. The regular waiting period is similar to that for the Alberta Medical Plan. There are no special waiting periods for specific benefits.

As of February 1967, about 65.5 per cent. of the estimated provincial population were enrolled in the Alberta Health Programme.

(b) Alberta Health Plan

Every resident may apply to the Minister of Health or to any approved carrier acting as his agent for a standard contract providing either basic health services or basic health services and certain optional health services for himself and his dependants. As of 1 July 1967, all new contracts must meet the terms of the Alberta Health Plan and any existing contracts under the Alberta Health Programme must be adjusted to these terms by a fixed period of time.

Range of Benefits

(a) Existing Alberta Health Programme

(i) Alberta Medical Plan

Contracts may be either first-dollar ones or include deductible and coinsurance provisions. Benefits, which continue as long as medically necessary, cover medical services provided directly by or under the supervision and direction of registered physicians, including the full range of diagnosis, treatment, and care in the home, office and hospital; surgery; obstetrical services; specialist and consultant services; anaesthetist services; 20 per cent. of the cost of laboratory, radiological, and related diagnostic services at hospital, private clinics, and laboratories[2] (cost provided under hospital insurance).

Exclusions include sterilisation for non-health reasons, examinations required by a third party, eye examinations for glasses, drugs, appliances, dental services, physiotherapy, nursing services, ambulance services provided under other federal and provincial government programme, such as Workmen's Compensation, the Hospital

---

[1] i.e., three to four months.

[2] Remainder of cost covered under Hospital Insurance Programme in Alberta.

Insurance Programme, Extended Health Benefits Plan, the programme for social assistance recipients, the Canadian Armed Forces Programme, the Indian health services and mental hospital patients.

Out-of-province benefits include all benefits at the rate of the same services in Alberta or the actual charges of the physician, whichever is less.

(ii) Extended Health Benefits Plan

The Extended Health Benefits Plan is designed to provide coverage for the cost of necessary health services not included under either the Alberta Medical Plan or the Alberta Hospital Insurance Programme. All benefits are subject to a deductible amount of $25.00 per person with a maximum of $50.00 per family in a year. After the deductible has been paid, the family must also pay 20 per cent. of drug and nursing accounts. Exclusions include benefits under these and other government programmes. Some of the benefits included with the plan are approved drugs, optometry, physiotherapy, psychology counselling with nursing in hospitals and similar facilities outside Canada, ambulance transportation, osteopathy, various aids and appliances, medical supplies, radioactive treatments and blood or blood plasma.

(b) Alberta Health Plan

Basic health services, which will be provided as long as medically necessary, include first-dollar coverage for medical services provided by a physician, oral surgery provided by a dental surgeon, services provided by an optometrist in eye infractions for glasses, services and appliances provided by a podiatrist, and services provided by osteopaths, subject to any limitations and exclusions in the regulations under the Alberta Health Plan Act of 1967. At the time of writing this monograph, the regulations were not available.

Optional services will generally consist of services now provided under the Extended Health Benefits Plan, except optometric, podiatric and osteopathic services to be included under basic health services, plus certain hospital services. Two levels of optional services appear to be planned with two scales of premium. The second level adds naturopathic and chiropractic service benefits. Optional contracts are expected to include deductible and coinsurance provisions, as under the present Extended Health Benefits Plan. Further details are unavailable at the time of writing this monograph.

For coverage under group contracts, a group must have basic health services coverage as a condition to having additional coverage for optional health services.

Financing Arrangements

(a) Existing Alberta Health Programme

(i) Alberta Medical Plan

Financed by personal premiums.[1] The Plan establishes maximum premiums which an approved[2] carrier may charge. Contracts may be first-dollar coverage ones or have deductible and coinsurance features. The maximum allowed premiums are:

(i) For first-dollar coverage contracts (either individual or group contracts):

One person	- $ 63.00 per year
Family of two	- 126.00 per year
Family of three or more	- 159.00 per year

(ii) For deductible and coinsurance contracts (individual or group):

One person	- $ 42.00 per year
Family of two	- 84.00 per year
Family of three or more	- 114.00 per year

The province will subsidise the premiums of people with little or no taxable income in the previous calendar year for the first-dollar contracts, if they apply. Subsidies are paid to the carrier selected by the subscriber.

No taxable income	- 80 per cent. subsidy
Taxable income $1.00 - $499.00	- 50 per cent. subsidy
Taxable income $500.00 - $1,000.00	- 25 per cent. subsidy

As of 31 January 1967, 267,460 persons or about 27 per cent. of participants were subsidised, of whom approximately 74 per cent. were at the 80 per cent. subsidy level.

(ii) Extended Health Benefits Plan

Financed by personal premiums.[3] All contracts have deductible

---

[1] The actual premiums charged are almost always lower than the allowed maximum. About 75 per cent. of subscribers have group contracts and 25 per cent. have individual contracts.

[2] Thirty-nine approved carriers - 38 private insurance carriers and Medical Services (Alberta) Incorporated, the medically-sponsored, non-profit plan.

[3] The actual premiums charged are almost always lower than the allowed maximum. About 75 per cent. of subscribers have group contracts and 25 per cent. have individual contracts.

and coinsurance provisions.[1] The maximum allowed premiums for individual and group contracts by approved carriers[2] are:

One person	- $31.20 per year
Family of two	- 62.40 per year
Family of three or more	- 79.20 per year

The province will pay subsidies to the carriers for the premiums of the same people and at the same percentage rate as under the Alberta Medical Plan. The deductible and coinsurance amounts are also subsidised.[3]

(b) Alberta Health Plan

The maximum premiums for the standard contracts for basic services issued by the Minister of Health or an approved carrier appointed as his agent are:

One person	- $ 60.00 per year
Family of two	- 120.00 per year
Family of three or more	- 160.00 per year

All premiums paid under standard contracts will be paid over to the Provincial Treasurer for deposit in the Alberta Health Plan Fund, together with any funds appropriated by the Legislature for the Plan. All claims for benefits under standard contracts and all administration and agency fees, payable by the Minister of Health to approved carriers for administering standard contracts on his behalf, are to be paid out of the Fund. All claims are subject to assessment and approval of the Minister of Health.

At the time of writing this monograph, information on the rate of subsidisation for people in lower income levels and the premiums for the optional services contracts is not available. It is expected that there will be deductible and coinsurance provisions under the optional services contracts.

---

[1] Maximum of $25.00 per person and $50.00 per family in a year, and 20 per cent. of drug and nursing accounts after the deductible has been paid.

[2] Thirty-four approved carriers. Only the non-profit Alberta Blue Cross Plan does not also sell Alberta Medical Plan contracts.

[3] Fifty per cent. of all coinsurance charges; for deductibles between 80 per cent. and 60 per cent. for families and between 60 per cent. and 20 per cent. for single persons, depending upon their taxable incomes.

Cost Sharing by Beneficiary

As stated previously.

Administration

(a) Existing Alberta Health Programme

Approved carriers set and collect premiums, enrol residents, assess claims, and make payments to physicians for insured services provided to covered persons. Premium charges for subscribers of both the Alberta Medical Care Plan and Extended Health Benefits Plan, must be shown separately. Also, all arrangements must be under separate financial accounting systems.

The Minister of Health approves carriers. The Medical Services Division of the Department of Public Health handles all arrangements on subsidies.

The Co-ordinating Directorate, a committee with representatives of the Minister of Health, Alberta College of Physicians and Surgeons, Canadian Health Insurance Association and Medical Services (Alberta) Incorporated, co-ordinates the Alberta Health Programme, approves changes in maximum premium rates and mediates problems between subscribers and carriers.

Alberta Medical Carriers Incorporated in a non-profit agency to which every approved carrier must belong. It operates a special financial pooling arrangement among the carriers for persons 65 years and over and for extra-risk persons under 65 years.

An assessment committee with representatives from the Alberta College of Physicians and Surgeons, the insurance carriers, and Medical Services (Alberta) Incorporated, mediates problems between doctors and carriers and a liaison committee with representation from the Minister of Health, the Canadian Health Insurance association, the Alberta Hospital Association and the Alberta Pharmaceutical Association mediates problems between those providing benefits and the carriers.

(b) Alberta Health Plan

The Minister of Health is responsible for the administration and operation of the Plan. The Lieutenant Governor-in-Council (Provincial Cabinet), may make regulations on an extensive range of matters related to the Plan. These details are not available at the time of writing this monograph.

A new co-ordinating directorate appointed by the Minister of Health and consisting of an employee of the Department of Health as Chairman, three persons nominated by the approved carriers, one person nominated by the College of Physicians and Surgeons of Alberta and one representation of all associations providing insured services, other than physicians' services, may make recommendations to the Minister of Health on approving carriers, the operation of the Act and its regulations, any matters referred to it by the Minister or

any committee set up under the regulations, and exercise any other functions assigned by the regulations. An advisory committee may also be established to consider, at least once a year, the operation of this Plan.

The Lieutenant-Governor-in-Council may establish a programme to provide financial assistance in cases where because of sickness or disability a resident is faced by unforeseen and unduly burdensome expenses on his financial resources.

The Act establishing Alberta Medical Carriers Incorporated is to be repealed as of 1 July 1967.

Right of Appeal

(a) Existing Alberta Health Programme

Matters related to eligibility are the responsibility of the co-ordinating directorate and on subsidies of the Medical Services Division of the Department of Health. Appeals related to the quality or quantity of care may be made to the co-ordinating directorate, the College of Physicians and Surgeons of Alberta as the provincial medical licensing authority, and the courts, if deemed necessary.

(b) Alberta Health Plan

At the time of writing this monograph the information is not available but presumably appeals, depending on the subject, will be possible to the Minister, the College and the courts.

(4) British Columbia Medical Plan

Scope and Qualifying Conditions

As of 1 September 1965, any resident is eligible for enrolment in the Plan for himself and his dependants[1] on registration and payment of the premium to the Plan. There are no group contracts. There are annually three open enrolment periods of one month each. Coverage begins the first day of the month following the end of the open enrolment period (15 to 45 days waiting period). There are no waiting periods for particular benefits. If a person is insured for the same services with another agency, the Plan will pay only the difference between the amount of a claim and the amount payable under the other coverage. Persons eligible for coverage for the same service under any other federal or provincial government programme, such as those for public assistance recipients, the Canadian Armed Forces, the Indian Health Services, are ineligible for coverage.

---

[1] Dependants include the spouse and dependent unmarried children or wards under 21 years or in full-time attendance at an educational institution and who is dependent on the subscriber and who is not eligible for medical care coverage through his own employment.

As of March 1967, 378,879 persons, or 20 per cent. of the population of British Columbia, were covered under the Plan.

Range of Benefits

Benefits are provided on a first-dollar coverage basis for as long as medically necessary under individual contracts. They are:

Doctors' Services - preventive, diagnostic, obstetric and therapeutic treatment at home, in the office or a hospital. Consultations and specialist services at specialist rates on referral only.

Diagnostic X-rays - by a physician.

Anaesthesia - by a physician.

Laboratory services - requested by a physician.

Radiological therapy - X-ray, radium, cobalt, isotopes, under supervision or on orders of a physician.

Psychotherapy - on referral to a psychiatrist, on basis of $300.00 per patient at specialist rates and then at general practitioner office visit rate.

Osteopathic services - no dollar limit.

Special nursing - up to $40.00 per person per year on medical advice.

Physiotherapy - on medical referral up to $50.00 per person per year.

Orthopedic treatments - on medical order up to $25.00 per person per year.

Chiropractic and naturopathy - up to $50.00 per person and $100.00 per contract per year. X-rays and services outside British Columbia not insured.

Payments are made to only one physician, surgeon or osteopath, for a single illness, except on medical referral or prior Plan approval.

Exclusions are diagnosis and treatment for cosmetic effect for persons over 15 years (except on prior approval), examinations for glasses, alcoholism, drug addiction, voluntary abortions, tuberculosis, venereal disease, disease or injury from criminal code infractions, routine physical examinations, dentistry, podiatry, prosthetic appliances, drugs, ambulance services and services provided under other legislation.

Out-of-province benefits are similar except where specifically excluded as noted above.

Cessation of Protection

Benefit coverage ceases 90 days after a change of residence to outside British Columbia. A contract is renewable for the lifetime of the contract holder, and is terminated only on failure to pay the premium at the end of the period for which premiums have been paid. If a contract holder fails to pay his premium, he may rejoin on payment of the premium in the next open period.

Financing Arrangements

Individual, first-dollar contracts only are sold by the Plan at an annual total premium of $60.00 for a single subscriber, $120.00 for a family of two, and $150.00 for a family of three or more. Premiums are payable monthly, quarterly, semi-annually or annually. Approximately 40 per cent. of revenues currently come from premiums.

The province will subsidise the premiums of people with little or no taxable income in the previous calendar year as follows[1]:

No taxable income	- 90 per cent.
Taxable income $1.00 - $1,000.00	- 50 per cent.

The province may pay up to $2,000,000.00 annually to the Medical Grant Stabilisation Fund to absorb the extra costs of persons with high medical expenses rather than to distribute the costs among all premium payers, to make up any Plan deficit prior to an increase in premiums, and to allocate for cost changes due to an increase in the cost of living. Payments from the Fund must be authorised by the Provincial Secretary.

Cost Sharing by Beneficiary

There is no cost sharing except for limits on certain benefits as previously noted.

Administration

Administration is by a non-profit agency incorporated under the Societies Act of British Columbia with a board of six directors appointed by the Government, three on recommendation of the British Columbia Medical Association and three by the Provincial Secretary. Three must be doctors and a fourth may be.

Under the Medical Grants Act of 1965, there is an advisory committee to assist the Provincial Secretary to administer the Act. The Plan has been using committees of the British Columbia Medical Association to deal with problems between the Plan and physicians.

---

[1] As of February 1967, 49.99 per cent. of subscribers receive a 90 per cent. grant and 14.67 per cent. receive a 50 per cent. grant towards payment of premiums.

Right of Appeal

Matters related to eligibility may be taken to the Plan. Appeals related to the quality or quantity of care may be made to the Plan, to the British Columbia College of Physicians and Surgeons as the provincial medical licensing authority, and the courts if deemed necessary.

Special Note

Under legislation (Medical Services Act, 1967), currently before the Legislature, a provincial medical services commission of up to three members is to be appointed to be responsible to a minister, to be designated, for the administration and operation of a voluntary medical care insurance plan for the province. The commission would carry out its programme, including existing non-government carriers, or do so directly by taking over their functions. The commission will establish an accounting system approved by the Minister of Finance and its books will be open for inspection. The Comptroller-General will audit the books of the commission. No date has been set for implementation of the Act.

(5) Ontario Medical Services Insurance Plan

Scope and Qualifying Conditions

Any person who has resided in Ontario for the preceding 90 days and who is not enrolled as a group contract subscriber with a voluntary plan or is not covered under other federal or provincial legislation, such as for members of the Canadian Armed Forces, or under the Indian Health Services, may purchase medical insurance for himself and his dependants. The government automatically pays the premiums for any person and his dependants covered under public assistance allowances and for old-age security pensioners declared eligible by the Ontario Department of Public Welfare.

For persons who enrolled during the initial open enrolment period from 1 March to 16 May 1966, the Plan began covering payments on 1 July 1966. Those who enrolled after 16 May 1966 do not become eligible to receive benefits until three months after acceptance of their application. There are no additional waiting periods for particular benefits.

When a person subscribes during an open enrolment period other than the initial one, coverage becomes effective the first day of the month following the closing date of the open enrolment period. However, when a subscriber to a group medical insurance contract with a private carrier ceases to be so covered he may apply for O.M.S.I.P. coverage within 30 days of the termination of the private group contract, and his O.M.S.I.P. coverage becomes effective on the date of receipt of his application and premium payment. In actual practice and in the interest of continuity of coverage provided the above conditions are met coverage becomes effective on the day following termination of the previous private carrier group contract.

Also where a dependant becomes 21 years of age or person qualified as a resident after the end of an open enrolment period if he applies and pays the premium within 30 days of his birthday or the day he qualifies as a resident, coverage takes effect the first day of the month following the date of application and payment of premium. Again in actual practice and in the interest of continuity of coverage, dependants who reach 21 years and apply within the above time limit may receive coverage effective from the 21st birthday.

As of 1 March 1967, approximately 1,820,000 people, or 26.5 per cent. of the provincial population, were covered in O.M.S.I.P.

Range of Benefits

There are no limitations on the number or the duration of services for which payment may be made so long as they are deemed medically necessary. Practically all physicians' services for subscribers and their dependants whether provided in the home, in the doctor's office, or in hospital are covered. These include diagnosis, treatment, medical care and surgery. The Plan also pays for laboratory services in clinical pathology when ordered by a physician, billed by a physician and performed under the direction of a physician, other than those matters covered under the Ontario Hospital Services Plan. It pays also for specific surgical procedures performed in a hospital by a dental surgeon on the staff of the hospital. These include surgical removal of erupted, unerupted or impacted teeth, exposure of teeth for orthodontic treatment and treatment of injuries to soft tissue within the mouth.

Exclusions are services provided under other federal or provincial legislation such as for the Canadian Armed Forces, Workmen's Compensation and laboratory and diagnostic procedures provided as hospital services under the Ontario Hospital Services Commission Act. Also excluded are services provided by a physician for conditions that are not detrimental to the health of a covered person, such as services for cosmetic purposes only. Other exclusions are examination of the eyes by refraction, travelling expenses for the physician, and advice by telephone, or any examination or service required by a third party for insurance or employment.

Out-of-province benefits are covered at the O.M.S.I.P. rates for Ontario or the amount actually charged whichever is the lesser amount.

Cessation of Protection

When a person covered by O.M.S.I.P. ceases to be a resident of Ontario his coverage may be terminated 90 days after the date of ceasing to be a resident. A contract may be cancelled for misrepresentation or fraud as to material fact. If a subscriber fails to pay his premium, he may be reinstated on payment of the required amount on the same basis as new subscribers. In practice, consideration is generally given to valid reasons for non-payment on time. The new health insurance registration board will handle these matters in the future.

Financing Arrangements

As already noted, only individual and family contracts are provided. No group coverage is included. Voluntary non-profit and private insurance carriers continue to operate separately outside the provisions of O.M.S.I.P., and may provide both group and individual contracts of varying types. Annual premiums for O.M.S.I.P. coverage are:

Single person	- $ 60.00
Family of two	- 120.00
Family of three or more	- 150.00

Premiums may be paid quarterly, semi-annually or annually. As of an amendment in April 1967, premium payments under O.M.S.I.P. and Ontario Hospital Services Plan are made to a newly established health insurance registration board.

Persons unable to continue to pay their medical insurance premium because of lack of income due to unemployment, illness or disability, may apply to the health insurance registration board for temporary assistance toward continuing coverage. Application must be made within the first 30 days of default for assistance in payment of premiums during the period of unemployment, illness or disability. As noted previously the province pays the full premium for persons in receipt of public assistance allowances and for old-age security pensioners declared eligible for such assistance by the Ontario Department of Public Welfare.

