Canada's Health Care System (Medicare)

Canada's national health insurance program, often referred to as "Medicare", is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, we have a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Framed by the *Canada Health Act*, the principles governing our health care system are symbols of the underlying Canadian values of equity and solidarity.

Roles and responsibilities for Canada's health care system are shared between the federal and provincial-territorial governments. Under the *Canada Health Act* (CHA), our federal health insurance legislation, criteria and conditions are specified that must be satisfied by the provincial and territorial health care insurance plans in order for them to qualify for their full share of the federal cash contribution, available under the Canada Health Transfer (CHT). Provincial and territorial governments are responsible for the management, organization and delivery of health services for their residents.

What Information is Available

In this section, you will find detailed information on the criteria and conditions of the federal act (CHA), current CHA compliance issues, and descriptions of provincial and territorial health insurance plans.

Canada Health Act: Overview

"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."

(Roy J. Romanow, Q.C. November, 2002)

What is the *Canada Health Act*?

The *Canada Health Act* (CHA or the Act) is Canada's federal legislation for publicly funded health care insurance.

The Act sets out the primary objective of Canadian health care policy, which is "*to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.*"

The CHA establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive the full federal cash contribution under the Canada Health Transfer (CHT).

The aim of the CHA is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without direct charges at the point of service for such services.

Key Definitions under the CHA

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the CHA as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the CHA include serving members of the Canadian Forces or Royal Canadian Mounted Police and inmates of federal penitentiaries.

Insured health services are medically necessary hospital, physician and surgical-dental services provided to insured persons.

Insured hospital services are defined under the CHA and include medically necessary in- and out- patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required;

nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services as defined in the CHA are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

Requirements of the *Canada Health Act*

The *Canada Health Act* (CHA or the Act) contains the following nine requirements that the provinces and territories must fulfill to qualify for the full federal cash contributions:

- five program criteria that apply only to insured health services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charge provisions that apply only to insured health services.

The Criteria

1. **Public Administration (section 8)**
   The public administration criterion, set out in section 8 of the CHA, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans are administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision making on benefit levels and services, and whose records and accounts are publicly audited.

2. **Comprehensiveness (section 9)**
   The comprehensiveness criterion of the CHA requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services which require a hospital setting) and, where the law of the

province so permits, similar or additional services rendered by other health care practitioners.

3. **Universality (section 10)**
   Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement. Newcomers to Canada, such as landed immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health services.

4. **Portability (section 11)**
   Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage.

   Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

   The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

   If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

   Prior approval by the health care insurance plan in a person's home province or territory may also be required before coverage is extended for elective (non-emergency) services to a resident while temporarily absent from their province or territory.

5. **Accessibility (section 12)**
   The intent of the accessibility criterion is to ensure insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age,

health status or financial circumstances). In addition, the health care insurance plans of the province or territory must provide:

- reasonable compensation to physicians and dentists for all the insured health services they provide; and
- payment to hospitals to cover the cost of insured health services.

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the Act using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

1. ***Information (section 13(a))*** - the provincial and territorial governments shall provide information to the Minister of Health as may be reasonably required, in relation to insured health services and extended health care services, for the purposes of the CHA.
2. ***Recognition (section 13(b))*** - the provincial and territorial governments shall recognize the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the CHA, that discourage extra-billing and user charges for insured health services in a province or territory, are outlined in sections 18 to 21. If it can be determined that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory according to the Extra-billing and User Charges Information Regulations described below.

Extra-billing (section 18)

Under the CHA, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e., a surgical-dentist providing insured health services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician were to charge patients any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care and is therefore, contrary to the accessibility criterion.

User Charges (section 19)

The CHA defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, the fee would be considered a user charge. User charges are not permitted under the Act because as is extra-billing, they constitute a barrier or impediment to access.

Other Elements of the Act

Regulations (section 22)

Section 22 of the CHA enables the federal government to make regulations for administering the Act in the following areas:

- defining the services included in the CHA definition of "extended health care services."
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require from a province or territory to qualify for a full federal transfer; and
- prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

The only regulations in force under the Act are the Extra-billing and User Charges Information Regulations, which require the provinces and territories to provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with the actual deductions can be made. (For reference purposes, view the office consolidation of the Extra Billing and User Charges Information Regulations of these regulations).

Penalty Provisions of the *Canada Health Act*

Mandatory Penalty Provisions

Under the CHA, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the Canada Health Transfer. For example, if it has been determined that a province has allowed $500,000 in extra-billing by physicians, the federal transfer payments to that province would be reduced by that amount.

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the CHA is subject to discretionary penalties. The amount of any deduction from federal transfer payments under the Canada Health Transfer is based on the gravity of the default.

