Information

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Canada Health Act Overview

What is the Canada Health Act?

The *Canada Health Act* is Canada's federal health insurance legislation.

Backgrounders
- Canada Health and Social Transfer
- Federal Transfers to Provinces and Territories
- Fact Sheet CHA Dispute Avoidance and Resolution
- Canada's Health Care System at a Glance

The provinces of Canada are constitutionally responsible for the administration and delivery of health care services. They decide where their hospitals will be located, how many physicians they will need, and how much money they will spend on their health care systems. The *Canada Health Act* establishes the criteria and conditions related to insured health care services-the national standards-that the provinces and territories must meet in order to receive the full federal cash transfer contribution under the transfer mechanism, that is, the Canada Health and Social Transfer (CHST).

The aim of Canada's health care system is to ensure that all residents of Canada have reasonable access to medically necessary insured services without direct charges.

Evolution of the Act

The Canadian health care system evolved into its present form over five decades. Saskatchewan, in 1947, was the first province to establish public, universal hospital insurance, and 10 years later, the Government of Canada passed legislation to share in the cost of these services. By 1961, all 10 provinces and two territories had public insurance plans that provided universal access to hospital services.

Saskatchewan again pioneered in providing insurance for physicians' services beginning in 1962. In 1968, the federal government began cost-sharing of physician services and by 1972, all provincial and territorial plans had been extended to include these services.

A health services review was undertaken in 1979 by Justice Emmett Hall. He reported that health care services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the accessibility of care.

In response to Canadian's needs and wishes, The *Canada Health Act* was passed in 1984, receiving the unanimous consent of the House of Commons and the Senate. The Act replaced the two preceding acts, but retained and entrenched the criteria, or basic principles, underlying the national health insurance program that had been contained in the earlier legislation, the *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1968).

The most striking difference between the old acts and the new *Canada Health Act* was the addition of provisions aimed at eliminating direct charges to patients in the form of extra-billing and user charges, with respect to insured health care services. These charges are discouraged under the Act by being subject to mandatory dollar-for-dollar deductions from federal transfer payments to the provinces and territories.

Reporting to Canadians

In accordance with one of the requirements of the Act, governments are required to provide information on the operation of their health care plans as they relate to the conditions of the Act.

The purpose of the *Canada Health Act* Annual Report is to report to Parliament all relevant information on the extent to which provincial and territorial health care insurance plans have satisfied the criteria and conditions for payment under the *Canada Health Act*.

The *Canada Health Act Annual Report 2000-2001* was presented to Parliament in February 2002. Health Canada has expanded the range and depth of information in its latest Report to facilitate a better understanding of how provinces and territories comply with the *Canada Health Act*. For instance, the Annual Report now provides an introductory description of each province's and territory's health care insurance plan, a review of how insured health care services satisfy each requirement of the *Canada Health Act* and a description of major changes and developments during the year.

The Annual Report is online at www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2003-cha-lcs-ar-ra/index_e.html, or you can order a copy directly from Health Canada Publications, (613) 954-5995.

Principles of the *Canada Health Act*

The Criteria

1. **Public Administration:** This criterion applies to the health insurance plans of the provinces and territories. The health care insurance plans are to be administered and operated on a non-profit basis by a public authority, responsible to the provincial/territorial governments and subject to audits of their accounts and financial transactions.

2. **Comprehensiveness:** The health insurance plans of the provinces and territories must insure all insured health services* (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners. *See definition under Health Care Services Covered by the Act.

3. **Universality:** One hundred percent of the insured residents of a province or territory must be entitled to the insured health services provided by the plans on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

4. **Portability:** Residents moving from one province or territory to another must continue to be covered for insured health care services by the "home" province during any minimum waiting period, not to exceed three months, imposed by the new province of residence. After the waiting period, the new province or territory of residence assumes health care coverage.

   Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services. This allows individuals to travel or be absent, within prescribed limits, from their home provinces or territories but still retain their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is more intended to entitle one 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, insured services are to 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.

In some cases, coverage may be extended for elective (non-emergency) service in another province or territory, or out of the country. Prior approval by one's health insurance plan may also be required.

5. **Accessibility:** The health insurance plans of the provinces and territories must provide:

- reasonable access to insured health care services on uniform terms and conditions, unprecluded, unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (age, health status or financial circumstances);
- reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting;
- reasonable compensation to physicians and dentists for all the insured health care services they provide; and
- payment to hospitals to cover the cost of insured health care services.

Further Requirements of the Act

The *Canada Health Act* contains the following nine requirements that the provinces and territories must meet in order to qualify for the full federal cash contributions:

- five program criteria that apply only to insured health care services (see Principles of the *Canada Health Act*);
- two conditions that apply to insured health care services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health care services.

The Conditions

Information - the provincial and territorial governments are to provide information to the Minister of Health as may be reasonably required, in relation to insured health care services and extended health care services, for the purposes of the *Canada Health Act*.

Recognition - the provincial and territorial governments are to appropriately recognize the federal contributions toward both insured and extended health care services.

Extra-billing and User Charges

Extra-billing - this occurs if a physician or a dentist directly charges an insured person for an insured service that is in addition to the amount that would normally be paid for by the provincial or territorial health insurance plan. For example, if a physician were to charge patients five dollars for an office visit that is insured by a health insurance plan, the five-dollar charge would be extra-billing.

User charges - these are direct charges to patients, other than extra-billing, for

insured services of a province or territory's health insurance plan that are not payable, directly or indirectly, by the health insurance plan. For example, if patients were charged a fee before being provided treatment at a hospital emergency department, the fee would be considered a user charge.

Health Care Services Covered by the Act

There are two groups of services covered by the *Canada Health Act*:

- insured health care services; and
- extended health care services.

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

Insured hospital services are defined under the *Canada Health Act* and include medically necessary in-patient and out-patient services such as standard or public ward accommodation; nursing services; diagnostic procedures such as blood tests and X-rays; drugs administered in hospital; and the use of operating rooms, case rooms and anaesthetic facilities.

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.

Insured persons are eligible residents of a province, but do not include those who may be covered by other federal or provincial legislation. Persons not covered by the *Canada Health Act* include serving members of the Canadian Forces or Royal Canadian Mounted Police, inmates of federal penitentiaries, and persons covered by provincial workers' compensation. Some categories of resident, such as landed immigrants and Canadians returning to live in Canada from other countries, 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 care services.

Extended health care services covered by the *Canada Health Act* 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.

Health Care Services not Covered by the Act

In addition to the medically necessary insured hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of services and benefits outside the scope of the Act. These additional services and benefits are provided at provincial and territorial discretion, on their own terms and conditions, and may vary from one province or territory to another. Additional services may include optometric services, dental services, chiropractic services and prescription drug benefits.

The additional services provided by the provinces and territories may be targeted to specific population groups (e.g., children or seniors), 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, cosmetic surgery, 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 surgery.

Mandatory and Discretionary Penalties

Consultation process - the *Canada Health Act* mandates a consultation process with the province or territory before discretionary penalties can be levied. In April 2002, federal, provincial and territorial governments agreed to a *Canada Health Act* dispute avoidance and resolution process.

Mandatory penalties - under the *Canada Health Act*, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments. 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 penalties - breaches of the five criteria and two conditions of the *Canada Health Act* are subject to discretionary penalties. The amount of any deduction is based on the gravity of the default.

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Important Notices