As well, the province subsidises the premiums of residents who have lived in Ontario for the preceding 12 months and who meet certain income tests. The subsidies are as follows:

Single person or families with no taxable income in the preceding year	- 100 per cent.
Single person with taxable income from $1.00 to $500.00 or family of two with income from $1.00 to $1,000.00	- 50 per cent.
Family of three or more with taxable income from $1.00 to $1,500.00	- 60 per cent.

Of the estimated 700,000 individual and family contracts in force at the end of 1966, no premium payments were required on 525,000. Of the 525,000 a total of about 400,000 holders were welfare recipients and the remainder were not able to pay premiums. Another 40,000 contract holders paid only partial premiums, the balance being paid under the subsidy provisions of the legislation.

Cost Sharing by Beneficiary

Under the terms of the Plan no direct payment is made by the beneficiary at the time of receiving service. However, should a

physician wish to bill the patient directly rather than to bill the Plan directly he is free to charge a fee as he sees fit. The Plan will pay physicians' accounts at the rate of 90 per cent. of the current Ontario Medical Association tariff, including amendments in it as of 1 April 1967, and will reimburse patients billed directly by a physician on this basis. A proportion of patients may, therefore, have additional payments to make to physicians.

Administration

The Medical Services Insurance Division of the Ontario Department of Health, under the direction of the Minister of Health, is the administrative agency. The new health insurance registration board will be responsible for enrolment for benefits, contract and premium payment matters, and the maintenance of a central registry and records for insured persons under O.M.S.I.P. and the Ontario Hospital Services Plan. As well, a seven member medical services insurance council appointed by the government acts as advisor to the Minister in the administration of the Medical Services Insurance Act of 1965 and its subsequent amendments, and may make recommendations on any matter related to O.M.S.I.P. Specifically these may include recommendations on premium rates, open enrolment periods, the nature of the medical insurance contract, granting of temporary assistance to those unable to meet premium payments due to unemployment, illness or disability, and the method of paying the physicians when the benefits based on the schedule fees the Ontario Medical Association are considered to be not proper or equitable. It also deals with any complaints or other matters related to the Act referred by the health insurance registration board or the Medical Services Insurance Division, and with appeals arising from decisions of the Medical Services Insurance Division. Five of the members of the council are from the public at large and two represent the medical profession, as nominated by the Ontario Medical Association.

Right of Appeal

Matters concerning registration eligibility, contracts and premiums, will in future be a responsibility of the new health insurance registration board.

The board guarantees to renew any subscriber's insurance contract, unless he is guilty of misrepresentation, misuse of services, or non-payment of premium. Where a contract has been cancelled the person may appeal within 30 days to the board and its recommendation will be final. Appeals about the quality or quantity of care may be made to the Plan, the council, the College of Physicians and Surgeons of Ontario as the provincial medical licensing authority, and the courts, if deemed necessary. The contract is not cancelled until the decision is reached.

3. Health Care Programmes for Public Assistance Recipients

General Comments, Scope and Benefits

As noted previously in page 8 , under the Dominion-Provincial Hospital Insurance Plans in-hospital standard ward diagnostic and treatment services and, depending upon the province selected, out-

patient services are provided free of charge to all receiving social assistance allowances and general public assistance. In provinces without premium payments coverage is automatic. In provinces using premiums coverage is provided either through payment of the premium by the province or assumption of premium costs or actual costs of care by the municipality of residence.

Programmes for medical care and other types of benefit to public assistance recipients vary in detail from province to province. Special schemes have been established in nine provinces - British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia and Prince Edward Island. Additionally Newfoundland and Labrador has provisions for explicit certification which ensure eligibility for a wide range of benefits, including for indigent people resident in cottage hospital districts who are unable to pay premiums.

Potential enrolees may include recipients and their dependants of general welfare assistance, or public assistance, mothers' allowances, blind persons and disabled persons allowances, old-age assistance, and old-age security where either special needs or means tests are applied. A number of the provinces may also include special categories of assistance, such as wards of the province and children's aid societies.

Passage of the federal Canada Assistance Plan late in 1966 (retroactively effective for cost-sharing purposes to 1 April 1966), resulted in new legislation in most provinces that permits inclusion of a comprehensive range of benefits for existing or for potential beneficiaries. In New Brunswick, Quebec and Prince Edward Island, virtually all categories of persons in need are or can now be included. Indeed, the emphasis in all provinces is upon eligibility determined solely by need regardless of age, residence or condition category.

In the territories, the federal Government assumes the cost of treatment services and patient travel for indigent Indians and Eskimos provided either by its own medical officers or by private physicians on a fee-for-service basis. Those able to pay are expected to do so. Territorial governments pay for the cost of treatment services required by other indigents.

Finally, it should be noted that social assistance allowances and public assistance allowances are primarily provided for specific purposes of income maintenance. Eligibility for these allowances and payments is determined either by a means test or a needs test, according to the provisions of federal and provincial legislation. The provision of health services is in most instances an additional benefit automatically in provinces where a health benefit's programme for public assistance recipients is provided.

4. Workmen's Compensation Programmes

Scope

Each Canadian province has a Workmen's Compensation Act which provides that in any industry to which the Act applies workers who

sustain personal injury by accident arising out of and in the course of their employment or who are disabled by specified industrial diseases are entitled to medical care and if the injury entails loss of earnings, to cash compensation. The Acts vary in scope from province to province but in general they cover all employment, including manual labour, all types of industrial undertaking, most types of commercial, wholesale, retail and service occupations, and in most provinces provincial Government employees.

Range of Benefits in Cash and in Medical Care Services

Periodic cash payments are made to a workman during the period of temporary disability. The payments are based on 75 per cent. of average earnings, subject to the maximum annual earnings allowed in the particular provincial Act. In five provinces the limit is $5,000.00; in one it is $5,600.00; in three it is $6,000.00; and in one it is $6,600.00.

An award for permanent disability is provided. It is based on the medically rated degree of disability and is subject to the ceiling of 75 per cent. of average earnings up to the allowed maximum annual earnings in a province. It usually takes the form of a monthly pension for life, but when disablement is slight, it may be paid in a lump sum.

Payments are tied to the average earnings at the time of injury or accident, either of temporary or permanent cash benefits, and do not contain an automatic cost of living increase provision. However, several provinces have established minimum payments in relation to permanent disability pensions.

In all provinces full medical aid, including medical, surgical, nursing, hospital and rehabilitation services, is provided from the date of the accident. In most provinces limited care may be provided by other personnel licensed under provincial law to practise the healing arts, such as chiropractors and osteopaths. All provinces provide a wide range of prostheses and for their repair, subject in some cases to a number of repairs per year and a dollar maximum per year. Drugs are specifically included as benefits in most provinces and may be included for practical purposes in the others. Dental aid and optical aid in relation to an injury are benefits. Transportation must be provided either by the Workmen's Compensation Board or the employer, depending upon the province.

Initial free choice of physician is the standard practice but once the selection is made the workman may not change doctors without the approval of the Board. In most provinces he must also, if required by the Board, be prepared to submit to an examination by a medical referee chosen by the Board. Special medical review boards have been established in most provinces to handle questions where medical problems are in dispute or for problem cases.

Also included in provincial Acts are special provisions for vocational retraining and placement. Some provide additional "helplessness" allowances for those requiring special care in their own homes.

Cessation of Protection

Cessation of protection for new conditions occurs when the workman leaves the covered form of employment but any conditions arising from the former covered employment will continue to be covered. A workman may request the reopening of his claim at any time if he feels new circumstances have arisen to warrant it.

Financing Arrangements

Industries covered by a provincial Act are divided into groups and employers in each group are collectively liable for the payment of compensation to the workmen employed in industries in that group. Employers are required to contribute to an accident fund out of which compensation, medical aid and other benefits are paid by the Workmen's Compensation Board. Industries are classified according to the hazard in each class and each class is liable for the cost of accidents occurring in it. However, for purposes of compensation the accident fund is a single fund. At the beginning of each year an employer is required to send to the Board a statement of the amount of the wages paid by him during the preceding year and an estimate of his payroll for the current year. The Board fixes the provisional contribution rate for each class, which will produce sufficient funds to meet all claims including cash benefits payable during the year. Assessment is made at the provisional rate on the estimated payroll for each employer in the class. At the end of the year the assessment is adjusted according to the actual payroll and the accidents experienced by the group or class. If necessary the provisional rate is altered to meet the requirements of the year.

The right to compensation is not affected by the employer's neglect or refusal to furnish information or to pay his assessment, or by his insolvency.

In addition to the general system of collective liability, there are laws of the individual liability type which provide for payment of compensation directly by the employer in certain areas of employment. In general these are public authorities and certain large corporations which are permitted to carry their own liability for accidents to their employees. The amount of compensation payable, and all other cost matters, are determined by the Workmen's Compensation Board, just as in the case for accidents in the collective liability group. Compensation and other costs are paid from the accident fund, the employer being assessed for the actual amounts involved. In the Yukon and north-west territories only the individual liability of the employer is in existence. The Alberta Workmen's Compensation Board acts as referee in disputed claims, and the ordinances covering the two territories are substantially the same as those of the Alberta Act.

Cost Sharing by Beneficiary

There is no direct cost sharing by the beneficiary at the time of receiving service.

Administration

Each Workmen's Compensation Act is administered by a Workmen's Compensation Board. There are three members in all provinces but Quebec where there are five. The members are appointed by the Lieutenant-Governor-in-Council (Provincial Cabinet). All administrative costs are borne from the accident fund. No financial assistance is presently given from the general tax revenues of any province, although in some provinces it would be allowable. Where Workmen's Compensation Boards have assumed responsibility for accident prevention education programmes the province concerned may contribute to the costs.

The Boards have the right in almost all provinces to inspect the premises of any employer within the scope of the Act to ascertain whether proper precautions are being taken to prevent accidents and whether the safety mechanisms required by law are being used. In Manitoba the Provincial Department of Labour is the responsible body for such supervision. In certain provinces the Board may assign the work of accident prevention to associations of employers known as accident prevention associations or safety associations. They operate on funds received from the Workmen's Compensation Board which are charged against the industries in the class or classes the associations represent.

Right of Appeal

The compensation to which a workman is entitled under the Act takes the place of his right of legal action and he may not sue his employer in court for damages for an injury he received in the course of his employment. - All claims for compensation are received and adjusted by the Workmen's Compensation Board, whose decision is final. In certain provinces a worker outside the collective liability system may bring an action for negligence against the employer. Where a third party is involved in an accident the Compensation Board assumes the legal rights of the workman to take an action to court. In return for this the workman is covered completely under workmen's compensation and any awards by the court come to the Compensation Board.

Any party to a claim - employer, employee, doctor or Board - may ask for a review of a claim, and there are under all boards a variety of review procedures. However, the ultimate decision of the Workmen's Compensation Board itself is final, subject to a reopening of a claim at any time on request of one of the parties concerned because of new relevant circumstances or evidence.

C. Application of Statutory Schemes and a Discussion of Experience and Problems

1. Ambulatory and Domiciliary General Practitioner Care

The general pattern of general practitioner care in Canada is that of private practice. Practitioners either work singly or in partnership and groups of varying size. They may work from offices located in their own homes or from office space which they rent or own. In a few instances the office facility may be owned by the consumers of medical care, as in the case of the community clinics in Saskatchewan and of the Sault Ste. Marie and District Group Health Association, in Sault Ste. Marie, Ontario.

Some statutory programmes for special categories of people, such as the Indian and Northern Health Services, Department of Veterans Affairs, and Workmen's Compensation Boards, provide services by full-time staff members through hospital out-patient clinics, and other clinics.

Medical licensing requirements in Canada are established by provincial Colleges of Physicians and Surgeons in co-operation with the Medical Council of Canada which sets national examinations.

(a) Provincial Hospital Insurance Plans

These are primarily hospitalisation plans and, therefore, include only services of personnel who are employed directly by the hospitals. Interns and residents are included, but not most other general or specialist doctors, who are private practitioners. Regular out-patient services at hospitals are largely restricted to teaching hospitals and to urban hospitals. The staff working in these facilities are either full-time hospital interns or are general practitioners and specialists who receive an honorarium for their services.

Patients not possessing insurance are normally expected to make some payment based on a hospital-applied means test. For patients covered under public assistance programmes or under provincial and private medical care plans the accounts are billed against the particular scheme. Generally, it is the policy to encourage patients with medical care insurance coverage to seek care from private physicians rather than from hospital out-patient clinics.

Services provided in the emergency department of hospitals are provided either by the intern staff and other hospital staff in the case of teaching hospitals and in the case of other hospitals by staff doctors in private practice who either have established a rota system with the emergency department or who come to the emergency department to care for their own patients. In all provinces emergency care within 24 hours of an accident is one of the benefits of the hospitalisation plans. Benefit coverage is only for the service of the personnel employed by the hospitals. Payment of private general and specialist doctors is the responsibility of the patient either through insurance coverage or directly.

(b) Provincial Medical Care Plans

Almost all provincial medical care plans do not operate directly any medical services of their own but make use of the services of all licensed physicians. There is free choice of physician by the patient within the obvious limits of availability and geography. Plans allow either for billing of the patient by the private physician and subsequent reimbursement of the latter at the level set by the plan or for billing of the plan directly by the physician for payment at the set fee schedule rate. In cases where the physician does not bill the plan directly but bills the patient, the patient would be responsible for any difference in the bill between the claim made by the doctor and the amount paid by the plan.

The Cottage Hospital Medical Care Plan in Newfoundland and Labrador is an exception since full-time medical staff are employed to provide general practitioner and hospital care. People have free choice of physician but in practice it is the physician providing service in the district from whom care is usually sought.

(c) Health Care Programmes for Public Assistance Recipients

In provinces with a special public assistance medical care programme the people covered may seek care from any registered physician willing to accept them as patients. The physicians are reimbursed by the programme on a fee basis using a schedule agreed upon between the provincial medical association and the provincial government. The trend is toward the inclusion of such patients under statutory, provincial medical care plans for the population as a whole. Where these latter plans allow for direct billing by the physician and reimbursement at an agreed rate, it may either be the responsibility of the patient and physician jointly to identify the fact that the patient is a public assistance recipient or where an identification card is provided there will be an indication on it that this is a public assistance patient. In these instances no extra billing is done by the physician.

In Newfoundland and Labrador, outside the Cottage Hospital Medical Care Plan districts, care to certified indigents is provided by agreement with private physicians, or in St. John's through salaried medical officers employed by the City.

In plans allowing free choice of physician, patients are free to change physicians as they wish, and physicians are free to suggest a change. In programmes where services are provided by specially employed personnel, patients are free to request a change of physician if circumstances arise which make it undesirable for them to continue to see a particular one.

From time to time there are complaints that some doctors are unwilling to accept public assistance patients. In such instances patients would have to seek care either from other physicians in the community or from hospital out-patient departments.

(d) Workmen's Compensation Programmes

Most medical work under provincial Workmen's Compensation Programmes is carried out by private physicians. The patient has initial free choice of physicians and hospital. The Workmen's Compensation Board, however, has the right under special

circumstances and for special injuries to transfer a patient to the care of a particular doctor. In almost every case they are also private physicians with special qualifications, but in a few special situations may be general practitioners. The latter involves a very few doctors whose work is unacceptable to the Board. A patient may also request a change of doctor but must show an acceptable reason.

Physicians are reimbursed on a fee basis from a schedule established by a Workmen's Compensation Board in consultation with the provincial medical association.

Most Boards also operate some type of rehabilitation hospital. In these facilities care is provided by salaried medical and other personnel, including some general practitioners.

2. Specialist Care at Hospitals for In-patient and Out-patient and Specialist Care Outside Hospitals

As in the case of general practitioners most specialists in Canada are private practitioners providing service on a fee-for-service basis. All specialists accept referred patients and also accept some patients without referral. It is common also for many paediatricians, obstetricians, internists, opthalmologists, psychiatrist, and some surgeons to accept patients directly and without referral from a general practitioner. Specialist qualifications in Canada are established by the Royal College of Physicians and Surgeons of Canada.

(a) Provincial Hospital Insurance Plans

Medical services by salaried staff such as interns and residents, some of whom may be in training for specialties, are covered under the plans but not most other medical services except for certain laboratory and radiology services. The method of payment for professional services of pathologists, medical bacteriologists, and radiologists to hospital patients has been a problem in most provinces and has not yet been settled in all cases.

(b) Provincial Medical Care Plans

Except in the Newfoundland Cottage Hospital Medical Care Plan, no physicians, general or specialist, are directly employed by provincial medical care plans for service.

As a rule, provincial medical care plans pay specialist rates only on referral. A patient is free to select his specialist, subject to the agreement of the general practitioner concerned. The latter usually recommends a specialist to his patient and generally the patient concurs.

(c) Health Care Programmes for Public Assistance Recipients

The provincial public assistance programmes do not employ salaried specialists. In most provinces, payment for specialist services is provided at specialist fee rates only on referral from a general practitioner.

(d) Workmen's Compensation Programmes

Specialists are paid on a fee-for-service basis at specialist rates only on referral from a general practitioner or on referral by the Workmen's Compensation Board itself. The patient has the right to request services of a particular specialist, subject to the agreement of the Workmen's Compensation Board. As well, a general practitioner attending a patient has the right to request the services of a particular specialist, subject to the general approval of the Board. A few specialists are employed on salary by some provincial Boards to provide service in special rehabilitation hospitals and centres.

3. Pharmaceutical Supplies

Except in specific instances, drugs outside the hospital are not usually provided under programmes presently in effect in Canada. Most pharmacists are in private practice or are employees of private retail companies.

(a) Provincial Hospital Insurance Plans

All necessary drugs in general use in the hospital are provided under the provincial hospital insurance plans. They are provided directly by the hospital concerned through the hospital pharmacy. The hospital is reimbursed under the established basis by the provincial hospitalisation authorities.

(b) Provincial Medical Care Plans

Existing provincial medical care plans do not include drug coverage as a benefit. Patients requiring drugs are expected to obtain these from private pharmacists or from hospital pharmacies at generally accepted rates.

(c) Health Care Arrangements for Public Assistance Recipients

Comprehensive drug benefits are provided in British Columbia, Saskatchewan and Manitoba. Payment for drugs under these three provinces are administered directly by the government departments concerned. In the case of Saskatchewan the province accepts financial responsibility for 50 per cent. of the cost of drugs, based on allowable charges by the pharmacist. In British Columbia, payment is based on price ceilings for a generic name list of drugs prepared by a drug advisory committee. Manitoba pays an established fee on the particular drugs provided. Other provinces do not provide drugs as a comprehensive benefit, although Ontario may pay a limited amount for drugs where financial hardship is demonstrated. Under separate welfare legislation a number of provinces, together with municipalities, do make ad hoc allowance arrangements for life-saving drugs required by indigent persons on special application. As well, most provinces provide free biological products for immunisation to all residents and insulin and drugs for special types of health problems, such as cystic fibrosis, to indigents.