The CHA sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

Excluded Services and Persons

Although the CHA requires that insured health services are provided to insured persons in a manner that is consistent with the criteria and conditions set in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusion for insured services:

- services that fall outside the definition of insured health services; and
- certain services and groups of persons are excluded from the definitions for insured services and insured persons.

These exclusions are discussed below.

Non-Insured Health Care Services

In addition to the medically necessary insured hospital and physician services covered by the CHA, provinces and territories also provide a range of programs and services outside the scope of the Act. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services and optometric services.

The additional services provided by provinces and territories may be targeted to specific population groups (e.g., children, seniors or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary and thus, are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services, and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice, the provision of medical certificates required for work, school, insurance purposes and fitness clubs, testimony in court and cosmetic services.

Excluded Persons

The CHA definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police, persons serving a prison term in a federal penitentiary, and persons who have not completed a minimum period of residence in a province or territory (a period that must not exceed three months). In addition, the definition of "insured health services" excludes services to persons provided under any other

Act of Parliament (e.g., foreign refugees) or under the workers' compensation legislation of a province or territory.

The exclusion of these persons from insured health service coverage predates the adoption of the CHA and is not intended to constitute differences in access to publicly insured health care.

Policy Interpretation Letters

There are two key policy statements that clarify the federal position on the CHA . These statements have been made in the form of ministerial letters from former federal Ministers responsible for health, to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the CHA in Parliament, Jake Epp, the federal minister responsible for Health at the time, wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the CHA.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements on the federal policy intent, which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in assessing and interpreting compliance with the Act. The Epp letter continues to be an important reference for interpreting the Act.

Marleau Letter - Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal-provincial-territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal-Provincial-Territorial Health Ministers Meeting of September 1994 in Halifax, all ministers of health present, except for Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

On January 6, 1995, Diane Marleau, the federal minister responsible for Health, wrote to all provincial and territorial ministers of health, to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the CHA as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the CHA, includes any public

facility that provides acute, rehabilitative or chronic care. Thus, when a provincial or territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

Dispute Avoidance and Resolution Process

In April 2002, the then-federal Health Minister A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal, provincial and territorial interests of avoiding disputes related to the interpretation of CHA principles, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal-provincial-territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities are unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the CHA. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

Canada Health Act: Administration and Compliance

In administering the *Canada Health Act* (CHA), the federal Minister of Health is assisted by Health Canada policy, communications and information officers located in Ottawa and in the six regional offices of the Department, and by lawyers with the Department of Justice.

Health Canada takes its responsibilities under the *Canada Health Act* seriously, working with the provinces and territories to ensure that the principles of the CHA are respected. Health Canada's preference is always to work with provinces and territories to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

The Canada Health Act Division (the Division) is part of the Intergovernmental Affairs Directorate of the Health Policy Branch at Health Canada and is responsible for administering the CHA. Officers of the Division located in Ottawa, and in regional Health Canada offices, fulfill the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charge provisions of the CHA;
- working in partnership with provinces and territories to investigate and resolve CHA compliance issues and pursue activities that encourage compliance with the CHA;
- informing the Minister of possible non-compliance and recommending appropriate action to resolve the issue;
- developing and producing the Canada Health Act Annual Report on the administration and operation of the CHA;
- developing and maintaining formal and informal contacts and partnerships with health officials in provincial and territorial governments to share information;
- collecting, summarizing and analysing relevant information on provincial and territorial health care systems;
- disseminating information on the CHA and on publicly funded health care insurance programs in Canada;
- responding to information requests and correspondence relating to the CHA through the preparation of responses to inquiries about the CHA and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media;
- conducting issue analysis and policy research in order to provide policy advice and recommendations to the Minister concerning the interpretation of the CHA; and
- collaborating with provincial and territorial health department representatives on the Interprovincial Health Insurance Agreements Coordinating Committee.

Interprovincial Health Insurance Agreements Coordinating Committee

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee (formerly named the Federal-Provincial/Territorial Coordinating Committee on Reciprocal Billing), and acts as a secretariat for the Committee. The Committee was formed in 1991 to address issues affecting the interprovincial billing of hospital and medical services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the *Canada Health Act*.

The within-Canada portability provisions of the CHA are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/ territorial and signing them is not a requirement of the CHA.

In 2003-2004, the Committee updated hospital in-patient rates for all hospitals that bill for interprovincial services in Canada and updated the set of current national out-patient service rates.

The Committee is currently reviewing its high cost procedure (e.g. organ transplants) rates to reflect current costs.

Compliance

Provinces and territories must comply with the criteria and conditions of the *Canada Health Act* in order to receive the full amount of the Canada Health Transfer (CHT) cash contribution (prior to April 1, 2004, the cash contribution became payable under the Canada Health and Social Transfer). The following section outlines how Health Canada determines provincial and territorial compliance.

Health Canada's approach to resolving possible *Canada Health Act* compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to the administration and interpretation of the CHA have been addressed and resolved without resorting to deductions.