(d) Workmen's Compensation Programmes

Full medical aid is provided for compensable injuries or illnesses, including drugs. Private pharmacists may provide such drugs and are reimbursed at a fee schedule established by the provincial Workmen's Compensation Board. Drugs in any Compensation Board facility are provided directly by the Board itself.

4. In-Patient Care in Hospital (Including Other Medical Establishments) Belonging (a) to the Body Administering the Scheme, or (b) Public Authorities or Private Bodies With Which the Scheme Has Contracted for Care and/or Beds.

Most hospitals in Canada are not owned and operated directly by the federal and provincial governments. Exceptions to this general rule are hospitals for special programmes, such as the Indian and Northern Health Services, the Canadian Armed Forces, Department of Veterans Affairs, the Newfoundland cottage hospitals, and provincial mental and tuberculosis hospitals. Most Canadian hospitals are of the public, general type and are owned and operated by voluntary associations or religious organisations. In western Canada, however, a number of hospitals are operated and owned by municipalities. This pattern on the other hand is relatively uncommon in eastern Canada. Universities in a few instances operate hospitals.

Except under special circumstances in-patient hospital care is provided only by members of the active hospital staff. Appointments to the hospital staff are made by the hospital board of directors or trustees on recommendation of the medical staff committee in the case of non-government hospitals. Hospital privileges granted to a doctor are based on his qualifications and experience. Teaching and large urban hospitals tend to grant full hospital privileges chiefly to specialists, although a number of them now have developed general practice units and have general practitioners on their staffs. Hospitals in medium and smaller communities tend to admit any qualified physician but may set limits on the type of practice permitted, according to his training and experience. Thus, a patient's family physician may follow his patient into hospital and continue to provide supervision of care, provided he has hospital admitting privileges. In any case, however, he is welcome to visit the patient and to confer with the doctor providing care. In teaching hospitals on the standard wards, it is customary for all care to be provided by the hospital interns, residents, and teaching staff. In general, also patients are free to select their hospital, subject to realities of geography and the hospital appointment of the physician caring for them.

For practical purposes the entire Canadian population is now covered under the provincial and territorial hospital insurance plans for the costs of hospitalisation[1], other than the payment of private physician. The remainder not so covered are covered under special government programmes for selected categories of people.

---

[1] See pp. 2 and 16.

(a) Provincial Hospital Insurance Plans

Only the services of medical and other personnel directly employed by the hospitals are included as benefits under the schemes.[1] Special arrangements for other medical personnel providing professional aspects of laboratory and radiological services have been made by the provincial hospital plan authorities.

(b) Provincial Medical Care Plans

Provincial medical care plans do not own and operate their own hospitals. In-patient care is provided by physicians with staff privileges who either bill the plan or the patient, as described elsewhere.[2]

(c) Health Care Programmes for Public Assistance Recipients

Provincial public assistance programmes do not own and operate their own hospitals. In-hospital care is provided by physicians with staff privileges. Until recently such medical care to indigents was provided free by these staff doctors. Where public assistance recipients are included in provincial medical care plans, the physician may bill the plans as for any other patient.[3]

(d) Workmen's Compensation Programmes

Hospital services are in general provided by special contract arrangements with community hospitals. In a few instances, where a Board operates special rehabilitation hospitals and centres, care is provided by its own full-time staff. Otherwise care is provided by the patient's doctor who is reimbursed on the fee basis established by the Board for the type of service provided.

5. Dental Care

Most dental care in Canada is provided through private dentists, although a number of local health units and health departments do provide a preventive dental service for school children. A few provide treatment services for school children for low income families and a very few for all school children on request. A number of general hospitals have emergency dental services available on an out-patient basis. Dentists are registered for practice by provincial colleges of dental surgeons.

(a) Provincial Hospital Insurance Plans

Unless a dentist is an employed member of the hospital staff, that is a dental intern, which is relatively rare in Canada, dental services would not be covered under these plans.

---

[1] See pp. 16 and 48.

[2] See pp. 23-40.

[3] See pp. 27-38.

(b) Provincial Medical Care Plans

The plans are designed to pay the cost of physicians' services but some do provide limited dental benefits. The Ontario Medical Services Insurance Plan pays for specified surgical procedures performed in hospital by a dental surgeon on the staff of that hospital. These procedures include the surgical removal of erupted, unerupted, or impacted teeth, exposure of teeth for orthodontic treatment, and treatment of injuries to soft tissues within the mouth. The Saskatchewan Medical Care Plan provides dental services when provided by a dentist in conjunction with maxillo facial surgery on referral by a physician. The British Columbia Medical Plan includes oral surgery by certificated dental practitioners. In Alberta the Health Plan does not include services provided by dentists. In Newfoundland the Cottage Hospital Medical Care Plan does allow physicians to make tooth extractions, but dental services as such are not provided, and the Children's Health Service does not include dental services.

(c) Health Care Programmes for Public Assistance Recipients

Coverage of persons for dental benefits varies from province to province. In Ontario, Manitoba, Saskatchewan and Alberta specified dental care is available to public assistance recipients and their dependants. Elsewhere, except for emergencies, dental services are limited to children under prescribed ages.

(d) Workmen's Compensation Programmes

Workmen's Compensation programmes provide dental treatment in relation to an accident or illness which is compensable. A dentist would be reimbursed on the fee basis established by the Workmen's Compensation Board.

6. Medical Care by Members of Professions Allied to the Medical Profession

Coverage varies depending on the particular programme concerned but, in general, such personnel must be under the supervision and direction of qualified physicians and be employed in institutions and facilities recognised by the programmes.

(a) Provincial Hospital Insurance Plans

Services of all personnel directly employed by hospitals are covered for in-patient services and for the specified out-patient services.

(b) Provincial Medical Care Plans

Unless otherwise specified, the provincial medical care plans restrict their services to medical practitioners and to those ancillary personnel employed by them.[1] Some of the plans do allow services provided by other personnel such as osteopaths, chiropractors, podiatrists, etc. There are usually limitations on the extent of such services.

---

[1] See pp. 6 and 23.

(c) Health Care Programmes for Public Assistance Recipients

Provincial Public Assistance Plans vary widely as noted under the description of the plans.[1] In general the services of persons directly employed by a physician or in a facility in which coverage is recognised by the plan would be included for benefits. Plans in British Columbia, Alberta, Saskatchewan, and Manitoba, cover services provided by dentists, optometrists, and other professional personnel.

(d) Workmen's Compensation Programmes

Services of all medically necessary ancillary personnel are provided under the Workmen's Compensation Programmes.

7. Personal Health Services Other Than Curative Medical Care Provided by or Through the Body Administering the Scheme

Public health units and departments throughout Canada provide community immunisation programmes for children and adults, as well as other preventive programmes. A number of public health authorities carry out mass screening programmes and some have even begun assessment clinics for older people. Biological products for immunisation, both active and passive, are provided free of charge by the provinces to any practising physician, although he is permitted to make a charge for the service provided.

Specific services of the personal type other than curative medical care which are allowed under various schemes described vary from plan to plan.

(a) Provincial Hospital Insurance Plans

The plans are designed for in-patient hospitalisation care and for selected out-patient diagnostic and emergency services. Accordingly the non-curative services, as understood under this sub-section, would not be specifically included, although prophylactic protection against tetanus would, for example, be covered in accident cases.

(b) Provincial Medical Care Plans

Provincial medical care plans specifically include all physician services, whether of a preventive, diagnostic, treatment, or rehabilitative character, with certain specified exceptions for services provided through other public and public health programmes. Physical examinations required by a third party are specifically excluded although some of the plans do allow for an annual preventive check-up. Needless to say what may happen on occasion in plans that do not specifically allow these benefits is that some people do obtain check-ups but the plan is billed for a diagnostic or treatment visit.

---

[1] See pp. 8 and 41.

(c) Health Care Programmes for Public Assistance Recipients

Personal health services other than curative medical care are not generally included in public assistance programmes.

(d) Workmen's Compensation Programmes

Workmen's Compensation Programmes are designed for the care of illness and accident arising from employment, and as such do not generally provide personal services of the periodic check-up, preventive, and screening types. However, such services are provided frequently under the aegis of provincial departments of health through their occupational health services and through the occupational health programmes provided by most larger industries.

8. Social Services Provided by or Through the Body Administering the Scheme

Social services are rarely insured as separate items but are frequently included in comprehensive medical care and hospitalisation schemes.

(a) Provincial Hospital Insurance Plans

Where social services are provided as part of a hospital's services, they would be covered for in-patients and, as specified for out-patients.

(b) Provincial Medical Care Plans

At present social services are not included as benefits in existing provincial medical care plans.

(c) Health Care Programmes for Public Assistance Recipients

Since eligibility for public assistance medical care benefits is dependent upon identification for general public assistance, social services are provided at the stage of determining eligibility for public assistance. As well, certain counselling services may be provided through the general programme. They are, however, not specifically a part of the medical care plans.

(d) Workmen's Compensation Programmes

Extensive social work, counselling, and placement services are provided by the staff of the provincial Workmen's Compensation Boards.

9. Medical Certification of Incapacity for Cash Benefits

At the present time cash benefits are provided only under provincial Workmen's Compensation Board programmes. Since the programmes are based upon providing benefits for disability due to illness or accident arising from employment, medical certification is an important aspect.

10. Continuing Medical Record of Persons Protected - Procedures, Notably When Patient Transferred Among Physicians, Clinics, and/or Hospitals

No statutory schemes have requirements in this field. However, all programmes maintain records under suitable legal protection for the patient concerned, and data may be obtained when the patient transfers from one programme to another. In practice this may sometimes be difficult to achieve. For practical purposes, therefore, a continuing record would only be reasonably certain where the person returns to the same facility or physician for service.

11. Professional Secrecy Within the Scheme

Professional secrecy is protected under all statutory schemes within the limits possible for adequate care to be provided. Medical and other personnel providing care and employees who have access to records maintained by the various schemes are required to maintain ethical standards in protecting confidential information. Should such information be divulged to other than proper personnel directly concerned in a patient's care, then the persons revealing such information would be subject to prosecution in the courts. Data are made available for research study purposes but research personnel are required to maintain ethical standards in the use of such information. Thus, provisions for professional secrecy are not as a rule a part of the statutes themselves although they may be implied in the statutes concerned but are part of the general legal basis under Common Law by which professional health services are provided in Canada.

12. Internal Control of Benefits

In general in Canadian schemes, control of the quality of benefits is the responsibility of the professional personnel or of the administration of the institutions and facilities concerned. In the case of hospitals this is carried out through the organised hospital committees, such as staff credentials committees, tissue committees, maternal and child health committees, mortality committees, etc. Hospitals are also required to meet certain provincial standards in order to be allowed to provide services. The widespread use of the hospital accreditation programme provided by the Canadian Council on Hospital Accreditation, which is a voluntary body sponsored by the Hospital and Medical Associations, plays an important role in the maintenance and upgrading of hospital standards. Until recently this programme could only be applied to hospitals over 50 beds but arrangements have now been developed for smaller hospitals. Accreditation is of course a voluntary procedure but it is unusual for hospitals to be unwilling to seek accreditation. As well, on a voluntary basis, there are private programmes for hospital audit which are available on a commercial basis and are increasingly being used.

Professional services outside the hospital are the responsibility of the provincial Colleges of Physicians and Surgeons, and the appropriate governing bodies of the other professional groups concerned. These bodies have been granted self-governing rights in licensing and the control of ethics and discipline by the provincial

legislatures and are therefore responsible to the legislatures for carrying out the responsibilities in a proper manner.

Health personnel who commit criminal offences are subject to criminal action in the courts.

However, a number of the statutory schemes have measures for the internal control of benefits in relation to quality, volume, costs, and for the prevention of abuse either by the beneficiary or by those providing service.

(a) Provincial Hospital Insurance Plans

The federal Government has established certain broad principles for the type of service which must be provided before it will share in costs with the provinces. Otherwise it leaves control entirely to the provinces and pays them according to specific dominion-provincial agreements.

The provinces all maintain budgetary controls. All hospitals must submit annual budgets and these budgets are subject to scrutiny and change by the provincial hospital authorities. Payment to the hospitals is on a variety of bases. Precise methods of payment will be described in Section D.[1] Hospitals are required to have common administrative procedures and records so that these may be scrutinised by the provincial authorities. All provincial plans have admission sheets and long-stay forms which must substantiate the hospitalisation is medically necessary. The provincial plans have the right to send review physicians to hospitals to check on questionable cases. Most of the provincial plans now maintain statistical data on utilisation rates, admission rates, and other matters related to hospital utilisation in their provinces. Where unusual circumstances are revealed they endeavour to look into them in order to determine the cause and rectify it, if possible. It should finally be noted that admission to hospital is only possible on the order of a qualified physician.

Those interested in medical care research feel that greater attention should be given to the question of quality than is generally the case in most provincial plans.

(b) Provincial Medical Care Plans

Provincial medical care plans operating primarily on a fee-for-service basis require itemised accounts before they will make payment either to the patient on a reimbursement basis or directly to the physician. Questionable accounts are subject to review by qualified physicians and where necessary follow-up is made to the physicians concerned. Payment is made only for services actually rendered and where demand is medically necessary. Abuse by beneficiaries is essentially the responsibility of individual physicians to control although through the use of statistical profiles of patient histories, the plans are developing insights into abuses that can be assessed and controlled administerially, such as "shopping" around for doctor care.

---

[1] See p. 64.

Questions of quality control are still largely left to the appropriate provincial Colleges of Physicians and Surgeons as the professional governing bodies. However, the plans do have some impact on the quality of care provided because although payment is based on provincial medical associations' fee schedules, the government usually in consultation with the provincial medical associations and by mutual agreement determines the level at which payment is made. In general some degree of pro-rating of accounts is involved. Those interested in medical care research feel that greater attention and study should be given to the question of quality of care provided as well as to the present emphasis on payment for services.

(c) Health Care Programmes for Public Assistance Recipients

Controls are similar to those under provincial medical care schemes. Care is only provided as medically necessary and according to the terms specified in a programme. The schemes are essentially payment oriented and questions of quality are largely left to the professional and hospital groups providing care. However, the plans keep records and look into cases which are questionable, either through medical review committees or through control doctors, and take appropriate action. Some carry out further superficial analyses for control purposes. Payment is based on an agreed fee schedule between the provincial medical association and the provincial government, usually subject to a degree of pro-rating of accounts.

(d) Workmen's Compensation Programmes

Workmen's Compensation Boards enter into agreements for specific hospital services provided by community hospitals. The quality and volume of work done would be controlled therefore as for any other hospital services in a hospital. The Board also has the right to look into any services which it believes to be questionable. This is equally true for the payments to physicians and other forms of health service. Full statements must be provided of services rendered and of follow-up on a patient. The Board has the right to ask fuller explanations and investigate any situations which it believes to be open to question. Extensive records and statistical data are kept by most Boards, partly for control use.

13. Procedures to be Followed When Care is Sought

(a) Provincial Hospital Insurance Plans

In provinces which do not have a premium system, people may be required to show evidence of being a bona fide resident of the province concerned. In provinces in which premiums are paid an identification card is issued and is presented when hospitalisation is obtained.

(b) Provincial Medical Care Plans

An individual or family identification certificate is issued to all participants in these plans and is presented when benefits are sought.

(c) Health Care for Public Assistance Recipients

In most provinces, people who are receiving public assistance allowances are issued an identification card which is presented when medical assistance is sought. In Newfoundland and Labrador, they are individually certified at the time care is desired by the local welfare officer.

(d) Workmen's Compensation Programmes

Every employee in covered employment is automatically entitled to receive benefits on the basis of claim reports from employer, employee, and attending physician. The Workmen's Compensation Board determines whether the claim is acceptable.

14. Records

The panel system is not used in statutory schemes in Canada. Individual records are kept by physicians, hospitals, and other facilities which provide care for individuals and families. Certain statistical records are kept by the various government programmes, largely required hospital statistics and billing statistics for medical care plans. Data on benefits provided to individual beneficiaries are potentially available in most statutory schemes but in many cases are not routinely compiled unless specific research or other reasons for doing so arise. The general emphasis in routine patient reporting is on regional or provincial averages for utilisation and payment, etc.

D. Methods of Remunerating Members of Medical and Allied Professions and of Paying for Hospital Facilities, Pharmaceutical Products, and Other Medical and Surgical Supplies

1. Methods of Remunerating and Affixing Rates of Remuneration for Members of Medical and Allied Professions

(a) Provincial Hospital Insurance Plans

Medical and other professional and technical personnel who are hospital employees and who provide services to patients on an in-patient or out-patient basis under the Hospital Insurance and Diagnostic Services Programme in a province are paid on a salary basis by the hospital for all services which they provide. These salaries are part of the budget which the hospital submits to the provincial hospital authorities on an annual basis.

The exception to this rule in certain of the provinces is that of pathologists, medical bacteriologists, and radiologists. Payment to these medical personnel for the professional component of services provided to hospitals may be on an agreed salary retainer[1] or on a fee-for-service[2] basis, depending upon the general provincial arrangements by the provincial hospital authority with the professional groups concerned. In some instances, however, the type of agreement may even vary from hospital to hospital where the hospital board and these doctors have special agreements. In any case the hospital is reimbursed for such payments as part of its over-all payment from the provincial hospital authority for its operating costs.

(b) Provincial Medical Care Plans

The federal Medical Care Act of 1966 states that a provincial plan acceptable for federal assistance should "... provide for the furnishing of insured services ... by the payments of amounts in respect of the costs of insured service in accordance with a tariff of authorised payments established or in accordance with any other system of payment authorised by provincial law on a basis that provides for reasonable compensation for insured services rendered by medical practitioners, and it does not impede or preclude either directly or indirectly whether by charges made to insured persons or otherwise reasonable access to insured services by insured persons ..." It is obviously intended that the tariff or payments to doctors and other health personnel under the Act should be set by the provinces. It is noteworthy that the Act allows for flexibility in method of payment. Thus practitioners who wish to

---

[1] Generally subject to annual negotiation and related to the volume of work.

[2] In some provinces, attempts have been made to determine the professional medical portion of the cost of laboratory, X-ray, and pathological services in order to try to establish suitable fees for the doctors and a lump-sum payment to the hospitals for the non-medical portion. A recent complication has been the development of equipment capable of doing a number of tests mechanically and simultaneously on a sample. The whole question of payment under such circumstances requires rethinking.

practise in a setting other than that of an individual, self-employed person could be included, for example, physicians who are salaried in hospitals, doctors in group practice wishing to receive remuneration on some type of contractual basis, and salaried personnel practicing in isolated areas. It will remain to be seen to what extent these alternative methods of payments may be used. Certainly at the present time existing provincial medical care plans with the exception of Newfoundland are paying doctors on a fee-for-service basis.