Health Canada officials routinely liaise with provincial and territorial health ministry representatives and health insurance plan administrators to help resolve common problems experienced by Canadians related to eligibility for health insurance coverage and portability of health services within and outside Canada.

Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Sources for this information include: officials representing provincial and territorial governments; provincial and territorial government publications; media reports and correspondence received from the public and other non-government organizations

and individuals. Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and making recommendations to the Minister for appropriate follow-up action. Verification of the facts with provincial and territorial health officials may reveal issues that are not directly related to the CHA while others may pertain to the CHA but are a result of misunderstanding or miscommunication and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff then discuss the issue and its possible resolution with provincial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, do the penalty provisions of the Act come into consideration.

Compliance Issues Arising in 2003-2004

During fiscal year 2003-2004, the Canada Health Act Division or the federal Minister of Health discussed or otherwise communicated the CHA concerns related to the following issues with the respective provincial/territorial Health Ministries. This information is factual as of March 31, 2004. Unless otherwise indicated, bilateral communications on these issues are on-going.

With respect to private payment for insured health services, Health Canada is concerned that any trend toward privatization that results in a two-tiered system, where individuals can pay for quicker access to medically necessary hospital or physician services represents a threat to the fundamental principles of the CHA, and therefore to the overall health care system. Access to insured services must be based on need, not the ability to pay.

Some jurisdictions have recently questioned the definition of the term "medically necessary" in the Act. As noted by former federal Health Minister Jake Epp in his 1985 interpretation letter to all provincial and territorial health ministers, provinces and territories, along with their medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces and territories determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care. In practice, this means that provincial and territorial health insurance plans, in consultation with their respective medical professional colleges or groups, are primarily responsible for determining which services are medically necessary for health insurance purposes. Once a service has been determined by a province to be an insured service, it must be covered by the provincial health insurance plan, regardless of where it is delivered.

Patient charges for magnetic resonance imaging (MRI) and computed tomography (CT) scans

There are private MRI and CT clinics in British Columbia, Alberta, Quebec and Nova Scotia, and these provinces do not provide coverage for medically necessary

MRI and CT scans performed at these private clinics. Under the *Canada Health Act*, MRI and CT services are considered to be insured health services when they are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, and are provided in a hospital or a facility providing hospital care. Health Canada originally communicated these CHA concerns to all provinces in 2000, and a multilateral examination of the issue was subsequently conducted, however the issue of charges to insured persons for MRI and CT services was not resolved. In July 2003, former federal health minister Anne McLellan wrote to the four provincial health ministers concerned to communicate her objection to the queue jumping that results in provinces that allow private clinics to sell quicker access to medically necessary diagnostic services. Consultations with provincial officials in all four provinces except Quebec followed. Although multilateral discussions were scheduled to begin in 2004, these discussions were postponed at the request of the provinces, pending the First Ministers' discussions on sustainability of the health care system.

In 2003, Health Canada learned that a Newfoundland resident paid MRI Canada to arrange an MRI service under the guise of a third-party payer arrangement at a Newfoundland Hospital in July 2002. Health Canada relayed the CHA concerns about this situation to the Newfoundland and Labrador Department of Health and Community Services. Newfoundland responded that there are no plans to reimburse the patient. A Canada Health Transfer (CHT) deduction in respect of this charge will be taken if the issue is not resolved.

Patient charges by specialty referral centres and for self-referrals to physician specialists

Since 2002, two specialist referral clinics in Vancouver have been offering expedited consultations with physician specialists for a fee for individuals who choose to bypass their family physicians to seek specialized treatment. Charges to insured persons for insured services contravene the CHA. This practice is also a concern from a CHA perspective because it encourages queue jumping for insured health services. During a meeting between British Columbia Ministry of Health Services and Health Canada officials in 2003, the province indicated that Medical Services Plan (MSP) policy allows specialists to bill self-referred patients for the difference between the fee paid by MSP and the fee charged to self-referred patients. Health Canada officials informed the province that this practice constitutes extra-billing under the CHA and further bilateral consultations are required on this issue.

Patient charges for insured health services in private surgical clinics

Health Canada has been engaged in bilateral discussions with British Columbia on patient charges for insured health services in private surgical clinics since June 2000. Currently, the British Columbia *Medicare Protection Act* prohibits charges to insured provincial residents for medically necessary services, but allows third parties, e.g,. Workers' Compensation Board, to pay for these services. Some physicians working in private clinics allow insured residents to purchase health services under the guise of third-party payor arrangements. Health Canada has

continued to press British Columbia to improve its capacity to audit and investigate charges at these facilities so that insured persons are not charged for insured health services. Following bilateral discussions, British Columbia passed the *Medicare Protection Amendment Act* (Bill 92) in December 2003. This legislation would have strengthened British Columbia's ability to audit and investigate those responsible for charging beneficiaries for insured health services, but it was not proclaimed. Health Canada officials had not indicated that legislative amendments were required, and left it to provincial officials to determine how best to resolve the problem of inappropriate patient charges. However, had this legislation come into effect, it would have addressed Health Canada's concerns. CHST deductions in respect of these charges were applied against the March 2004 CHST cash contribution, and future CHT deductions will be levied unless this issue is resolved.