British Columbia Medical Plan

The Plan pays physicians for services provided at a minimum of 90 per cent. of the fees listed in the current schedule of the British Columbia Medical Association. Payments are at 90 per cent. of the general practitioner fee and, on referral by another physician, at 90 per cent. of the specialist fee in the schedule for the service rendered. When an insurance person seeks specialist services without referral by another physician the Plan makes payment for such services at 90 per cent. of the general practitioner rate in the schedule. In emergency cases the Plan may on advice of its medical adviser authorise payment at the specialist rate. The Plan pays for services to insured persons by practitioners outside British Columbia at the same rate as practitioners within the province or according to the actual charges of the practitioners, whichever is the lesser amount. A physician may collect additional charges from the subscriber when there is a private arrangement to that effect between them. The Plan is not responsible for these additional amounts. The Plan will make either direct payments to physicians for insured services provided to covered persons or it will reimburse subscribers for 90 per cent. of amounts paid to physicians for accepted, insured services on presentation of receipted amounts. Practically all amounts paid out to date have been paid directly to physicians for insured services.

Under an agreement between the British Columbia Medical Plan and the British Columbia Medical Association, an arrangement for revisions of the schedule effective 1 January 1967 and 1 January 1969 has been included. This has been done in an effort to keep the aggregate payment for all physicians in line both with the changes in the cost of living and the level of earnings in British Columbia. A composite index has been developed using the Consumer Price Index for the City of Vancouver, prepared by the Dominion Bureau of Statistics, and a second index constructed from the Dominion Bureau of Statistics' Industrial Composite of Average Weekly Wages and Salaries in British Columbia. An average is collected for these two indexes and should the average index called the Composite Index increase in the years prior to a fee schedule revision the then current fee schedule will be revised, so as to give a percentage increase in aggregate payment to all physicians equal to the percentage change in the Composite Index. In adjusting the fee schedule to achieve accurate payments to all physicians by the British Columbia Plan and also by the Medical Services Association Plan, a professionally-sponsored, non-profit plan, the provincial Medical Association has agreed to use the combined experience of the two plans regarding frequency of utilisation per fee schedule item for the relevant years, that is, 1967 and 1969. The percentage increase in the Composite Index has an upper limit set by the agreement at which time the limit will apply or the physicians may request negotiation to establish a higher percentage increase.

Alberta Health Plan

The non-profit plan, Medical Services (Alberta) Incorporated, covers about 80 per cent. of the persons insured under the present Alberta Medical Plan and makes payment for physicians' services at the rate of 90 per cent. of the fees listed in the current schedule of the Alberta College of Physicians and Surgeons. The commercial insurance companies which cover the remainder of beneficiaries must pay doctors the full fees listed in the current schedule of the College. The existing Extended Health Benefits Plan which provides additional benefits, some of these being through non-medical, private practitioners of varying types, pays at rates established by the province for the particular services in consultation with the practitioner groups concerned.

Physicians and other professional personnel providing service on a fee basis may either bill the various carriers directly or may bill the patient who is reimbursed at the rate that the carrier would have reimbursed the physician. Any additional charges made directly to the patient are the responsibility of the patient concerned.

Under the Alberta Health Plan to come into effect on 1 July 1967 all claims for benefits under standard contracts will be paid from the new Alberta Health Fund to be administered by the Provincial Treasurer. Regulations about the methods and amounts of payment to those providing benefits under the Plan are not available at the time of writing this monograph. However, there seems to be no reason to suspect that there will be any fundamental departure from the existing methods and amounts.

Ontario Medical Services Insurance Plan

O.M.S.I.P. makes payment to physicians for insured services at 90 per cent. of the current fee schedule of the Ontario Medical Association. When an ancillary or incidental matter is changed in the fee schedule or a new procedure is added between revisions of the fee schedule and when such changes are accepted by the Minister of Health, the Plan will pay 90 per cent. of the schedule as amended. There has so far not been complete agreement on whether the Medical Association may alter its schedule without due consultation with the Minister. This occurred in the early spring of 1967. The Minister finally accepted the revised schedule and agreed to pay at the 90 per cent. rate but indicated that such a step would not be looked upon favourably in the future unless due consultation had taken place. Specialist rates are paid when the specialist rendering treatment does so within his particular speciality and consultation rates are paid only when the patient has been referred from his attending doctor to a particular specialist. Physicians may submit bills directly to O.M.S.I.P. and be paid directly. There is no contractual arrangement under which doctors paid directly by O.M.S.I.P. are bound to accept the payment to them by the Plan as payment in full. Most appear to be doing so to date. On the other hand a doctor may bill the patient directly and in such a case O.M.S.I.P. will reimburse the patient at the rate it would have paid the physician. Any additional charges to the patient are then the responsibility of the patient.

Saskatchewan Medical Care Plan

Payment for physician services is based on the schedule of minimum fees of the College of Physicians and Surgeons of Saskatchewan and is at 85 per cent. of the fees listed. The Medical Care Insurance Act makes provision for three methods by which the Medical Care Insurance Commission may make fee-for-service payments:

(1) Direct payment: the physician may choose to submit a bill for an insured service provided to a beneficiary directly to the Commission for payment. This comprises a contract or agreement about the particular service, so that he in effect agrees to accept Commission payment as payment in full. Specialists are paid at 85 per cent. of their rates in the schedule when the item is not listed in the general practitioner tariff. Generally, however, payment for specialist services is calculated at the general practice fee when the beneficiary is not referred to the specialist for a specific condition. Thus, the beneficiary may be liable for the difference between the specialist fee and the general practice fee in these instances.

(2) Payment through approved health agencies: a physician may become a medical member of an approved health agency. At the present time only two such agencies are in operation, Group Medical Services, Regina, and Medical Services Incorporated, Saskatoon, both of which are non-profit plans sponsored by the medical profession. Two agencies, formerly approved and operated, one by a co-operative group and a second by private insurance agencies, as group agencies were discontinued at their own request in 1964 and 1965 respectively. Physicians who become medical members of the approved health agencies agree to submit all bills for service to lay or subscriber members to the agency for payment. The agency in turn submits the bills to and receives payment from the Medical Care Commission and then forwards payment to the physician. In submitting an account to an approved health agency a physician agrees to accept payment as payment in full, subject to the same qualifications under the direct payment method in the case of certain specialists' services.

(3) Payment to patient: where the patient or the physician is not a member of an approved health agency or they are not members of the same one and if the physician chooses not to bill the Commission directly, he may submit his bill to the patient. The amounts of fees are private matters between the physician and the patient. The patient, however, may submit the bill to the Commission and receive payment for the services, if they are suitably itemised insured services, to a maximum of 85 per cent. of the schedule of fees.

Two other methods of payment may be used:

(1) Direct payment (fixed-sum contract): there is provision for a physician, subject to acceptance by the Commission, to be paid an agreed sum on a periodic basis, in lieu of a fee for each service. This method of payment is used in some under-doctored areas. In 1966 two physicians were paid under the arrangement. The physician reports the items of service provided, so that his volume of work may be periodically reviewed.

This is an interesting development and is essentially applicable in isolated and northern areas, but could have wider application if the physicians and the Government mutually agreed.

(2) Private agreements: the act also provides that where a physician advises the beneficiary that he wishes to treat him on an entirely private basis and the beneficiary agrees only the provisions of the Act will apply relating to registration and payment of premium.

Commission Experience, 1963 and 1966

	Claims Received by Method of Billing[1]	
	1963	1966
(a) From provider of service	21.1%	32.6%
(b) From beneficiaries	10.8%	5.2%
(c) From approved health agencies	68.1%	62.2%

Cottage Hospital Medical Care Plan, Newfoundland and Labrador.

Medical services under the Plan are provided by doctors employed on salary by the provincial Department of Health. Doctors employed by the three voluntary plans, the International Grenfell Association, the Notre Dame Bay Memorial Hospital Association, and the M.J. Boylen Hospital, which provide services to people in certain areas of Newfoundland and Labrador, are also paid on a salary basis.

Children's Health Service, Newfoundland and Labrador

Under an agreement with Newfoundland Medical Association, remuneration to private practitioners who provide in-hospital and out-patient services under the programme is at fixed rates which are generally 80 per cent. of the current fee schedule of the Association. A Medical Service Committee set up jointly by the Department of Health and Newfoundland Medical Association determines the proper fee scale in unusual medical procedures.

(c) Health Care Programmes for Public Assistance Recipients

The methods of remunerating members of the medical and allied professions for services rendered to public assistance recipients show considerable variation between provinces. In British Columbia and Alberta physicians are paid, within built-in ceilings, from funds especially set up for the purpose. In Saskatchewan physician care and its payment are included under the Medical Care Plan for all residents. Manitoba pays doctors on a fee-for-service basis through a medically sponsored non-profit plan. The Ontario physician payments are made according to a fee schedule through the Ontario Medical Services Insurance Plan. Physicians in Quebec are paid directly by

---

[1] Annual Report, 1966, Saskatchewan Medical Care Insurance Commission, p.33.

the Medical Assistance Service of the Department of Health. Within the Cottage Hospital Medical Care Plan of Newfoundland and Labrador, physician care is provided by salaried personnel employed by the Department of Health.

(d) Workmen's Compensation Programmes

Doctors and other staff who are employed by a Workmen's Compensation Board to provide services through its own rehabilitation centres and hospitals are paid a salary. All personnel employed by hospitals with which a board has contract arrangements for caring for in-patients are paid by the hospitals. Payment to the hospitals under the contract includes coverage for their services. Payment to private doctors, dentists, and other persons permitted to give treatment in some of the provinces, such as chiropractors, osteopaths, etc., is on a fee-for-service basis. The fee schedule is fixed by the provincial Workmen's Compensation Board concerned, but corresponds closely to the prevailing fee schedules of the medical and other professional associations of the particular groups concerned in the province.

2. Payment for Hospital Facilities Provided to Beneficiaries at or through Hospitals not Belonging to the Body Administering the Scheme

(a) Provincial Hospital Insurance Plans

Public assistance recipients are now covered as are other citizens for hospitalisation benefits under the provincial and territorial hospital plans. The federal Government pays on the average 50 per cent. of the operating costs, based on the formula previously described,[1] to the provincial plan authority.

(b) Provincial Medical Care Plans

These plans do not cover hospitalisation services but only the services of physicians.

(c) Health Care Programmes for Public Assistance Recipients

Public assistance recipients are now included under the provincial and territorial hospitalisation plans for hospital care.

(d) Workmen's Compensation Programmes

Workmen's Compensation Boards in each province have entered into agreements with the provincial hospital authorities to make payment on an agreed basis to hospitals which provide services to compensation cases.

---

[1] See p. 4.

3. Payment for Pharmaceutical Products and Other Medical and Surgical Supplies obtained for Beneficiaries in and out of Hospitals from Pharmacies, etc., Not Belonging to the Body Administering the Scheme

(a) Provincial Hospital Insurance Plans

All in-patient and out-patient services provided by salaried hospital staff and supplies described as benefits are covered under the regular payments made to the hospitals by the provincial hospital plan authorities.

(b) Provincial Medical Care Plans

British Columbia Medical Plan

Special nursing services, including the cost of board, are insured up to a maximum of $40.00 per patient per year, if deemed advisable by a physician. Physiotherapy is an insured benefit when the patient is referred by a physician. The maximum benefit allowed is $50.00 per patient in any one year and payment is at 90 per cent. of the fees agreed upon by the Plan and the Association of Physiotherapists and Massage Practitioners of British Columbia. Orthoptic treatments, when rendered upon instructions of a physician, are insured benefits up to $25.00 per patient in any one year. Chiropractic services are insured up to a limit of $50.00 per patient in any one year and a maximum of $100.00 in any one year per contract. Payments are made at rates agreed upon by the Plan and Chiropractics Association of British Columbia. X-rays taken by a chiropractor and services of a chiropractor outside British Columbia are not insured. The services of naturopathic physicians are insured up to a limit of $50.00 per patient, and a maximum of $100.00 in any one year per contract. Payments are made at rates agreed upon by the Plan and the Naturopathic Physicians' Association of British Columbia. No payments are made for services of naturopathic physicians outside British Columbia.

Alberta Health Plan

All benefits under the present Extended Health Benefits Plan are subject to an annual deductible amount of $25.00 per person or $50.00 maximum for a family. The insured person must pay 20 per cent. of drug and nursing accounts after the deductible amount has been paid. Payment is by special agreement with the province and the vendors of services and supplies which are covered. Details of regulations under the Alberta Health Plan to start 1 July 1967 are not available at the time of writing this monograph.

Saskatchewan Medical Care Insurance Plan

Only medical and certain dental services are covered.

Ontario Medical Services Insurance Plan

Only physician services are covered.

Newfoundland and Labrador

Services and supplies provided to the Cottage Hospital Medical Care Programme are included free of charge; drugs are sold at cost. Services and supplies to children under the Children's Health Plan for in-hospital ward care and out-patient diagnostic services and physiotherapy are covered by the province.

(c) Health Care for Public Assistance Recipients

In Novia Scotia authorised drugs and optical benefits are provided only through physicians who receive payment through the same fund and on the same basis applicable to physician services. Pharmacists and dispensing physicians in Saskatchewan are entitled to bill at retail rates for drugs provided. Unless special hardship is demonstrated, beneficiaries are required to pay 50 per cent. of retail costs. In other provinces prescribed drugs and their appliances are supplied by vendors of the services who are in turn paid on the basis of agreed unit prices by the appropriate provincial authority.

(d) Workmen's Compensation Programmes

Drugs and other medical supplies are included as benefits. They are paid for by the Boards according to schedules established by them.

E. Rural Medical Services

Several statutory programmes in Canada have been established either basically or in part to serve the needs of rural and isolated communities.

By agreement with the territorial governments the Medical Services Branch of the Department of National Health and Welfare established the Northern Health Services in conjunction with the Indian Health Services. It serves also as a "provincial" health department in both the north-west and Yukon territories. Thus, the Indian and Northern Health Services through its hospitals, doctors, dentists, nurses and other facilities provide combined preventive and public health service, medical care and hospital service. In the north-west territory these are the bulk of health care services available but in the Yukon territory there are also a number of private physicians, dentists and non-government hospitals.

The Yukon territory has an area of 207,000 square miles in the north-west part of Canada north of British Columbia. The north-west territories cover the entire northern part of Canada, an area of 1.3 million square miles. Although they constitute two-fifths of the area of Canada, most of the land of these two northern territories is barren because of Arctic climate and poor soil and moisture conditions. Chief sources of wealth are mining, some forest lumber production, fur and fishing industries. The combined population of the two territories is about 40,000 persons, 15,000 in the Yukon territory, and 25,000 in the north-west territories; of these 21 per cent. are Eskimos, 21 per cent. Indians, and 50 per cent. others, many of these being of mixed racial origin. Although much of the population is concentrated in a few towns, others are scattered in small pockets living under low social and economic conditions.

As well the Indian Health Service provides direct services through its own personnel in parts of some of the provinces where large numbers of Indians live and the indigent percentage among them is numerous. In other areas, the Department reimburses local doctors and hospitals for services provided to indigent Indians.

Another programme which developed essentially for the needs of rural and isolated communities is the Cottage Hospital Medical Care Plan[1] which began in 1934. Over 60 per cent. of the population of Newfoundland and Labrador live in small towns and villages scattered along some 6,000 miles of coastline, where the sea may form the only means of communication. Recent economic growth has led to a vastly improved road system and under encouragement people are gradually moving into larger communities. Nevertheless, the scattered population remains a serious problem for all types of services, including health. The Cottage Hospital Medical Care Plan has salaried physicians who provide a combined public health, medical care and hospital service. They are based on cottage

---

[1] See pp. 6 and 23.

hospitals which have been established on a district basis. Similar programmes maintained by the International Grenfell Association, the Notre Dame Bay Memorial Hospital Association, and the M.J. Boylen Hospital at Baie Verte, are subsidised by the Government of Newfoundland and Labrador. In total these programmes cover approximately 52 per cent. of the population of Newfoundland and Labrador. As well the province maintains an extensive system of air, sea, and land ambulance services.

In almost all provinces with large areas of northern and sparsely settled territory, some type of air ambulance service for emergency care either directly themselves or through an agreement with private airlines is provided. As well, in many rural and northern communities the public health services attached to the local health unit provide some home nursing care, in addition to preventive and educational work. A small number of rural health units have experimented with organised home care programmes, with home nursing, homemaker and related services. Almost all provinces also have special public health programmes of a mobile character for the northern areas. These also provide a basic amount of emergency medical care.

It is the usual practice for mining, lumber, and other companies, which operate in isolated areas and which are the chief reason for the existence of a community in the region, to provide small hospitals and physicians on a full-time basis or to subsidise them to come to these communities. This is not a legal requirement but is a practical measure which the companies have introduced to attract and retain sufficient employees.

One of the earliest responses to the needs of rural and isolated populations was the development in the period immediately following First World War in Saskatchewan of the Municipal Doctor Plans. The province granted to municipalities the right to levy taxes based on a property assessment to maintain doctors on salary in order to provide services to the residents of the municipality. As time went on the province also established model contracts. Some of these programmes paid physicians on a salary basis whereas others allowed charging of limited fees for certain services. In 1920 Manitoba passed similar legislation and in 1926 so did Alberta. The Saskatchewan programmes continued until the introduction of the Saskatchewan Medical Care Insurance Act in 1962, when province-wide medical care insurance was introduced. At their peak in 1950 in Saskatchewan there were 173 municipalities with municipal doctor service, covering approximately 25 per cent. of the population and employing about 110 physicians. In Manitoba at the same period there were 17 such plans covering about 40,000 people. At present there are nine municipal doctors remaining in rural Manitoba covering under 20,000 people. The plans were never very active in Alberta. The programmes have been declining numerically and in coverage since about 1950 because the non-profit, medically-sponsored, plans were able to offer community contracts and in the case of Saskatchewan the introduction of the province-wide medical care plan.

It is of interest that under the terms of the Saskatoon Agreement of 1962 between the Government of Saskatchewan and the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Medical Care Insurance Commission retains the power to advise and assist hospital boards in municipalities to obtain the services of a resident physician when the community qualifies as an undoctored area and the local authorities have exhausted all other avenues of recruitment. Assistance may include recruitment of a physician, travel assistance, and a contractual guarantee or fixed payment arrangements with the Medical Care Insurance Commission. Two types of contracts are available. In one the physician practices on a fee-for-service basis and the Commission guarantees a minimum annual gross return and under the second a fixed payment covering all insured services is provided. In determining the level of payment the physician's training, experience, and such factors as the expected volume of service and degree of isolation, are taken into account. At the end of 1966 two contracts on a fixed payment basis were in effect.

Related to these developments in the prairies for assuring physicians' services was the passage of provincial legislation which in several provinces permitted groups of municipalities to join in providing small hospitals from local tax sources. This was the beginning of the union hospitals as they were called which today are an important component of the hospital services in the prairie provinces.