Patient charges for bone density scans

In April 2002, the press reported that a Saskatchewan physician was providing preferred access to bone density scans to patients in return for a donation of $95 to a research foundation incorporated by the physician in 1995. Charges to insured persons for insured services contravene the CHA. This practice is a concern from a CHA perspective because it encourages queue-jumping for insured health services, and Health Canada subsequently communicated these concerns to Saskatchewan Health. In 2003, Saskatchewan Health informed Health Canada that they had exchanged correspondence with the physician about Saskatchewan's concerns and dissatisfaction with the practice. Health Canada has asked Saskatchewan about next steps.

Patient Charges for medical/surgical supplies

In September 2002, the press reported that Manitoba physicians were charging for medical/surgical supplies or "tray fees" to patients. Health Canada communicated the CHA concerns to Manitoba, namely, that charges to insured persons for insured services contravene the CHA. This issue was raised at a bilateral meeting between Health Canada and Manitoba Health officials in 2003, and Health Canada requested further information on Manitoba's policy regarding tray fees. Later in 2003, Health Canada obtained evidence of tray fees having been charged to a Manitoba resident at a non-hospital medical/surgical facility, and subsequently wrote to Manitoba to request an investigation. A response is still pending.

Patient charges by a private surgical clinic

Following media reports in March 2000, the Régie de l'assurance maladie du Québec (RAMQ) launched an investigation into claims that a Quebec private clinic was charging patients up to $400 for the use of operating rooms to perform medical procedures for which physicians billed the RAMQ. Health Canada originally communicated the *Canada Health Act* concerns about insured persons being charged for insured health services to the Quebec Department of Health and Social Services in 2000, requesting details about the RAMQ investigation. In October 2002, press reports continued to indicate that the clinic was still charging

patients. Health Canada has continued to advise Quebec that the practice of charging patients for the use of a facility during the provision of an insured service is a contravention of the CHA, and has made repeated requests that Quebec inform Health Canada of the results of its investigation into this practice. Quebec health ministry officials have responded that they are not at liberty to reveal the status of the province's investigation of the charges.

Drugs administered in hospitals

Health Canada is also concerned about patient charges for drugs administered in out-patient clinics of hospitals, and their appropriateness under the CHA. Some provinces cover such drugs e.g., Remicade, under provincial pharmacare programs rather than under hospital insurance programs. Health Canada officials have collected and are reviewing information provided by provinces during consultations on this issue.

Canada Health and Social Transfer (CHST) Deductions in 2003-2004

British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during 2001-2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST cash contribution, based on the Health Canada estimate for the amount of these changes, for the 2001-2002 fiscal year period.

With the closure of its abortion clinic in Halifax in November 2003, wherein patients were charged the facility fees in relation to the service, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Including adjustments for prior years, a net deduction of $7,119 was applied against Nova Scotia's CHST cash contribution during fiscal year 2003-2004.

Canada Health Act: Interpretation

There are two key policy statements that clarify the federal position on the *Canada Health Act* (CHA). These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the CHA. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal-provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal-Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all ministers of health present, with the exception of Alberta's health minister, agreed to "*...take whatever steps are required to regulate the development of private clinics in Canada.*"

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

Epp Letter

Minister of Health and Welfare - Ministre de la Santé et du Bien-être social
Ottawa, Canada
K1A 0K9

June 18, 1985

Dear Minister: [*The following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.*]

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act*. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priori-ties of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role - both financial and otherwise - to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physical and mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government

based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the *Canada Health Act* is to ensure that all bona-fide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for

obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act.*

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bona-fide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bona-fide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting inter-provincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a co-ordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can

implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/ territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;

2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985-86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth on page 6.

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It

encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communication are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp
Minister of Health

Federal Policy on Private Clinics

Minister of Health and Welfare - Ministre de la Santé et du Bien-être social
Ottawa, Canada
K1A 0K9

January 6, 1995

Dear Minister: [*Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.*]

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally

or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary

services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system - resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure

reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal-Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

"*... we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability*."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project. As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

Canada Health Act: Federal Transfers and Deductions

Provinces and territories must comply with the criteria and conditions of the *Canada Health Act* (CHA) in order to receive the full amount payable under the Canada Health Transfer. Prior to April 1, 2004, the cash contribution was payable under the Canada Health and Social Transfer (CHST). The following section outlines how Health Canada determines provincial and territorial compliance.