One other approach to the needs of rural and isolated areas which should be mentioned is the policy of several of the provinces, notably Newfoundland and Labrador, Saskatchewan, and Ontario, to provided bursary support for medical and dental students. In the case of Newfoundland and Labrador the grants are made for the entire seven-year period of training either in Newfoundland or elsewhere in Canada and overseas. Students who have received seven years financial assistance are obliged to serve for four years on the medical staff of the Department of Health. The remaining three years of contractual obligation may be satisfied either by entering private practice in the province or by repayment of the grant for those years. As of 1 January 1966, 114 pre-medical and medical students and 35 pre-dental and dental students were being assisted. In Saskatchewan a combination of scholarships and bursaries are used during the final four years of the medical course. Recipients must agree to practice medicine in Saskatchewan for a period of six months for each bursary year received. During the year 1965-66 31 scholarships and 94 bursaries were provided. In Ontario scholarships during the final two years of the medical and dental courses have been offered in return for an agreement to provide service in rural or isolated areas of the student's own choice on graduation. These have been extensively used by dental students but the number of medical students studying is considerably less than the number of bursaries available. Approximately 30 in total are currently held largely by dental students.

F. Relations Between Statutory Social Insurance Schemes and Public Health Authorities Including Planning and Co-ordination of Services

Reference should be made to the administrative patterns of the various schemes which have been described previously.

(a) Provincial Hospital Insurance Plans

In five provinces the administration of the plan is provided through a division of the provincial health department. This is the case in Newfoundland and Labrador, New Brunswick, Quebec, Saskatchewan, and Alberta. In British Columbia the programme is provided under the Minister of Health through a separate deputy-minister. In Prince Edward Island, Nova Scotia, Ontario, and Manitoba, provincial hospital commissions have been established. In every case they report through the Minister of Health and in many cases also through the Deputy-Minister of Health. In several provinces the Deputy-Minister of Health is a member of the hospital commission. In all provinces where there are hospital commissions co-operative relations with the health departments are being fostered by special committees at senior and divisional levels. It is interesting that in Ontario an advisory body, the Ontario Council of Health, has been established and in its subcommittees there is representation from both the Ontario Hospital Services Commission and the Ontario Department of Health which operates the medical care and public health plans in the province. Thus, in every province the provision of a good working relationship between the hospital plans and the health departments either through direct departmental arrangement or through working committees has been developed.

One should not, however, give the impression that co-ordination is as effective as it might be since this is not only a question of administrative arrangement but also of the understanding and interest of those involved in the two fields. At the moment one of the problems is a scarcity of personnel with an understanding of both public health and medical care needs. As these personnel are developed the administrative arrangements for co-ordination should become more effective.

(b) Provincial Medical Care Plans

The administration at the moment of the provincial medical care plans is quite variable as are their relationships to the health departments and hospital plans.

Newfoundland and Labrador

The administration of the Cottage Hospital Medical Care Plan and the Children's Health Service are part of the Health Department as are the hospital insurance and public health programmes.

Ontario

The Ontario Medical Services Insurance Plan is administered by a division of the Health Department.

Saskatchewan

The Medical Care Insurance Commission has been established to operate the Medical Care Plan. The Deputy-Minister of Public Health is an ex-officio member and the Commission itself is responsible to the Minister of Public Health.

British Columbia

The Medical Plan has been administered by a six-member board appointed by the Government under the aegis of the Provincial Secretary. Legislation currently before the Legislature would change this to a Medical Services Commission of not more than three members. Precise relationship both to the public health and hospital programmes in the province and the minister to which it would report have not been designated to date.

Alberta

The present programme is in part handled through the Medical Services Division of the Alberta Department of Health and in part by the Co-ordinating Directorate, representing the Minister of Health and the participating agencies and professional associations. Recent legislative changes will bring the new Alberta Health Plan, to begin on 1 July 1967, more closely under government supervision through the Minister of Health, although the Government of Alberta has indicated that it wished at present to have the non-profit and private carriers continue to act as insuring agencies on its behalf.

The patterns which will develop in the other provinces are of course not yet determined. However, it does seem likely that because of the requirement in the federal Medical Care Act of 1966 for programmes to be publicly administered either directly by the provincial government or a provincial government agency, if federal sharing is to be possible, that efforts will be made by the provinces to assume either direct operation through the Health Department or through an agency which will have close working relations with the Health Department and with the hospital programmes. Again the question is not merely one of administrative structure, although this can make a great difference in the possibility of close working relationships. It is also one of the availability of suitable administrative personnel.

Some of the provinces still appear to look on their medical care programmes, and even to some extent their hospitals programmes, as essentially payment mechnisms for physicians' and hospital bills and have paid much less attention to the need for looking at them as integral components in the health services pattern of the province.

In planning increasing efforts are being made to carry out co-ordinated planning in the public health, medical care, and hospital fields. A number of provincial health departments and the Department of National Health and Welfare have established planning units to carry out active planning themselves and to serve as co-ordinating bodies for planning within other divisions of the departments. In some provinces active governmental committees have been established among the various health programmes and in some advisory commissions and committees made up of representatives of professional and other groups in the population, as well as civil servants, have been established. In part their function is planning and advice on schemes which might be developed. Most of these planning developments are relatively new.

(c) Health Care Programmes for Public Assistance Recipients

Some provinces have tended to regard these plans as essentially social welfare measures. They have been organised in such cases under departments other than the Health Department. Even where the Health Department is the active agency the programmes have been regarded largely as payment mechanisms for specified services. An interesting trend in Saskatchewan and Ontario has been the transferring of the physicians' care component for public assistance recipients to the provincial medical care plans.

Under the provisions of the Canada Assistance Plan the federal Government will assist in a wide range of benefits provided by the provinces to public assistance recipients. However, the federal Government does regard this as a temporary measure which would gradually disappear as provinces develop universal plans for medical care and associated services. Some people have advocated that the Government should include in the Plan a statement that, where comparable services are available under universal public plans, sharing by the Government through the Canada Assistance Plan should terminate. In general one may say that co-ordination of services and of planning between the public assistance schemes and other health care and public health programmes has been limited in extent.

(d) Workmen's Compensation Programmes

These programmes are essentially treatment and rehabilitation ones. However, there is co-operation as required with the health authorities in the public health and in the hospital fields.

G. Attitudes of Parties Interested in the Scheme

(a) Provincial Hospital Insurance Plans

At the time the programmes were introduced there was concern on the part of the medical associations and hospital associations that it would lead to a loss in the independence of the hospitals and physicians and to a deterioration in the quality of medical care provided. These attitudes have been largely dispelled. There seems little doubt that the independence of the hospitals has been reduced to some extent since they must now work within the budgets submitted to provincial authorities. On the other hand, none would wish to return to the former situation of difficulty in obtaining both capital and maintenance funds. There are problems from time to time between the provincial hospital authorities and individual hospitals since the latter do have the right to enforce certain regulations. This enforcement may sometimes lead to temporary inequities for an individual hospital. However, every effort is made to solve problems on an amicable basis.

The public appear to be well satisfied with the programme except for the problem of bed shortages in many larger urban centres. The urban communities in Canada are growing rapidly and also tend to serve as referral areas for their surrounding regions. Thus, the provision of beds in some of these areas is running behind the actual demand and there are waiting lists for elective procedures of various kinds. It is a problem which is generally recognised as not solely one for the hospital authorities but as a community problem involving the professions, the public, and the hospital authorities and every effort is being made in the provinces to solve it.

At government level a number of the provinces argue that the federal sharing arrangements should include mental and tuberculosis hospital care but the federal Government has maintained the position that since the provinces were already covering these costs it did not feel it to be a federal responsibility to share in the cost.

A subject of disagreement between certain groups within the medical profession and the hospital authorities has been that of the payment of pathologists, medical bacteriologists, and radiologists for services provided under the hospital schemes. Some of these doctors want fee-for-service payment whereas the provincial authorities point out that it is difficult to isolate the professional and non-professional components of laboratory and radiological services. It is a problem which has not yet been solved completely in most provinces. Also the medical profession has generaly resisted the extension of out-patient services, except in provinces where there are serious shortages of general and specialist personnel, since they see it as an encroachment on private practice. Nevertheless, the trend has been toward a gradual extension of these services.

(b) Provincial Medical Care Plans

The programmes in Newfoundland are well accepted because of the great difficulty in providing health services on any other basis. Elsewhere, however, the introduction of government medical care plans has been a source of great concern and even opposition by the medical associations. The Canadian Medical Association and the provincial associations are voluntary in character. Although a majority of physicians are members they cannot be said to represent all doctors nor the total opinion of the medical profession. Nonetheless, in Canada the majority of doctors are concerned about the extension of government activity into the payment for medical services for the population as a whole. The most notable example of this opposition took place during the introduction of the Saskatchewan Medical Care Insurance Act in the period 1961 to the midsummer of 1962. Before the scheme was enacted the College of Physicians and Surgeons of Saskatchewan repeatedly stated its opposition to a universal plan but its support for subsidisation of indigent people through existing private carriers. This was also the position adopted by the insurance industry and business groups generally. Labour and farm groups on the other hand supported a government programme. Discussion between the provincial government and the College of Physicians and Surgeons in Saskatchewan finally broke down. When the Act was implemented on 1 July 1962, the majority of doctors withdrew regular services but continued to supply emergency services through selected hospitals. A few doctors in isolated communities and some others who favoured the government scheme continued to practice; a number of doctors came into the province to work in community clinics established by citizens favouring the government programme. The situation was a tense and bitter one. It was resolved by the Saskatoon Agreement in August 1962 under which the present pattern of operation of the Plan was established. It is interesting that the incomes of doctors in Saskatchewan have continued to increase and that, although initially a larger number of doctors left than entered the province, the balance has now been restored and the province's supply of physicians is increasing. A climate of greater trust has gradually developed. It would appear that the Plan will continue to flourish and that the present trend of more and more physicians directly billing the Medical Care Insurance Commission will continue.

The programme in Alberta has been based on the attitude of the Government in that province that it would only subsidise existing carriers and that it did not wish to operate a plan itself. This approach has the approval of the medical association in that province. However, there are indications that provincial government supervision may become more complete in order to meet the terms of the federal Medical Care Act.

The situtation in British Columbia and Ontario has been that the provincial governments have established plans for low income groups and for individuals but have permitted non-profit and private insurance carriers to continue in the field for groups and others wishing to enrol with them. Although it is not yet clear what the future will be it appears in both provinces that the Governments are prepared to extend their provincial medical care schemes to universal coverage ones if they are unable to persuade the federal Government that supervision of non-profit and private carriers will meet the terms of the federal Medical Care Act.

In other provinces the governments are also likely to establish universal plans under government auspices in the near future.

The medical profession both nationally and in the provinces has in general adopted the point of view that the role of government is to subsidise and cover services for indigent and low income persons but to leave others free to purchase non-profit and private insurance contracts. This is also the position of the insurance industry and of chambers of commerce and related groups. On the other hand the labour organisations, farmers' groups, and a good many consumer and welfare groups have consistently supported universal government operated medical care plans.

It is noteworthy that, over the last ten years, the medical associations have moved closer to the position of the various governments.

The principle of the rights of people to have adequate coverage for costs is not in dispute but rather the methods for achieving this end. One feels that an acceptable agreement between the providers of services and governments as representing the public can be achieved. There seems little question that the precise arrangements will vary from province to province and that in some there may be a continuing role for non-profit and private carriers under government supervision. It appears unlikely that the medical associations will adopt the position in Saskatchewan of withdrawing services since under the programmes proposed to date doctors will be free to bill patients directly, if this is agreed upon between the doctor and the patient. On the other hand it would appear, as in Saskatchewan, that the majority of doctors will in the long run be prepared to work within the plans, provided that the administrative structures recognise professional independence and judgment in professional matters and provided that incomes are reasonable and fair.

(c) Health Care Programmes for Public Assistance Recipients

These plans have never been enthusiastically accepted by any of the parties concerned. Governments have tended to regard them as limited schemes. Those receiving services find that special needs such as drugs, appliances, glasses and other types of care are either unavailable or could only be obtained by special permission and with difficulty. They have also found reluctance on the part of doctors in some areas to accept them as patients and there have been difficulties in obtaining care in certain instances. The medical associations on the other hand have objected to partial payment for services in relation to the provincial medical association fee schedule under the plans. In the long run the plans will probably be amalgamated with universal provincial medical care plans as has happened under the hospital insurance plans for hospitalisation for public assistance recipients. However, for the immediate future separate plans will certainly continue since in most cases they provide additional benefits beyond the services of the physician.

(d) Workmen's Compensation Programmes

In every province there is provision for periodic review of workmen's compensation legislation and programmes. Since the workmen's compensation boards are generally representative of the employers, employees, and the medical profession, the attitudes of all three groups have been favourable on the whole to the programmes. From time to time doctors complain that the payment of fees is not at the level some of them would like and that the boards have unnecessarily removed patients from the care of one physician to that of another. The boards in general have tried to maintain their fee schedules in close relationship to those of the provincial medical associations. In the case of employers, from time to time some have felt that they could cover themselves under other forms of insurance more cheaply but in general employers recognise that the collective approach used by the compensation board is an effective and reasonable way of providing good coverage for injured and sick workmen. Labour unions sometimes express the view that the boards may at times favour management in their decisions but in general the unions are also strong supporters of the workmen's compensation board programmes.

Thus, while minor changes in legislation and regulations are made following each review the basic pattern has remained undisturbed and is likely to remain so unless schemes of equal comprehensiveness are developed for the entire population in the future.

H. Special Problems

1. Manpower - Numbers and Distribution

Canada is in a favourable position in terms of the numbers of health personnel in relation to population in comparison with most parts of the world. However, there are shortages of all types of professional, ancillary, and technical health personnel in relation to the demand for service. Furthermore, the distribution of these personnel markedly favours the larger urban centres and the more prosperous provinces over the rural areas and less prosperous provinces. The situation is best illustrated by reference to specific types of health personnel.

(a) Doctors

Table 3 shows the physician population ratios for active civilian physicians of the country as a whole and of the various provinces. The provinces with lower per capita incomes and lesser degrees of urbanisation have the poorest ratios. In 1961, 23 metropolitan areas in Canada had 47.2 per cent. of the population but 69.4 per cent. of the physicians, for a ratio of 1 : 581, whereas the rest of the population had a ratio of 1 : 1474.[1] Some 95 per cent. of all specialists are in communities of over 10,000 populations.[2] Of course, good communications and transportation make the situation better than it might first appear. Even so, it is clear that the rapidly growing urban areas are more fully serviced than are the smaller communities and rural areas.

In table 4, it may be seen that there has been a steady increase in the percentage of active civilian doctors in specialist practice as compared to those in general practice. It should also be noted that approximately 25 per cent. of active civilian physicians are engaged in other than full private practice, for example, interns, residents, medical school teachers, research workers, public health and industrial physicians, and administrative doctors in government and non-government work. It is interesting as well that a recent study of Canadian medical students indicated only 26.6 per cent. of students as selecting general practice as their first field of interest and 53.6 per cent. as selecting it among their first three fields of interest.[3] Such data suggest that general practice is likely to continue to decline proportionately as a field of medical work unless steps are taken to alter the trend.

---

[1] Judek, S., Medical Manpower in Canada, a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964, table 4-24, p. 134.

[2] Ibid, table 4-36, p. 161.

[3] Mount, John H., and Fish, D.G., Canadian Medical Studies of Interest in General Practice and the Specialties, The Canadian Medical Association Journal, 94, 723-728, April 1966.

Table 3

POPULATION PER ACTIVE CIVILIAN PHYSICIAN, BY PROVINCE, SELECTED YEARS 1948 TO 1965

Province	Population per Physician (a)					
	1948	1951	1954	1959	1962	1965
Newfoundland	(b)	2,279	2,101	1,864	1,539	1,505
Prince Edward Island	1,329	1,367	1,232	1,232	1,218	1,227
Nova Scotia	1,211	1,158	1,179	1,106	1,008	987
New Brunswick	1,491	1,405	1,417	1,287	1,321	1,295
Quebec	1,017	1,012	1,005	917	902	883
Ontario	851	874	870	811	808	791
Manitoba	1,001	1,001	1,030	912	859	841
Saskatchewan	1,354	1,288	1,161	1,002	1,010	989
Alberta	1,127	1,125	1,070	998	998	977
British Columbia	911	866	794	782	748	733
Yukon and N.W.T.	1,412	1,394	1,688	1,789	1,560	1,481
Canada	967	989	977	900	881	864

(a) Based on numbers of physicians as shown in Table 13 and Dominion Bureau of Statistics' intercensal estimates of population or census data (1948, June 1; 1951, Census, June 1; 1954, June 1; 1959, March 1; 1962, April 1; 1965, June 1).

Source: Physicians Register, Research and Statistics Directorate, Department of National Health and Welfare.

Table 4

PERCENTAGE OF ACTIVE CIVILIAN PHYSICIANS IN SPECIALIST PRIVATE PRACTICE, BY PROVINCE, SELECTED YEARS 1951 to 1962

Province	Percentage of Physicians in Specialist Private Practice (a)			
	1951(b)	1954(c)	1959(d)	1962
	%	%	%	%
Newfoundland	10.7	16.5	20.0	
Prince Edward Island	18.1	26.8	28.8	
Nova Scotia	21.1	25.0	28.3	
New Brunswick	25.3	31.5	38.7	
Quebec	24.1	30.8	39.0	
Ontario	26.2	28.0	33.0	
Manitoba	26.5	29.8	35.2	
Saskatchewan	20.9	23.4	27.3	
Alberta	25.7	29.5	36.3	
British Columbia	32.6	32.8	35.2	
Canada	25.5	29.1	34.6(e)	35.9(f)

(a) Includes those in group practice regardless of method of remuneration.
(b) Based on information for all physicians, obtained originally from the physicians concerned.
(c) Based on information for all physicians, 85 per cent. of whom returned 1954 survey questionnaires.
(d) Information for all physicians not available by province; estimated per cent. for active civilian physicians for Canada as a whole, 35.7; date given here represent the distribution of the 75 per cent. of active civilian physicians who responded to the 1959 survey, and include some differential response for provinces totally and probably also for nature of major work.
(e) See footnote (d) above.
(f) Estimated; estimates for provinces not available; survey response for Canada as a whole approximately 55 per cent.

Source: Physicians Register, Research and Statistics Directorate, Department of National Health and Welfare.

It is important to point out that a major factor in the relatively good physician population ratios in Canada has been the large inflow of doctors from other countries, a gain for Canada but a loss to their mother countries. During the years 1961 to 1965 the annual output of doctors from Canadian medical schools has been in the order of 800. On the other hand the number of new immigrant physicians entering the country has steadily increased from 445 in 1961 to 792 in 1965.[1]

Moreover, a varying but substantial number of physicians emigrate from Canada each year largely to the United States of America. Thus, Judek[2] points out that between 1953 and 1961, 1,694 emigrated to the United States as compared to 3,815 who came to Canada from all countries, including 471 from the United States. In 1961, 296 physicians emigrated to the United States compared with 834 Canadian medical school graduates and 445 immigrant physicians. Incidentally, some 9.1 per cent. of Canadian medical school students in 1965-66 were foreign students, of whom 47.1 per cent. were from Commonwealth countries and 45.5 per cent. were from the United States.[3] Many of these students do not remain in Canada permanently.

Plans are under way to increase the number of Canadian medical school graduates through the opening of new medical schools and the enlargement of existing ones but even so without continuing large net gains through immigration, it will not be possible to maintain the present physician : population ratios because of the rapid growth in Canada's population of over 2 per cent. per year at present.