Health Canada's approach to resolving possible *Canada Health Act* compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. Deductions have only been applied when all options to resolve the issue have been exhausted. To date, most disputes and issues related to the administration and interpretation of the CHA have been addressed and resolved without resorting to deductions.

Health Canada officials routinely liaise with provincial and territorial health ministry representatives and health insurance plan administrators to help resolve common problems experienced by Canadians related to eligibility for health insurance coverage and portability of health services within and outside Canada.

Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the CHA. Sources for this information include: officials representing provincial and territorial governments; provincial and territorial government publications; media reports and correspondence received from the public and other non-government organizations and individuals.

Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and making recommendations to the Minister for appropriate follow-up action. Verification of the facts with provincial and territorial health officials may reveal issues that are not directly related to the CHA while others may pertain to the CHA but are a result of misunderstanding or miscommunication and are resolved quickly with provincial assistance. In instances where a CHA issue has been identified and remains after initial enquiries, Division officials then ask the jurisdiction in question to investigate the matter and report back. Division staff then discuss the issue and its possible resolution with provincial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, do the penalty provisions of the Act come into consideration.

Canada Health and Social Transfer (CHST) Deductions in 2003-2004

British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during 2001-2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST cash contribution, based on the Health Canada estimate for the amount of these changes, for the 2001- 2002 fiscal year period.

With the closure of its abortion clinic in Halifax in November 2003, wherein patients were charged the facility fees in relation to the service, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Including adjustments for prior years, a net deduction of $7,119 was applied against Nova Scotia's CHST cash contribution during fiscal year 2003-2004.

History of Deductions under the Canada Health Act

The *Canada Health Act*, which came into force April 1, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the Medical Care Act and the Hospital Insurance and Diagnostic Services Act. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the CHA provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244.732 million in deductions were refunded to New Brunswick ($6.886M), Quebec ($14.032M), Ontario ($106.656M), Manitoba ($1.270M), Saskatchewan ($2.107M), Alberta ($29.032M) and British Columbia ($84.749M).

Following the CHA's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the CHA did not reoccur until fiscal year 1994-1995. As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the CHA. Including deduction adjustments for prior years, dating back to

fiscal year 1992-1993, deductions began in May 1994 until extra-billing by physicians was banned when changes to British Columbia's Medicare Protection Act came into effect in September 1995. In total, $2.025 million was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992-1993 and 1995-1996. These deductions and all subsequent deductions are non-refundable.

In January 1995, the federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the CHA. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

During the period from November 1995 to June 1996, total deductions of $3.585 million were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996, Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of $284,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998.

For the period from November 1995 to December 1998, deductions from Manitoba's CHST cash contribution amounted to $2,055,000, ending with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001-2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of $50,033.50 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured services in fiscal years 1997-1998 and 1998-1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to $2,355,201.

With the closure of its abortion clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Prior to the closure, a total deduction of $372,135 was made from Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee.

In January 2003, British Columbia provided a financial statement in accordance with the CHA Extra-Billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and

user charges during fiscal year 2000-2001, totalling $4,610. Accordingly, a deduction of $4,610 was made to the March 2003 CHST cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001- 2002, in accordance with the requirements of the CHA Extra-Billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001-2002.

Since the enactment of the *Canada Health Act*, covering the period April 1984 to March 2004, deductions totalling $8,753,151 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the *Canada Health Act*. This amount excludes deductions totalling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces as per subsection 20 (5) of the CHA.

Table: Deductions to Cash Contributions under the Canada Health Act: 1994-95 through 2003-04

Evolution of Federal Health Care Transfers

Grants to help establish programs

Federal support for provincial health care goes back to the late 1940s when the National Health Grants were created. These grants were considered to be essential building blocks of a national health care system. While the grants were mainly used to build up the Canadian hospital infrastructure, they also supported initiatives in areas such as professional training, public health research, tuberculosis control and cancer treatment. By the mid 1960s, the grants available to the provinces totalled more than $60 million annually.

In the mid-1950s in response to public pressures, the federal government agreed to provide financial assistance to provinces to help them establish health insurance programs. In January 1956, the federal government placed concrete proposals before the provinces to inaugurate a phased health insurance program, with priority given to hospital insurance and diagnostic services. Discussions on these proposals led to the adoption of the *Hospital Insurance and Diagnostic Services Act* in 1957. The implementation of the Hospital Insurance and Diagnostic Services (HIDS) program started in July 1958, by which time Newfoundland, Saskatchewan, Alberta, British Columbia and Manitoba were operating hospital insurance plans. By 1961, all provinces and territories were participating in the program.

The second phase of the federal intervention supporting provincial and territorial health insurance programs resulted from the recommendations of the Royal

Commission on Health Services (Hall Commission). In its final report, tabled in 1964, the Hall Commission recommended establishing a new program that would ensure that all Canadians have access to necessary medical care (physician services, outside a hospital setting).