One of the serious problems outside larger urban communities is the relative and sometimes total absence of qualified specialists of all types, including even basic ones such as the general surgeon, internist, obstetrician, and pediatrician. This situation makes it difficult to develop quality supervision of hospital work and to establish a policy on the nature of work which doctors with differing degrees of training may undertake. Moreover, it makes it difficult for hospitals serviced by such personnel to obtain accreditation by the Canadian Council on Hospital Accreditation. It is interesting, however, in some areas to find less common types of specialists such as radiologists, pathologists, and ophthalmologists. These fields require highly specialised skills and really are staff services for other doctors. These specialists present no economic threat to the family doctors in an area and therefore can be assured of sufficient work and incomes in rural areas provided they service several hospitals and a large enough population. The question of attracting

---

[1] News and Views on the Economics of Medicine, prepared by the Department of Medical Economics, The Canadian Medical Association, August 1966, No. 135.

[2] Judek, op. cit., table 2-6. p. 38.

[3] Fish, D.G., and Clarke, G.G., Medical Students in Canadian Universities, The Canadian Medical Association Journal, 94, 693-706, 2 April 1966.

basic specialists, such as pediatricians, obstetricians, internists, and general surgeons, is a more complex one. If they come to rural and smaller urban communities on a solo practice basis they usually have to do some general practice in order to earn acceptable incomes. This puts them in competition with their colleagues. The general practitioners are reluctant to refer patients to them since the patients may become the general practice patients of the specialist and not returning to the referring general practitioner following the consultation.

One answer would appear to be some form of group practice. Group practices in urban communities and even in some rural areas are increasing steadily in number. In many areas group practice has been successful in attracting specialists. However, there is the difficulty that only doctors belonging to the group may wish to refer patients to a specialist in that particular group. Doctors outside the group or in another group may be reluctant to do so. It would appear therefore that some type of regional health services organisation will be necessary to attract a sufficient number and variety of specialists to smaller urban communities and rural areas. They could either be paid on a full salary arrangement or an agreed consultation fee arrangement with or without a basic salary. These specialists could serve as consultants to an entire region. This would not be an economic threat to their general practitioner colleagues but in fact would enable them to maintain a better standard of service.

Shortages of general practitioners are also serious in rural areas and increasingly so in large metropolitan communities. There is a declining percentage of medical graduates wishing to enter general practice and as well a considerable number are leaving general practice for specialist or administrative positions. Thus, many rural communities which previously had general practitioners are no longer able to obtain them. Also in the rapidly growing cities it is often difficult to obtain general practitioner care. Attempts are being made by some provincial health departments to provide bursaries as a means of attracting students to the field. However, this device appears to be insufficient as an attraction unless in addition satisfactory hospital facilities, ancillary staff and services, reasonable referral arrangements, suitable living accommodation and better schools for children are also available. As well, there must be an acceptable basic income on some type of guaranteed basis. The situation is such that it may become necessary to employ general practitioners on a salaried basis in many rural and sparsely settled areas. In cities and other urban communities the encouragement of group practice with both general practitioners and specialists should be encouraged as one means of attracting more general practitioners. Certainly, unless such steps are taken general practice will become steadily more rare. A personal physician is both necessary and desirable but doctors will only be attracted to the field if they are related to the ongoing stream of medical work through group practice and hospital relationships which will enable them to have opportunities to keep up to date, to maintain a standard and quality of work which is acceptable to the public and satisfying to themselves, and to have some time for their families and personal lives.

(b) Dentists

The manpower situation is even more serious for dentists. Dentist : population ratios are shown in Table 5 and show the wide disparity from province to province, in favour of the more populous and wealthier provinces.

Table 5

POPULATION PER DENTIST

	1959	1963[1]
Newfoundland	9,522	10,682
Prince Edward Island	3,030	3,419
Nova Scotia	3,737	4,032
New Brunswick	4,653	4,935
Quebec	3,612	3,742
Ontario	2,344	2,485
Manitoba	3,141	3,327
Saskatchewan	4,229	4,769
Alberta	2,880	3,004
British Columbia	2,459	2,377
Canada	2,969	3,096

The disparity is even more startling if one looks at Table 6. There has been a steady migration from smaller communities to larger urban areas in recent years.

[1] The ratios are based on the numbers of dentists at 1 January 1963 and the Dominion Bureau of Statistics' Intercensal estimates for June, 1962.

Source: Department of National Health and Welfare, Research and Statistics Branch, and "Dental Personnel in Canada, 1963". Journal of Canadian Dental Association, 29, No. 5, May, 1963, pp. 341-347.

Table 6

POPULATION-DENTIST RATIOS, BY SIZE OF COMMUNITY AND PROVINCE, 1960

	Community Size		
	Under 10,000 A	Over 10,000 B	Ratio of Column B to A
Newfoundland	30,859	3,424	1:9
Prince Edward Island	5,304	902	1:6
Nova Scotia	5,146	2,693	1:2
New Brunswick	8,604	2,682	1:3
Quebec	7,828	2,538	1:3
Ontario	4,136	1,956	1:2
Manitoba	9,145	2,041	1:4
Saskatchewan	8,411	2,046	1:4
Alberta	7,167	1,790	1:4
British Columbia	3,920	1,933	1:2
Canada	6,061	2,119	1:3

Source: McFarlane, Bruce A. Dental Manpower in Canada, a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964, Table 2-7, p. 12.

In 1963[1] of the 219 dentists practising full-time specialties recognised by the Canadian Dental Association, 131 were orthodontists, 61 were oral surgeons and 27 were periodontists. Geographically, 125 were in Ontario, 40 were in Quebec, 18 in British Columbia, 14 in Alberta, 10 in Manitoba, seven in Nova Scotia, three in New Brunswick and two in Saskatchewan. Newfoundland and Prince Edward Island had none. Moreover, unlike the situation for most other health personnel, the main source of dentists to date has been from Canadian dental faculties because of the licensing requirements established by the provincial colleges of dental surgeons.2 On the other hand relatively few Canadian dentists emigrate.3

As of October 1962[4] there were 1,134 undergraduates enrolled in the six dental schools in Canada; of these, only 47 were women. In 1962 there were 225 graduates from these schools, of whom ten were women. It is planned to increase the number of Canadian

---

[1] "Dental Personnel in Canada 1963", Journal Canadian Dental Association, 29, No. 5, May 1963, pp. 341-347.

[2] McFarlane, Bruce A., Dental Manpower in Canada, a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964, pp. 20-26.

[3] Ibid. pp. 20-26.

[4] "Dental Students Register", Journal Canadian Dental Association, 29, No. 4, April 1963, pp. 246-256.

dental faculties and the enrolment in existing ones, but even so the picture is unlikely to improve because of population growth in the immediate future. Moreover, recruitment to dental schools comes increasingly from urban centres and very few of the graduates wish to practise in smaller communities or rural areas. Scholarship and bursary programmes introduced by some of the provinces may help. In addition to increased encouragement and financial support for those considering a dental career, a salaried dental service designed to attract new graduates to work for a time in rural and northern areas might be established. Dentists could be retained on the same basis as doctors and specialists as previously outlined together with the provision of suitable office and living arrangements. Some communities have established office-living units and are renting them to dentists and doctors at low rentals. More intensive use of auxiliary dental personnel is another field which is being actively explored although the dental profession has in general opposed the use of dental nurses of the New Zealand type. There is increasing use of dental hygienists and dental assistants and it would appear that auxiliary personnel will be used more in the future.

(c) Nurses

There is a general shortage of registered nurses in Canada in relation to demand. Registered nurse : population ratios for 1 January 1963 are as shown in Table 7.

Table 7

NURSE POWER RATIOS, CANADA AND THE PROVINCES, 1962

Area	Population per Registered Nurse
Newfoundland	497
Quebec	407
Nova Scotia	279
Alberta	302
New Brunswick	250
Manitoba	253
Prince Edward Island	231
Saskatchewan	246
Ontario	169
British Columbia	199
Canada	240

Source: Canadian Nurses' Association.

However, a substantial percentage of registered nurses are either not employed in nursing or are only employed part-time in the field, as shown in Table 8.

The division of active registered nurses by field of employment and sex is shown in Table 9.

Table 8

Registered Nurses, Employed or Resident in each Province,
Classified by Employment Status, Canada, 1965

Province	Total Number		Employment Status							
			Full-time in Nursing		Part-time in Nursing		Not Employed in Nursing		Employment Status not Reported	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Totals	98,190	100.0	52,130	100.0	17,226	100.0	23,304	100.0	5,530	100.0
Alberta	5,589	5.7	3,168	6.1	832	4.8	1,508	6.5	81	1.5
British Columbia	10,103	10.3	6,465	12.4	1,367	7.9	1,754	7.5	517	9.4
Manitoba	2,391	2.4	1,439	2.8	603	3.5	332	1.4	17	.3
New Brunswick	2,549	2.6	1,785	3.4	511	3.0	245	1.1	8	.1
Newfoundland	856	.9	701	1.3	98	.6	55	.2	2	.0
Nova Scotia	2,974	3.0	1,900	3.6	483	2.8	577	2.5	14	.3
Ontario	44,470	45.3	19,638	37.7	9,081	52.7	13,169	56.5	2,582	46.7
Prince Edward Island	506	.5	335	.6	142	.8	29	.1		
Quebec	25,024	25.5	14,381	27.6	3,221	18.7	5,126	22.0	2,296	41.5
Saskatchewan	3,728	3.8	2,318	4.5	888	5.2	509	2.2	13	.2

Source: Research Unit, Canadian Nurses' Association, 1966.

Table 9

Registered Nurses, Employed in Nursing,
Classified by Field of Employment and Sex, Canada, 1965

Sex	Total Number	Percent of Nurses by Field of Employment								
		Hospital or other Institution	School of Nursing	Private Practice	Public Health (Other than School Health)	School Health	Occupational Health	Office (phy. or dentist)	Other Specified Field	Field not Reported
Totals, number	69,356	51,648	2,720	3,738	4,517	462	1,223	1,863	363	2,822
per cent.	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Female	99.6	99.6	99.5	99.8	99.4	99.8	98.7	99.9	99.7	99.6
Male	.4	.4	.5	.2	.6	.2	1.3	.1	.3	.4
Sex not reported										

Source: Research Unit, Canadian Nurses' Association, 1966.

Moreover, a variety of factors have created an effective shortage over and above the actual shortage in numbers. Private nurses presently spend much of their time in non-nursing activities. Better use of skilled nurses could be achieved by the wider use of such measure of progressive patient care and the reorganisation of hospitals services on the basis of the degree of illness of patients rather than on a departmental structure. In larger urban centres especially, incomes and working conditions in nursing are not as attractive as in some other fields open to women. Salaries with added increments for post-graduate training need to be increased to a level comparable to other skilled work.

Outside cities and larger towns, an important factor appears to be the socio-economic status of an area. Areas which have diversity in business and industry attract families of higher educational status and in such families quite a number of wives are graduate nurses. On the other hand, communities which are predominantly mining or rural do not have the same attraction for such families.

Were it not for married nurses shortages in all areas would be more acute than they are. Health departments and hospitals are paying much greater attention to the use of married nurses on a part-day basis and some provide courses to help nurses who graduated some years ago to refresh their skills.

At the moment there is considerable discussion going on as to the best form of education for nursing personnel. The trend is to larger hospital nursing schools, regional schools and university schools. There is increasing emphasis on the educational content and on payment of students and a trend away from the traditional apprentice type of training, which has been the major approach in hospital schools until recently.

One development that would be helpful would be the development of more regional schools operated independently from any one hospital. This would enable the use of good teaching personnel and still permit clinical service and experience in hospitals in a region.

The problems for auxiliary nursing personnel are similar except that their precise uses and functions have not yet been fully established. As with registered nurses one answer would be the establishment of larger regional schools which could retain qualified teaching staff and would use the hospitals in the area for practical teaching. However, if sufficient numbers are to be attracted, the work must be interesting and salaries must be attractive.

(d) Other Professional Personnel

Except for pharmacists, even in some cities there are varying degrees of shortage in terms of demand of professional personnel, such as physiotherapists, occupational therapists, medical social workers and qualified dietitians. In rural areas the "other" did not exist at all or at best can be retained for short periods only from time to time. Incomes do not appear to be a major factor since there are actual numerical shortages of qualified personnel.

City hospitals and services are more fortunate partly because of the social amenities of the city but also because they can offer greater variety and challenge in their work. The employment of specialised professional and technical personnel in small and medium-size hospitals is generally not warranted. On the other hand some type of regional employment under which these personnel could serve the hospitals and services in the region on a combined basis would appear to be a partial answer to the problem. A similar situation applies to laboratory, X-ray, records and other skilled workers.

There seems little doubt that with a shortage of highly skilled professional personnel there will need to be greater use of more technical and auxiliary personnel. Some of the professional groups concerned at the moment are reluctant to use this personnel fully but this attitude appears to be changing. The development of courses in educational institutions is taking place and an improvement in working conditions and salaries should serve as a means of attracting more personnel into the field.

2. Hospitals and Related Facilities

Tables 10 and 11 show the hospital bed picture in Canada. An underlying problem in the hospital field is that of organisation and administration. In rural and smaller communities when transportation was less efficient it was a matter of necessity as well as local prestige to have a small hospital in most towns. Thus, one commonly finds several independent, small or medium-size hospitals in most rural and semi-rural regions. Such hospitals have difficulty in obtaining special equipment and facilities and in attracting staff. They cannot provide the variety and level of services of a large hospital. Until recently it was not possible for small hospitals to seek accreditation through the Canadian Council of Hospital Accreditation. Although the Council now has arrangements for smaller hospitals, relatively few have been able to take advantage of the accreditation service. In spite of these realities there is still a strong tendency in many communities to try to rebuild and renovate existing small hospitals and to obtain costly equipment and scarce specialised personnel. There is a deep attachment by citizens in these smaller communities to their own hospitals in their own community and the doctors in such communities are often reluctant to lose the hospital in which there may be relatively few limitations on the type of work they may carry out. The administrators in small hospitals usually have not had formal training for their work either. Such a pattern which may have been warranted in the past is now uneconomic and inadequate as a way of providing hospital services.

In urban areas on the other hand there are many instances of serious shortages in the number of general and pediatric beds in particular. This is particularly the case in the rapidly growing metropolitan communities. It is further accentuated by the desire of many people in rural and semi-urban areas to go to large hospitals in the heart of cities and because the large urban hospitals often serve as specialised teaching institutions.

Part of the problem however, is the relative shortage of alternative kinds of accommodation, such as supervised nursing homes, convalescent facilities, chronic disease facilities and facilities for elderly and semi-senile patients. It is also related in most communities to the relatively limited home care arrangements. At the present time the dominion-provincial hospitalisation programmes and the existing medical care plans do not cover many home care services. Thus, there is pressure both on the physician and the public to seek admission to hospital and to remain there as long as any type of care is needed. In the larger cities and to a growing extent in the smaller ones as well there is an evident need for some type of co-operative planning in the use of available hospital beds, related institutional facilities and home care services, so that the best use can be made of each type and so ready transfer from one to another can be facilitated.

Efforts by the voluntary Canadian and provincial hospital associations to stimulate voluntary regional planning on the part of hospitals have had some degree of success in a number of areas, in which there is co-operative planning on future extensions and developments. However, in general, this is not a widespread development and by and large hospitals still operate as independent entities. In the last few years a number of provincial health authorities have become increasingly involved in studying and planning various types of regional organisation, although few formal steps have been taken in the hospital field by government in developing regional patterns. It appears likely that such steps will occur in the not too distant future, since in view of many people in the health service field, a regional hospital system is an essential development. It would permit economies through group purchasing, accounting, laundry and other readily centralised services. This has been demonstrated by the relatively few voluntary developments of co-operative planning among hospitals. It would also make it easier to obtain qualified special professional and technical staff, including administrative staff, who could be shared among the hospitals in a region. It would facilitate the co-ordination of services and more efficient use of scarce personnel and facilities. In rural areas and semi-urban areas one of the hospitals could be developed as a base hospital in which all specialised equipment and staff could be located. The others would provide emergency care, general medical care, obstetrical care and chronic care. Other hospitals which are not suitable for full hospital purposes could be converted into nursing homes. There is a growing feeling that parochial reasons, such as local pride and a reluctance by local doctors to lose presently unlimited hospital privileges, should not be permitted to hamper reasonable planning and co-operation in the hospital field.

3. Quality of Health Services

Up to the present time most of the attention in Canada by professionals, government and the public at large has been on methods of financing health services. However, there is increasing concern about the quality of health services in relation to the personnel providing services, the facilities and equipment, and the use of both in an efficient and economic manner. Under the Hospital Insurance and Diagnostic Services Programme a number of developments

Table 10

ESTIMATED ACUTE TREATMENT HOSPITAL BEDS SET UP[a], TOTAL AND PER THOUSAND POPULATION, BY PROVINCE, 1948 AND 1964

Province	Total		Per Thousand Population	
	1948	1964	1948	1964
Newfoundland	1,402	2,344	4.1	4.8
Prince Edward Island	468	577	5.0	5.4
Nova Scotia	2,588	3,999	4.1	5.3
New Brunswick	2,338	3,517	4.7	5.7
Quebec	13,828	26,622	3.7	4.8
Ontario	18,302	34,375	4.3	5.2
Manitoba	3,424	5,145	4.6	5.4
Saskatchewan	5,752	7,128	6.9	7.6
Alberta	5,637	8,417	6.6	5.9
British Columbia	6,056	9,258	5.6	5.3
Yukon and N.W.T.	282	571	11.7	13.9
Canada	60,077	101,953	4.6	5.3

(a) Includes public and private hospitals; excludes chronic and convalescent beds, tuberculosis units, federal hospitals and bassinets. However, in the territories federal hospitals are included.

Source: "Hospital Care in Canada; Trends and Development 1948-1962", Research and Statistics Division, Department of National Health and Welfare, Ottawa, September, 1964. Appendix Table A19; "Annual Report of the Minister of National Health and Welfare under the Hospital Insurance and Diagnostic Services Act, 1965-66", Appendix Tables A12 and A13.

Table 11

ESTIMATED CHRONIC AND CONVALESCENT HOSPITAL BEDS SET UP (a), TOTAL AND PER THOUSAND POPULATION, BY PROVINCE, 1948 and 1964

Province	Total		Per Thousand Population	
	1948	1964	1948	1964
Newfoundland	147	156	0.4	0.3
Prince Edward Island	0	51	.0	0.5
Nova Scotia	26	83	0.1	0.1
New Brunswick	26	188	0.1	0.3
Quebec	2,627	5,676	0.7	1.0
Ontario	2,090	8,466	0.5	1.3
Manitoba	520	1,011	0.7	1.1
Saskatchewan	79	719	0.1	0.8
Alberta	160	2,541	0.2	1.8
British Columbia	1,039	359	1.0	0.2
North-west Territories	0	67	.0	1.5
Canada	6,714	19,317	0.5	1.0

(a) Includes non-federal public and private hospitals, exclusive of institutions which provide custodial and/or domiciliary care only. In the territories federal hospitals are included.