The *Medical Care Act* was introduced in Parliament in early December 1966 and received Royal Assent on December 21,1966. The implementation of the Medical Care program started on July 1, 1968. By 1972, all provinces and territories were participating in the program.

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (1966), the federal contribution was set at 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory. Funding protocols based on conditional grants continued until the move to block funding was made in fiscal year 1977-1978.

Established Programs Financing (EPF)

On April 1, 1977, federal funding supporting insured health care services was replaced by a block fund transfer with only general requirements related to maintaining a minimum standard of health services through the passage of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, 1977. Known also as the *EPF Act*, the new legislation provided federal contributions to the provinces and territories for insured hospital and medical care services (as well as for post-secondary education) that were no longer tied to provincial expenditures. Rather, federal contributions made in fiscal year 1975-1976 under the existing cost-sharing programs were designated as the base year for contributions, to be escalated by the rate of growth of nominal Gross National Product (GNP) and increases to the population.

Under the *EPF Act*, and subsequent funding arrangements, the total amount of the provincial and territorial health entitlement was now made up of relatively equal cash and tax transfers. The federal tax transfer involves the federal government ceding some of its "tax room" to the provincial and territorial governments, reducing its tax rate to allow provinces to raise their tax rates by an equivalent amount. With the EPF "health" tax transfer, the changes in federal and provincial tax rates offset one another, meaning there was no net impact on taxpayers. The total amount of the health care entitlement did not change.

The *EPF Act* also included a new transfer for the Extended Health Care Services Program. This group of health care services, defined as nursing home intermediate care, adult residential care, ambulatory health care and the health aspects of home care, were block funded on the basis of $20 per capita for fiscal year 1977-1978, and subject to the same escalator as insured health services. This portion of the EPF transfer was made on a virtually unconditional basis and,

unlike the insured services transfer, was not subject to specified program delivery criteria.

The health care portion of the EPF cash transfer was made on a semi-monthly basis to each province and territory by Health Canada. While this federal-provincial-territorial health care insurance funding arrangement did include certain program delivery criteria, Health Canada did not have a viable mechanism to compel the provinces and territories to fully comply with the conditions set out in the existing hospital and medical care legislation. Under the prevailing legislative framework, the Government of Canada was required to withhold all of the monthly health care transfer to a province or territory for each month if the conditions were not met.

It was not until the enactment of the *Canada Health Act* in 1984 that special deduction provisions came into force allowing for dollar-for-dollar deductions for extra-billing and user charges, and discretionary deductions when provincial and territorial plans failed to fully comply with other provisions set out in the Act. These criteria and conditions remain in force to the present day.

Canada Health and Social Transfer (CHST)

In the 1995 Budget, the federal government announced a restructuring of the *EPF Act*, now to be called the *Federal-Provincial Fiscal Arrangements Act*, with special provisions for a Canada Health and Social Transfer (CHST). The new omnibus or block transfer, to begin in fiscal year 1996-1997, merged the health and post-secondary education funding of the *EPF Act* with Canada Assistance Plan funding (the federal-provincial cost-sharing arrangement for social services). When the CHST came into effect on April 1, 1996, provinces and territories received CHST cash and tax transfer in lieu of entitlements under the Canada Assistance Plan (CAP) and Established Programs Financing. The combined value of EPF and CAP cash was greater than the CHST cash amount provided to provinces and territories, reflecting the need for fiscal restraint at the time the CHST was introduced.

Minor amendments to the CHA reflected a new definition for "cash contribution", and deletion of definitions for "*Act of 1977*" and "contribution". Revised wording of section 5 made cash contributions relating to all aspects of the CHA, eliminating the requirement for section 6 (for extended health care services). As well, the wording of sections 5 and 13(b) were changed to reference the CHST instead of the *Act of 1977*.

The new block fund was provided to support the national criteria and conditions in the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility) and the provisions relating to extra-billing and user charges, as well as maintaining the CAP-related national standard that no period of minimum residency be required or allowed with respect to social assistance. Extended health care services continued as part of the *Canada Health Act*, subject only to the provision of information and recognition of the federal transfer, as set out in section 13 of the *Canada Health Act*. To this day, these requirements remain unchanged since 1984.

The new legislation also transferred the cash payment authority from Health Canada to the Department of Finance. However, the Minister of Health continued to be responsible for determining the amounts of any deductions or withholdings pursuant to the *Canada Health Act*, including those for extra-billing and user charges, and for communicating these amounts to the Department of Finance before the payment dates. The Department of Finance makes the actual deductions, on behalf of the Department of Health, from the twice-monthly CHST cash contributions.