Source: "Hospital Care in Canada; Trends and Development 1948-1962", Research and Statistics Division, Department of National Health and Welfare, Ottawa, September, 1964, Appendix Table A21; "Annual Report of the Minister of National Health and Welfare under the Hospital Insurance and Diagnostic Services Act, 1965-66", Appendix Tables A12 and A13.

related to quality have been described.[1] However, when it comes to physicians services and related programmes government initiative is more difficult than when one deals with institutions such as hospitals. The encouragement and assessment of good standards of service by practitioners rest primarily with the professions concerned. However, there are ways in which government working with the health professions are starting to try to promote improved standards of health services, such as through promoting and supporting developments in the training of health services personnel, through demonstration projects, through research and the collection of statistics, and through the regular evaluation of the results of programmes. This is an area in which only a beginning has been seen in Canada as in most countries and is one in which increasing attention must be paid in the future.

4. Administrative Considerations

No programme of health services however worthy its objective can hope to succeed without a clear and workable administrative structure, including the precise delineation of responsibilities and lines of authority among the various administrative levels. Within each province a major decision is whether at the provincial level an administratively integrated co-ordinated health services organisation is to be developed or whether a multiplicity of separate and, therefore, to some extent competing administrative agencies are to be established. If a multiple administrative pattern is to be encouraged it may well lead to a further fragmentation of administrative agencies for such groups as mental health services and rehabilitation services, in addition to hospitals, public health and medical care. Co-operation let alone co-ordination among the existing number of administrative agencies in some provinces is now at best difficult.

It, therefore, appears to an increasing number of those concerned with health services that the administrative approach at provincial level should be directed toward bringing all organised government activities in the health field into a functioning whole under the provincial health department and not to encouraging further separation of programmes. One recognises the hazards of an integrated administrative structure. For it to be efficient and effective there must be a vigorous and imaginative use of techniques for promoting internal understanding and co-ordination, such as inter-divisional committees, continuous in-service education activities, and the deliberate fostering of inter-divisional programmes. Otherwise one can easily end up with what in practice are separate administrative agencies coexisting in a single department. As well responsiveness to changing circumstances and to the needs of citizens in the health professions have to be deliberately fostered by such techniques as advisory councils and committees at both policy and technical levels. Co-operation and co-ordination cannot be guaranteed by an administrative arrangement but they can be made easier to achieve.

---

[1] See p. 56.

The other main administrative decision facing each province is about the kind of administrative organisation to be established at the local or community level. Some type of operational decentralisation is necessary in almost every province because of either large area or large population or commonly both. In practice one sees two broad patterns of local administration for public health services. Under the first, regional or local personnel work directly under the jurisdiction of the provincial authorities. Under the second pattern, basic policy and regulations are set at provincial level but at the local level there is considerable autonomy in responsibility for the detailed setting or policy and the operation of services. In the case of the hospital insurance plans provincial authorities exercise a broad measure of general control through the setting of standards and through the budgetary and grants processes but individual hospital boards continue to set policies and administer services for their respective hospitals.

In the course of a study on organised community health services[1] for the Royal Commission on Health Services it became clear to my colleague and myself that the real question was not which of the above arrangements is preferable but whether a pattern could be devised which would incorporate as many of the advantages and minimise as many of the disadvantages of each as possible. It was our conclusion that a regional system of health services administrations would meet this objective as closely as possible. The precise delineation of regions would have to take account of existing formal and informal patterns for certain services, as well as of factors of geography and population. Most provinces are moving toward regionalisation of public health services as mentioned and some are looking at the question of regionalisation of hospital services. However, to date there have been no moves to tie together hospital, public health and other community services. It was our suggestion that a province would establish a regional health services board in each region to cover all government health services programmes. It should be representative of the elected municipal councils in the region, professional groups providing health services and the general public. These boards would be responsible through the provincial health department and the minister of health to the legislature for implementing any responsibilities assigned to them. We proposed that a province should delegate to the regional board within defined limits powers for modifying general provincially established policies to meet regional circumstances, powers to initiate special programmes subject to provincial authority, and authority for the operation of local programmes. The regional board should have powers, within defined limits, to obtain financial resources from member municipalities for their programmes, especially those of a purely regional nature, although the bulk of their budgets including funds for all major activities defined by provincial legislation should come from the

---

[1] Hastings, J.E.F., and Mosley. Organized Community Health Services, a study prepared for the Royal Commission on Health Services. Ottawa: Queen's Printer 1964.

province based on the annual submission of a regional budget. Responsibility for setting basic policies and uniform standards and for assuring the establishment of basic programmes should rest on the province. As well, over-all supervision of local services, particularly as related to standards of staffing, general administrative procedures, budgetary methods and standards of service should be a provincial responsibility.

The regional boards would replace existing municipal boards of health and would assume responsibilities of regional importance from existing boards of hospitals and other institutions, such as the planning of extensions and alterations, the distribution and allotment of different kinds of beds, the acquisition of specialised equipment and facilities to be used in common, and the retention of specialised professional and technical staff to be shared in common. However, the boards of hospitals and other institutions would continue to be responsible for matters of direct internal administration.

Organised community programmes, other than public health services and the hospitals, which would fall within the concern of the regional board would include, for example, rehabilitation facilities and services, mental health facilities and services, home care programmes, ambulance services, and health services for older people. The regional health services organisation envisaged would result from a realignment or "gathering together" of community based health services. No service would be taken over by any other existing service but all would become part of a larger administrative body. It was our feeling that only some development of this type would permit the establishment of province-wide patterns of service and standards and at the same time encourage local flexibility and participation in matters of local importance.

With the many developments taking place in the health services field there will be an increasing need for qualified administrative personnel. In addition to basic types of administrator in public health, hospital administration, medical care administration and nursing services administration for these who would assume senior executive positions at regional or provincial levels, opportunities must be offered for advanced study in the broader area of health services administration, both through formal degree courses and short intensive courses. Steps are being taken by the schools of hygiene, governments and others to develop such courses in Canada.

5. Voluntary Health and Social Services

Voluntary agency financing is approaching a critical phase. Voluntary giving is not increasing as rapidly as the need for funds. Thus, the question of the place which voluntary giving as opposed to tax funds should play in providing direct health services has to be resolved. One suggestion is[1] that where a voluntary health

---

[1] Hastings, J.E.F. "Recent Developments and Current Issues in Health Care in Canada", Canadian Journal of Public Health, 58, No. 3, March, 1967, pp. 93-100.

agency is providing a direct health service which is considered to be one of the basic community services, such as visiting, nursing, home care and certain rehabilitation services, the regional board proposed above could purchase specific services at cost and acceptable standards from the agency concerned or alternatively take over the service as a direct public responsibility. Where the basic services do not at present exist or where they are only rudimentary they should be established by the regional board as soon as available staff and facilities permit or financial arrangements should be made with an existing voluntary agency to enable it to establish services on an acceptable basis.

6. Health and Welfare Relationship

It is often difficult to say whether the needs of a particular person or family are basically health, welfare or social counselling, because in many cases problems of all three types are involved. Deficiencies in public welfare benefits have frequently been at the root of health problems for those of low incomes and indigent families, for example, drug costs, preventive dental care for children, dentures, glasses, hearing aids, etc., for the elderly. In turn unmet health needs often lead to economic dependency. Certainly there must be growing attention to the inter-relationship between health and welfare. Some have proposed joint health and welfare programmes at the community level, others feel that this can be achieved through separate departments but with some mechanism for co-ordination being established.

Except for workmen's compensation programmes, cash assistance benefits related to income for those unable to work because of illness have not been established in Canada. This is a field which deserves increasing attention but which has not been intensively studied as such by most government and private groups. There is, however, some interest in the concept of a guaranteed annual income and related welfare concepts. It is quite clear in any case that there must be growing attention to the inter-relationship between health and welfare in the broadest sense of both these terms and their relationship in turn to employment and income maintenance.

In a generally prosperous society, special health and welfare problems are presented by the minority of the population, both urban and rural, which has not been able to adjust to the circumstances of modern society and who have been unable, therefore, to benefit fully from a rising standard of living, as has the large majority of Canadians. Socio-economic, educational, health and other such factors, as well as attitudes and customs are involved. Health workers are beginning to recognise that they will have to work more closely with social scientists, those in related welfare, educational and labour fields and with governments, as well as with the disadvantaged people themselves in trying to improve their standard of life. A number of studies and projects are under way but more are needed.

7. Jurisdictional and Related Questions

Fundamental issues are being faced in Canada at the present time about the jurisdictional, financial and administrative responsibilities and powers of the dominion, provincial and local governments in a wide variety of fields, including that of health services. These are involved matters and it is not proposed to discuss them further in this monograph, other than to state in concluding it that underlying importance to the future evolution of health services patterns, administration and financing.

Table 12

HEALTH EXPENDITURES BY ALL LEVELS OF GOVERNMENT,
SELECTED YEARS, CANADA

Fiscal Year	Amounts	Per Capita[a]	Per Cent. of G.N.P.[b]
	$ millions	$	
1937-38	50.2[c]	4.55	0.9
1943-44	69.9	5.93	0.6
1947-48	167.2	13.32	1.2
1949-50	252.9	18.81	1.5
1951-52	306.1	21.61	1.4
1953-54	374.0	24.93	1.5
1954-55	421.8	27.31	1.7
1955-56	438.6	27.70	1.6
1956-57	469.9	28.94	1.5
1957-58	530.9	31.58	1.7
1958-59	623.5	36.20	1.9
1959-60	818.9	46.47	2.3
1960-61	933.8	51.85	2.6
1961-62	1,125.7	61.32	2.9
1962-63	1,247.2	66.76	3.0
1963-64	1,333.8	70.16	3.0
1964-65[d]	1,551.7	80.15	3.2
1965-66[d]	1,674.3	84.97	3.1

(a) Population as at 1 June within fiscal year for 1913-14 to 1949-50 and as at 1 October for 1951-52 to date.

(b) G.N.P. data are on a calendar basis prior to 1947-48 and on a fiscal year basis from 1947-48 to 1965-66. They are subject to revision from 1962-63 on.

(c) Federal expenditures on after care for veterans were estimated on a pro-rata basis using the figures shown for the Department of Veterans' Affairs for the fiscal year 1938-39.

(d) Estimated or preliminary, except for federal programmes.

Source: Research and Statistics Directorate, Department of National Health and Welfare.

Table 13

EXPENDITURES ON PERSONAL HEALTH CARE[a], CANADA, 1953-1965

Year	Hospital Services					Physicians' Services	Prescribed Drugs(f,g)	Dentists' Services	Other (g,h)	Total(e)
	Active Treatment(b)	Mental(c)	Tuber-culosis(c)	Federal(d)	All Hospitals(e)					
	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000	$'000,000
1953	280.4	57.8	29.4	36.4	404.0	176.6	48.8	60.5	45.0	734.9
1954	314.0	64.5	30.4	37.9	446.8	188.6	52.1	66.4	50.0	803.9
1955	342.4	68.9	29.9	38.8	480.1	206.5	59.5	68.6	55.0	869.7
1956	380.8	77.6	30.6	40.8	529.9	240.1	71.8	81.5	65.0	988.3
1957	422.9	87.5	31.0	45.3	586.8	271.8	84.5	87.3	70.0	1,100.4
1958	462.3	99.0	30.4	48.4	640.1	301.3	90.3	98.1	85.0	1,214.8
1959	542.6	111.6	29.6	50.3	734.1	325.7	106.5	100.1	95.0	1,361.4
1960	625.2	120.2	30.1	53.9	829.4	355.0	107.3	112.4	105.0	1,509.1
1961	713.4	134.9	29.9	56.8	935.0	388.3	112.8	118.8	115.0	1,669.9
1962	802.9	144.4	29.1	60.1	1,036.5	406.1	114.6	123.8	125.0	1,806.0
1963	900.1	163.0	28.1	62.9	1,541.1	453.4	128.0	134.8	135.0	2,005.3
1964	1,003.7	182.1	25.9	65.4	1,277.1	495.7	137.6	152.0	145.0	2,207.4
1965 (g)	1,125.9	210.7	25.9	69.6	1,432.1	545.1	149.1	160.1	155.0	2,441.4

(a) Excluding expenditures on public health and for capital purposes.
(b) Including gross expenditures of public and private acute, chronic, and convalescent hospitals in 1953-1957 and, in non-participating provinces in 1958-1960; including gross expenditures of budget review and contract hospitals in 1961-1965 and, in participating provinces, in 1958-1960; excluding expenditures of mental, tuberculosis, and federal hospitals.
(c) Including gross expenditures of public and private hospitals; excluding expenditures of federal hospitals.
(d) Including acute, chronic, convalescent, mental, and tuberculosis hospitals of the Department of National Health and Welfare and the Department of Veteran Affairs; excluding hospitals of the Department of National Defence.
(e) Items may not add to totals because of rounding.
(f) Sold by retail drug stores only.
(g) Estimated.
(h) Including expenditures for services of private duty nurses, and chiropractors, osteopaths, and optometrists; excluding all employees of hospitals.

Source: "Expenditures on Personal Health Care in Canada 1953-1961", (Health Care Series No. 16, Research and Statistics Division), and unpublished data.

Table 14

PER CAPITA EXPENDITURES ON PERSONAL HEALTH CARE[a], CANADA, 1953-1965

Year	Hospital Services					Physicians' Services	Prescribed Drugs (f,g)	Dentists' Services	Other(g,h)	Total(e)
	Active Treatment(b)	Mental(c)	Tuber-culosis(c)	Federal(d)	All Hospitals(e)					
	$	$	$	$	$	$	$	$	$	$
1953	18.89	3.89	1.98	2.45	27.21	11.90	3.29	4.08	3.03	49.50
1954	20.54	4.22	1.99	2.48	29.23	12.34	3.41	4.34	3.27	52.59
1955	21.81	4.39	1.90	2.47	30.58	13.15	3.79	4.37	3.50	55.40
1956	23.68	4.83	1.90	2.54	32.95	14.93	4.46	5.07	4.04	61.46
1957	25.46	5.27	1.87	2.73	35.33	16.36	5.09	5.26	4.21	66.25
1958	27.07	5.80	1.78	2.83	37.48	17.64	5.29	5.74	4.98	71.12
1959	31.04	6.38	1.69	2.88	41.99	18.63	6.09	5.73	5.43	77.87
1960	34.99	6.73	1.68	3.02	46.41	19.87	6.00	6.29	5.88	84.45
1961	39.12	7.40	1.64	3.11	51.27	21.29	6.18	6.51	6.31	91.56
1962	43.24	7.78	1.57	3.24	55.82	21.87	6.17	6.67	6.73	97.25
1963	47.63	8.63	1.49	3.33	61.08	23.99	6.77	7.13	7.14	106.12
1964	52.18	9.47	1.35	3.40	66.39	25.77	7.15	7.90	7.54	114.76
1965(g)	57.53	10.77	1.32	3.56	73.17	27.85	7.62	8.18	7.92	124.75

(a) Excluding expenditures on public health and for capital purposes.
(b) Including gross expenditures of public and private acute, chronic and convalescent hospitals in 1953-1957 and, in non-participating provinces, in 1958-1960; including gross expenditures of budget review and contract hospitals in 1961-1965 and, in participating provinces, in 1958-1960; excluding expenditures of mental, tuberculosis and federal hospitals.
(c) Including gross expenditures of public and private hospitals; excluding expenditures of federal hospitals.
(d) Including acute, chronic, convalescent, mental and tuberculosis hospitals of the Dept. of National Health and Welfare and the Department of Veterans Affairs; excluding hospitals of the Department of National Defence.
(e) Items may not add to totals because of rounding. (f) Sold by retail drug stores only. (g) Estimated.
(h) Including expenditures for services of private duty nurses, and chiropractors, osteopaths, optometrists; excluding all employees of hospitals.

Source: "Expenditures on Personal Health Care in Canada 1953-1961", (Health Care Series No. 16, Research and Statistics Division), and unpublished data.

Table 15

PERCENTAGE OF GROSS NATIONAL PRODUCT SPENT ON HOSPITAL SERVICES AND PHYSICIANS' SERVICES, CANADA, 1953 TO 1965

Year	Percentage of Gross National Product spent on	
	Active Treatment Hospital Services	Physicians' Services
	%	%
1953	1.15	0.72
1954	1.26	0.76
1955	1.26	0.76
1956	1.25	0.79
1957	1.33	0.85
1958	1.41	0.92
1959	1.55	0.93
1960	1.72	0.98
1961	1.90	1.04
1962	1.98	1.00
1963	2.07	1.04
1964	2.12	1.05
1965	2.17[1]	1.05[1]

[1] Preliminary

Sources: Expenditure data from Research and Statistics Directorate, Department of National Health and Welfare, Gross National Product from Dominion Bureau of Statistics, "National Accounts - Income and Expenditures".

Table 16

PERCENTAGE DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR PHYSICIANS' SERVICES, 1953 AND 1965, AND ACTIVE TREATMENT HOSPITAL[1] CARE, 1953 AND 1964, BY SOURCE OF FUNDS

Source of Funds	Percentage Distribution of Expenditures			
	Physicians' Services		Active Treatment Hospital Care[1]	
	1953	1965	1953	1964[2]
	%	%	%	%
Private Sector:				
Self-paying patients	61.2	31.3	34.1	6.4
Voluntary prepayment plans	24.1	55.5	22.4	2.5
Other[3]	-	-	7.3	4.4
Public Sector:				
Governments[4]	7.9	8.6	33.8	85.3
Workmen's Compensation Boards	6.9	4.6	2.5	1.4
Total	100.0	100.0	100.0	100.0

[1] Excluding mental, tuberculosis and federal institutions.

[2] Estimated.

[3] Donations, investment income, deficits, etc.

[4] Excludes Alberta Medical Plan.

Source: Research and Statistics Directorate, Department of National Health and Welfare.

Table 17

ESTIMATED FEDERAL AND PROVINCIAL EXPENDITURES ON PUBLIC HEALTH SERVICES (EXCLUDING HOSPITAL AND MEDICAL CARE SERVICES). FISCAL YEARS 1956-57 TO 1965-66

Fiscal Year	Federal[1] Expenditures	Provincial[2] Expenditures	Total[3] Expenditures
	$ million	$ million	$ million
1956-57	44.7	23.5	68.2
1957-58	45.1	27.1	72.2
1958-59	53.2	31.0	84.2
1959-60	54.4	31.9	86.3
1960-61	57.4	40.1	97.5
1961-62	60.7	42.6	103.3
1962-63	64.7	45.1	109.8
1963-64	70.7	66.7[4]	137.4
1964-65	77.0	60.0[5]	137.0
1965-66[6]	72.0	70.0[5]	142.0

[1] Including health grants to the provinces for the extension of health services, which rose from $33.5 million in 1955-56 to $56.7 million in 1964-65 but totalled $45.5 million in 1965-66 due to the province of Quebec opting out of this programme, with the exception of research grants.

[2] Not including provincial expenditures on T.B. and Mental Hospitals which rose from $83.1 million in 1956 to $170.6 million in 1964, the most recent year for which data are available.

[3] These figures do not include any municipal expenditures. The portion of the $50 to $80 million annual health expenditures of municipalities during this period that was spent on public health services is not available.

[4] Increase from previous year due to substantial grants by the province of Quebec for the construction of public health buildings other than hospitals.

[5] Estimate.

[6] Effective 1 April, 1965, Quebec opted out of the General Health Grants programme (with the exception of research grants) and received federal payments of $7.5 million in tax abatements. This amount is excluded from the federal data but is included in the provincial expenditures.

Source: Department of National Health and Welfare, Research and Statistics Directorate.

Table 18

FEDERAL EXPENDITURES UNDER THE HEALTH GRANTS PROGRAMME, BY TYPE OF GRANT, FISCAL YEARS 1959-60 TO 1965-66

Grant	Federal Expenditures						
	1959-60	1960-61	1961-62	1962-63	1963-64	1964-65	1965-66(h)
	($000)	($000)	($000)	($000)	($000)	($000)	($000)
Hospital Construction	14,941	17,595	19,000	20,000	22,000	21,512	17,622
Professional Training(a)	656	1,290	1,447	1,511	1,743	1,933	1,280
General Public Health	8,669	10,521	9,660	10,425	10,064	12,781	10,840
Public Health Research(b)	444	1,467	1,617	1,458	1,579	1,647	4,214
Mental Health(c)	7,691	8,141	8,237	7,923	8,331	8,667	5,910
Tuberculosis Control(d)	3,796	3,376	3,249	3,152	3,061	3,392	1,719
Cancer Control(d)	3,328	3,020	2,785	2,898	3,160	2,890	1,133
V.D. Control(e)	411	-	-	-	-	-	-
Crippled Children(f)	503	-	-	-	-	-	-
Child and Maternal Health(d)	1,842	1,423	1,388	1,345	1,204	1,409	920
Medical Rehabilitation and Crippled Children	673	1,159	1,615	1,580	1,853	2,465	1,839
Laboratory and Radiological Services(e)	3,013	-	-	-	-	-	-
Total(g)	45,997	47,993	49,000	50,295	52,995	56,699	54,978(h)

(a) In 1960, this grant was increased from $516,000 to $1.74 million, since about $1.5 million per year has been spent on training under various grants.

(b) In 1960, grant raised from $513,000 to $1.74 million.

(c) In 1960, grant raised from $7.235 to $8.735 million.

(d) In 1960, amounts available under these grants reduced.

(e) In 1960, these grants were absorbed into the General Public Health Grant, which was raised by about $5.5 million.

(f) In 1960, this grant was merged with the Medical Rehabilitation Grant, which was raised from $1 to $2.6 million.

(g) May not balance exactly, due to rounding.

(h) Grant figures exclude an estimated amount of $9,500,000 representing Quebec's entitlement under the Established Programmes (Interim Arrangements) Act, which is included in the total.

Source: National Health Grants Administration and Research and Statistics Directorate, Department of National Health and Welfare.

Table 19

SELECTED STATISTICAL INDICES OF HOSPITAL UTILISATION AND EXPENDITURES IN PUBLIC HOSPITALS, (a) CANADA, 1948 TO 1964

Year	Admissions Per Thousand Population(b)	Average Length of Stay Per Case(b)			Days of Care Per Thousand Population(b)	Operating Expenditures Per Patient Day of Care (b,c)
		General	Chronic	Convalescent		
1948	111	10.0	(d)	(d)	1,318	7.88(est.)
1952	128	10.0	311.5	56.3	1,481	10.94(est.)
1956	140	10.0	434.6	40.5	1,568	14.84
1958	142	9.8	404.3	36.7	1,578	17.84
1959	143	9.8	418.5	42.1	1,624	18.88
1960	145	9.9	327.4	42.1	1,656	21.32
1961	149	10.0	241.2	40.0	1,676	23.10
1962	149	10.1	249.9	38.4	1,704	24.82
1963	151	10.1	267.3	38.9	1,719	26.87
1964	153	10.2	224.6	40.5	1,759	29.18

(a) Excluding private and federal hospitals.

(b) Excluding newborns.

(c) Excludes Northwest Territories and Yukon, 1948-60; excludes Newfoundland, 1948 and 1952.

(d) Information not available.

Sources: "Hospital Care in Canada; Trends and Development 1943-1962", Research and Statistics Division, Department of National Health and Welfare, Ottawa, September 1964, Tables A3, A5, A6; D.B.S., "Hospital Statistics", Vol. 1, 1952-64 and Vol. VI, 1964; "Annual Report of the Minister of National Health and Welfare under the Hospital Insurance and Diagnostic Services Act, 1964-65", Tables A2, A5 and A16; "...., 1965-66", Tables A2, A5; and other unpublished data.

Table 20

PER CAPITA COST OF IN-PATIENT SERVICES, AND PERCENTAGE INCREASE OVER PREVIOUS YEAR, BY PROVINCE, 1958 TO 1963

PROVINCE	1958	1959		1960		1961		1962		1963	
	Cost	Cost	Increase	Cost	Increase	Cost	Increase	Cost	Increase	Cost	Increase
Newfoundland	$13.7603	$16.3039	18.5	$18.4199	13.0	$19.5339	6.0	$21.4465	9.8	$24.2039	12.9
Prince Edward Island	15.2249	15.6719	2.9	19.2321	22.7	23.0063	19.6	24.8749	8.1	26.6156	7.0
Nova Scotia	17.2940	20.6938	19.7	25.1681	21.6	28.3157	12.5	30.6205	8.1	33.4375	9.2
New Brunswick	16.4678	21.2408	29.0	27.4360	29.2	32.7226	19.3	36.1266	10.4	38.4608	6.5
Quebec	17.6582	18.7399	6.1	21.3643	14.0	26.9919	26.3	32.0059	18.6	37.4275	16.9
Ontario	22.0245	27.4516	24.6	31.8345	16.0	35.0343	10.1	38.9579	11.2	42.6898	9.6
Manitoba	22.8411	27.8516	21.9	31.1363	11.8	33.4899	7.6	35.8371	7.0	38.7208	8.0
Saskatchewan	32.0523	34.7216	8.3	37.3806	7.7	38.8121	3.8	40.8859	5.3	40.0291	7.7
Alberta	25.6619	28.8487	12.4	32.9063	14.1	35.0002	6.4	37.7881	8.0	41.0656	8.7
British Columbia	25.2616	28.3514	12.2	31.7386	11.9	34.2686	8.0	35.9866	5.0	37.9856	5.6
Yukon)				47.9502	295.2	49.2003	2.6	55.6358	13.1	43.0296	-22.7
)	13.0843	8.7075	-33.5								
Northwest Territories)				26.4408	308.0	40.5183	53.2	46.1728	14.0	55.9859	21.3
CANADA	21.2329	24.6495	16.1	28.3140	14.9	31.9673	12.9	35.6077	11.4	39.4430	10.8

Source: Annual Report of the Minister of National Health and Welfare on the operation of Agreements with the Provinces under the Hospital Insurance and Diagnostic Services Act, for the fiscal year ended 31 March 1966.

Table 21

REVENUE FUND EXPENDITURES PER PATIENT-DAY[1] OF ALL BUDGET REVIEW HOSPITALS, BY TYPE OF ACCOUNT, BY PROVINCE, 1964

PROVINCE	Departmental Expense						Other (Non-departmental) Revenue Fund Expense	Total Revenue Fund Expense
	Salaries and Wages	Medical and Surgical Supplies	Drugs	Raw Food	Other Departmental Expense and Supplies	Total Departmental Expense		
	$	$	$	$	$	$	$	$
Newfoundland	13.81	.96	1.52	2.63	5.59	24.52	1.68	26.20
Prince Edward Island	12.75	.74	.89	1.69	4.52	20.59	2.06	22.65
Nova Scotia	16.97	.92	1.09	1.87	6.21	27.07	2.29	29.36
New Brunswick	16.65	.94	1.13	1.78	5.21	25.70	2.94	28.64
Quebec	21.21	1.00	1.28	1.64	4.76	29.89	2.43	32.32
Ontario	19.50	.94	1.10	1.47	4.93	27.94	1.88	29.82
Manitoba	16.66	.83	1.14	1.33	3.94	23.89	1.58	25.47
Saskatchewan	16.72	.81	1.00	1.38	4.14	24.04	1.80	25.84
Alberta	15.29	.74	.86	1.54	3.54	21.97	2.48	24.45
British Columbia	18.87	.90	1.03	1.39	4.14	26.34	1.63	27.98
Yukon	28.18	1.91	2.62	4.97	9.82	47.49	2.76	50.25
North-west Territories	18.84	1.18	.69	2.02	8.43	31.17	2.70	33.87
CANADA	18.89	.92	1.12	1.55	4.67	27.15	2.08	29.23

[1] Patient-days during year for adults and children, excluding newborns.

Source: Annual Report of the Minister of National Health and Welfare on the operation of Agreements with the provinces under the Hospital Insurance and Diagnostic Services Act for the fiscal year ended 31 March 1966.

Table 22

ADMISSIONS AND SEPARATIONS DURING YEAR IN REPORTING HOSPITALS LISTED IN HOSPITAL INSURANCE AGREEMENTS, AND RATES PER 1,000 POPULATION[1], ADULTS AND CHILDREN, BY PROVINCE, 1964

Province	Number of hospitals reporting	Admissions during year		Separations during year	
		Number	Rate per 1,000 population	Number	Rate per 1,000 population
Newfoundland	47	58,835	119.8	58,645	119.4
Prince Edward Island	9	17,372	162.4	17,334	162.0
Nova Scotia	48	114,036	150.0	114,019	150.0
New Brunswick	42	108,213	175.4	108,260	175.5
Quebec	269	788,590	141.8	788,029	141.7
Ontario	319	1,040,030	157.9	1,038,416	157.7
Manitoba	104	176,113	183.8	176,138	183.9
Saskatchewan	157	211,495	224.3	211,481	224.3
Alberta	138	283,880	198.2	283,387	197.9
British Columbia	111	307,190	176.7	307,080	176.7
Yukon Territory	5	2,931	183.2	2,931	183.2
North-west Territories	26	6,533	261.3	6,572	262.9
CANADA	1,275	3,115,218	162.0	3,112,292	161.8

[1] Based on 1964 intercensal population estimates as at 1 June, prepared by Dominion Bureau of Statistics.

Source: Health and Welfare Services in Canada. A report prepared for the Canada Year Book 1967, by the Research and Statistics Directorate, Department of National Health and Welfare. Ottawa, August 1966 p. 26.

Table 23

HOSPITALISATION, BY CLASS OF DISEASE, OF IN-PATIENTS[1] INSURED BY PROVINCIAL HOSPITAL INSURANCE PLANS[2], 1964

Class of disease[3]		Separations		Days of care for separations		Average stay of separations	Percentage distribution	
		Total	Per 1,000 population	Total	Per 1,000 population		Separations	Days of care
	All diseases	3,074,067	159.8	36,869,080	1,916.8	12.0	100.0	100.0
I.	Infective and parasitic diseases	43,624	2.3	615,626	32.0	14.1	1.4	1.7
II.	Neoplasms	165,867	8.6	3,187,484	165.7	19.2	5.4	8.6
III.	Allergic, endocrine system, metabolic and nutritional diseases	86,834	4.5	1,408,804	73.2	16.2	2.8	3.8
IV.	Diseases of the blood and blood-forming organs	17,403	0.9	263,037	13.7	15.1	0.6	0.7
V.	Mental, psychoneurotic, and personality disorders	84,208	4.4	1,561,524	81.2	18.5	2.7	4.2
VI.	Diseases of the nervous system and sense organs	148,699	7.7	4,100,623	213.2	27.6	4.8	11.1
VII.	Diseases of the circulatory system	243,297	12.6	5,411,556	281.3	22.2	7.9	14.7
VIII.	Diseases of the respiratory system	474,097	24.6	3,106,732	161.5	6.6	15.4	8.4
IX.	Diseases of the digestive system	414,223	21.5	4,289,031	223.0	10.4	13.5	11.6
X.	Diseases of the genito-urinary system	246,148	12.8	2,415,425	125.6	9.8	8.0	6.6
XI.	Deliveries and complications of pregnancy, childbirth and the puerperium	595,715	31.0	3,405,644	177.1	5.7	19.4	9.2
XII.	Diseases of the skin and cellular tissue	62,784	3.3	619,671	32.2	9.9	2.0	1.7
XIII.	Diseases of bones and organs of movement	105,887	5.5	2,118,420	110.1	20.1	3.4	5.7
XIV.	Congenital malformations	30,224	1.6	459,419	23.9	15.2	1.0	1.2
XV.	Certain diseases of early infancy	11,844	0.6	158,267	8.2	13.4	0.4	0.4
XVI.	Symptoms, senility and ill-defined conditions	71,991	3.7	595,028	30.9	8.3	2.3	1.6
XVII.	Accidents, poisonings and violence	271,222	14.1	3,152,789	163.9	11.6	8.8	8.6

[1] Excludes newborn.

[2] Newfoundland, Prince Edward Island, and Manitoba also include non-insured residents of the province; Quebec and Ontario include both resident and non-resident non-insured in-patients; Alberta includes insured resident in-patients and 6,438 non-insured residents.

[3] According to "International Statistical Classification of Diseases, Injuries and Causes of Death, 1955."

Source: Data supplied by the provinces to the Department of National Health and Welfare.

Table 24

DISTRIBUTION OF SERVICES BY TYPE OF SERVICE 1964-1966

	No. of Services (000's)			No. of Services per 1,000 Beneficiaries			
	1964	1965	1966	1964	1965	1966	% Change 1965-66
Visits - Initial Office	923.6	936.9	1,071.8	1,119.3	1,124.8	1,240.3	+ 10.3
Repeat Office	716.2	716.1	799.3	867.9	859.7	925.0	+ 7.6
Home and Emergency	245.9	247.7	303.4	298.0	297.4	351.1	+ 18.1
Hospital	942.5	906.0	1,052.3	1,142.2	1,087.7	1,217.8	+ 12.0
Sub Total	2,828.2	2,806.7	3,226.8	3,427.4	3,369.6	3,734.2	+ 10.8
Consultations	46.1	48.2	58.4	55.9	57.9	67.6	+ 16.8
Psychiatric Services	24.8	26.9	39.0	30.1	32.3	45.1	+ 39.6
Sub Total	70.9	75.1	97.4	86.0	90.2	112.7	+ 24.9
Laboratory Services	569.2	605.8	711.5	689.8	727.3	823.4	+ 13.2
Diagnostic Radiology	86.0	91.3	102.0	104.2	109.6	118.0	+ 7.7
Other Diagnostic Procedures	80.8	89.9	104.4	98.0	107.9	120.8	+ 12.0
Sub Total	736.0	787.0	917.9	892.0	944.8	1,062.2	+ 12.4
Major Surgery	46.5	44.2	48.2	56.4	53.0	55.8	+ 5.3
Minor Surgery	65.5	65.7	72.4	79.3	78.8	83.8	+ 6.3
Obstetrics	22.4	19.6	18.7	27.1	23.6	21.6	- 8.5
Anaesthesia	69.6	70.9	74.6	84.4	85.2	86.3	+ 1.3
Surgical Assistance	15.2	15.9	17.9	18.4	19.1	20.7	+ 8.4
Sub Total	219.2	216.3	231.8	265.6	259.7	268.2	+ 3.3
Allergy Services	22.1	26.9	36.7	26.8	32.3	42.5	+ 31.6
Major Therapeutic Procedures	2.3	2.3	3.2	2.8	2.8	3.7	+ 32.1
Minor Therapeutic Procedures	118.3	122.0	135.4	143.3	146.5	156.7	+ 8.0
Sub Total	142.7	151.2	175.3	172.9	181.6	202.9	+ 11.7
All Other Services[1]	93.0	65.9	1.1	112.7	79.1	1.3	- 98.4
GRAND TOTAL ALL SERVICES	4,090.0	4,102.2	4,650.3	4,956.6	4,925.0	5,381.5	+ 9.3

[1] Includes physicians' mileage and services by physiotherapists which ceased to be insured 1 July 1965.

Source: Saskatchewan Medical Care Insurance Commission, Annual Report 1966, p. 44.

Table 25

AVERAGE COST PER SERVICE BY TYPE OF SERVICE 1964-1966

	1964	1965	1966
Visits - Initial Office	4.12	4.07	4.01
Repeat Office	2.61	2.61	2.60
Home and Emergency	5.10	5.00	4.93
Hospital	2.35	2.35	2.33
Sub Total	3.23	3.23	3.20
Consultations	15.25	15.34	15.08
Psychiatric Services	7.28	7.34	7.46
Sub Total	12.46	12.47	12.03
Laboratory Services	.98	1.01	1.04
Diagnostic Radiology	10.13	9.92	9.80
Other Diagnostic Procedures	9.84	9.59	9.31
Sub Total	3.03	3.03	2.95
Major Surgery	82.60	85.97	85.33
Minor Surgery	8.82	8.68	8.86
Obstetrics	64.99	64.63	65.10
Anaesthesia	14.18	14.30	14.29
Surgical Assistance	16.71	16.64	16.55
Sub Total	32.48	31.96	31.62
Allergy Services	3.24	3.30	3.00
Major Therapeutic Procedures	26.35	24.62	25.25
Minor Therapeutic Procedures	3.51	3.47	3.37
Sub Total	3.84	3.76	3.69
All Other Services[1]	4.61	4.47	8.91
GRAND TOTAL ALL SERVICES	4.98	4.91	4.77

[1] Includes physicians' mileage and services by physiotherapists which ceased to be insured 1 July 1965.

Source: Saskatchewan Medical Care Insurance Commission, Annual Report 1966, p. 46.

Table 26

AVERAGE GROSS AND NET PROFESSIONAL EARNINGS OF ACTIVE FEE-PRACTICE PHYSICIANS, AND AVERAGE EXPENSES AS PERCENTAGES OF GROSS PROFESSIONAL EARNINGS, BY INCOME CLASS, CANADA, 1965

Income Class(a)	Average Gross	Average Net	Expenses as per cent of Gross	Number of Doctors in Fee-Practice
$	$	$	%	
Under 10,000	12,095	6,503	46.2	2,630
10,000-14,999	19,672	12,194	38.0	2,489
15,000-19,999	26,929	17,014	36.8	2,848
20,000-24,999	32,517	21,726	33.2	2,659
25,000-49,999	45,952	32,350	29.6	5,086
50,000-99,999	81,235	58,648	27.8	700
100,000 and over	160,352	120,188	25.0	29
All Income Classes	32,799	22,064	32.7	16,441

(a) Income in the context of these classes means income from all sources, including wages and salaries incidental to fee practice, and net proceeds from investments and other non-professional activities, but excluding expenses of professional fee practice.

Source: Unpublished Taxation Statistics, Department of National Revenue, and estimates of numbers of physicians, Department of National Health and Welfare.