Health Accords: Increasing and restructuring federal support for health

In 2000 and 2003, First Ministers met to discuss health care, focusing on reform, reporting and funding requirements. In 2000, the federal government announced $23.4 billion in new spending over five years on health care renewal and early childhood development. Between 2001-2002 and 2005-2006, the government announced an additional $21.1 billion dollars for increases to the CHST cash contributions, as well as an additional $1.8 billion for targeted programs (medical equipment and primary health care reform), and $500 million for Canada Health Infoway.

In 2003, the government committed $36.8 billion over five years to support priority areas of reform (primary care, home care and catastrophic drugs) through increased CHST transfers ($14 billion) and new, targeted transfers ($16 billion for the Health Reform Transfer; $1.5 billion for medical equipment), as well as support for federal direct spending on health. This included $3.9 billion in unrealized CHST increases committed under the original timeframe of the 2000 Accord (up to and including 2005-2006).

The federal government also agreed to restructure the CHST to enhance the transparency and accountability of federal support for health and other social programs.

The Canada Health Transfer (CHT)

The CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), effective April 1, 2004. The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the *Canada Health Act*. The CST, a block fund that support post-secondary education and social assistance and social services, continues to give provinces and territories the flexibility to allocate funds among social programs according to their respective priorities.

The existing CHST-legislated amounts have been apportioned between the new transfers, with the percentage of cash and tax points allocated to each transfer reflecting provincial and territorial spending patterns among the areas supported by the transfers: 62 percent for the CHT and 38 percent for the CST.

The government's 2003 budget set out a long-term predictable, sustainable and growing funding framework for CHT and CST transfers, providing legislated cash levels up to 2007-2008, while the tax transfer component continues to grow in line with the economy. CHT cash and tax transfers are forecasted to be $25.1 billion in 2004-2005 ($14.3 billion in cash transfers, including CHST supplements, and $10.8 billion in tax transfers). CHT cash and tax transfers will reach $26.9 billion in 2007-2008. In total, over the five-year period of the Accord, cash support for health alone will grow by an average annual rate of 10.2 percent.

Targeted federal transfers supporting health

Health Reform: As part of the 2003 Accord on Health Care Renewal, the Government of Canada created a five-year, $16-billion Health Reform Transfer (HRT) to help provinces and territories accelerate reform in priority areas identified by First Ministers: primary care, home care and catastrophic drug coverage. First Ministers agreed to prepare annual public reports to their citizens on each of the reform areas using comparable indicators, to inform Canadians on progress achieved and key outcomes. Funding provided under the HRT will be integrated into the CHT, subject to a review by First Ministers by March 31, 2008, of progress made in achieving reform objectives.

In 2004-2005, provinces and territories will receive $1.5 billion under the HRT, which is allocated on an equal per capita basis. All cash funding under the CHT, CST and HRT can be withheld under the *Canada Health Act*.

Medical Equipment: Under the 2000 and 2003 Accords, the federal government provided provinces and territories with $2.5 billion to enhance the availability of publicly funded diagnostic care and treatment services. The funds were paid to third-party trusts, giving provinces and territories the flexibility to draw down funds as required over the lifespan of the trusts. These funds were allocated on an equal per capita basis. As they did for the HRT, provincial and territorial governments were to report to Canadians on how they invested the funding.

Additional information on federal-provincial-territorial funding arrangements is available on request from the Department of Finance, or by visiting its Web site.

History of Federal Transfers Related to Health Care

1957 --The *Hospital Insurance and Diagnostic Services Act* is passed unanimously in both the House of Commons and the Senate, establishing a cost-shared program providing universal insurance coverage and access to hospital services to all residents of participating provinces. By 1961, all provinces and territories have joined this program.

1966 -- The Canada Assistance Plan (CAP) is introduced, enabling the federal government to pay for, among other things, half the cost of certain services

required by persons deemed to be in need, but not funded though other federal programs, including the *Hospital Insurance and Diagnostic Insurance Act.*

1968 -- The *Medical Care Act* is enacted, establishing a cost-sharing program that empowers the federal Health Minister to make financial contributions to those provinces and territories that operate medical care insurance plans and meet minimum delivery criteria. By 1972, all provinces and territories are participating in this program.

1977 -- The *Federal-Provincial-Territorial Fiscal Arrangements and Established Programs Financing Act* (*EPF Act*) is passed. The Extended Health Care Services Program is established providing virtually unconditional per capita funding for certain types of long-term residential care services, home care and adult day care services.

1984 -- The *Canada Health Act* (CHA) is passed, amalgamating the provisions of the *Hospital Insurance and Diagnostic Services Act* and the Medi*cal Care Act*. The Act also includes the extended health care services provisions, which had previously been included under the EPF. The *Canada Health Act* now provides for dollar-for-dollar deductions regarding extra-billing and user charges, and discretionary deductions relating to other elements of the criteria and conditions set out in the Act.

The *EPF Act* is re-named *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, 1977.

1995 -- It is announced in the federal budget that in "established programs" funding under the EPF Act and CAP cost sharing will be replaced by Canada Health and Social Transfer (CHST) block fund beginning April 1, 1996. CHST entitlements are set at $26.9 billion for 1996-1997. CHST entitlements for 1996-1997 are to be allocated in the same proportion as combined EPF and CAP entitlements for 1995-1996.

Section 6 of the CHA (amount payable for extended health care services) was deleted in 1995 to reflect the new fiscal arrangements adopted by the government (i.e., Canada Health and Social Transfer) that required one payment to provinces and territories rather than multiple payments. This change did not reduce the scope of insured health services under the Act. Extended health care services are not and never were insured health services under the CHA.

1996 -- A five-year CHST funding arrangement (1998-1999 to 2002-2003) is announced in the federal government budget. It provides a cash floor transfer to provinces and territories of $11 billion per year.

1998 -- The *Federal-Provincial-Territorial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* is amended to put in place a $12.5 billion CHST cash floor, beginning in 1997-1998 and extending to 2002-2003.

1999 -- Increases in provincial and territorial CHST cash entitlements of $11.5 billion over five years are announced in the federal government budget. The $11.5 billion is provided to address fiscal pressures in the health care sector.

2000 -- Increased CHST funding of $2.5 billion to help provinces and territories fund health care and post-secondary education is announced in the February Budget. This brings CHST cash to $15.5 billion for each of the years from 2000-2001 to 2003-2004.

Following the First Ministers Meeting of September 11, 2000, the Prime Minister announces an increase in health funding through the CHST of more than $21 billion dollars in cash entitlements over five years. The new money addresses concerns raised by provincial and territorial governments that additional funds are needed to deal with immediate fiscal pressures in the health, post-secondary education and social services/social assistance sectors.

A $1billion Medical Equipment Fund is established to enable provinces and territories to immediately purchase and install medical equipment for diagnostic services and treatment. The Fund was allocated on an equal per capita basis in fiscal years 2000-2001 and 2001-2002.

2003 -- Federal transfers supporting provincial and territorial health care are restructured following the February 2003 Health Care Renewal Accord and the subsequent 2003 Budget. The CHST is augmented by the five-year $16 billion Health Reform Fund beginning in 2003-2004. Two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), are to be established by April 1, 2004, from a split in the CHST.

As part of the 2003 Accord, the federal government also provided provinces and territories with a three-year, $1.5 billion Diagnostic/Medical Equipment Fund to support specialized staff training and equipment that improves access to publicly funded diagnostic services.

Canada Health Act: Provincial and Territorial Health Insurance Plans

The following material describes the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system, demonstrating clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* (CHA) program criteria and conditions in 2003-2004.

Officials in the provincial, territorial and federal governments have worked together to provide and review the information. The information submitted to Health Canada for this report by each provincial and territorial department of health consists of two components:

- a narrative description of the provincial or territorial health care system relating to the five criteria and the first condition (that of providing the Minister of Health with information in relation to insured health services and extended health care services) of the CHA; and
- statistics identifying trends in the provincial and territorial health care systems, which are included at the end of each narrative description.

The first component is used to help with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the CHA, while statistics identify current and future trends in the Canadian health care system.

To help prepare their submissions to the report, Health Canada has provided provinces and territories with the document *Canada Health Act Annual Report - 2003-2004: A Guide for Updating Submissions*. This guide is designed to help provinces and territories meet the reporting requirements of Health Canada and was developed through discussion with provincial and territorial officials. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

Provincial and Territorial Submissions

- Newfoundland and Labrador
- Prince Edward Island
- Nova Scotia
- New Brunswick
- Quebec
- Ontario
- Manitoba
- Saskatchewan

- Alberta
- British Columbia
- Yukon
- Northwest Territories
- Nunavut

Dispute Avoidance and Resolution Process under the Canada Health Act

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In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/ territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the CHA dispute avoidance and resolution process to deal with *Canada Health Act* interpretation issues.

In the material that follows you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the *Canada Health Act* Dispute Avoidance and Resolution process. In response, Premier Klein accepted the process as outlined in Minister McLellan's letter on behalf of all provincial and territorial governments with the exception of the Quebec government.

Fact Sheet: *Canada Health Act* Dispute Avoidance and Resolution Process

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*. Dispute Avoidance To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance

provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

Minister of Health - Ministre de la Santé
Ottawa, Canada
K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act*.

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad

hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has follo|wed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and health ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on

performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

Canada Health Act: Resources

Canada Health Act Annual Reports

Legislation

- Canada Health Act (June 2001) (Office Consolidation)
- Extra-Billing and User Charges Information Regulations (Office Consolidation)

Frequently Asked Questions

Glossary of Terms

Links and Related documents