6.2.5 Provincial medical care programs

When the criteria stipulated under the Medical Care Act (Section 6.1.1.1) have been met by a province, the federal government contributes an annual sum equal to half the national per capita cost of insured services multiplied by the average number of insured persons in that province. Although co-insurance or deterrent charges are not favoured by the federal government, they are not ruled out by the federal Act, provided that they are not of such a size as would violate the principle of universality by denying services to low-income groups. Since the implementation of the Act, only one province, Saskatchewan, charged a deterrent fee, but this was abandoned in 1971.

As with hospital insurance, a variety of methods is used at the provincial level to finance its share of the cost. Combined hospital and medical premiums are charged in Ontario and Alberta, but are waived for those over 65, as they are in Saskatchewan. Premiums partially finance the plans of British Columbia, Saskatchewan, Manitoba and the Yukon Territory, the remainder of the cost being covered by general revenues. No medicare premiums are charged in New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and the Northwest Territories, where the plans are financed through general revenues. Quebec levies a special income tax surcharge and a similar levy on employers to finance its program.

Coverage for medical care benefits in Canada is approaching the 100% mark. The only exclusions are those covered under workmen's compensation legislation, or programs for the Armed Forces, the Royal Canadian Mounted Police, war pensioners and inmates of federal penitentiaries. In Saskatchewan, coverage is compulsory, but eligibility for benefits is linked to premium payments. Coverage by the combined plan in Ontario is on a compulsory basis for employee groups of more than 15 persons, but is voluntary for others. British Columbia's plan is totally voluntary. In other premium-paying plans (such as in Manitoba and the Yukon Territory) premium payment has been separated from entitlement to benefits. In non-premium provinces, all residents are insured. As with hospital insurance, the patient is allowed free choice of physician when he seeks treatment. Many provincial medical plans also provide additional benefits beyond those required by the national legislation, such as optometrical services.

Although most basic medical costs are covered by the program, there still exists a need in certain quarters for benefits supplementary to those already provided. In the case of needy citizens, it is possible for the federal government, through the provinces, to finance half the cost of other health care services such as dental services, prescription drugs or eyeglasses through the Canada Assistance Plan. Eligibility for such assistance depends upon a needs test. Each province administers its supplementary welfare programs as it sees fit, and there is no uniformity among them.

Additional coverage for the balance of the population is either paid for entirely by the individual himself or can be purchased through a private carrier. At its discretion, any carrier can market coverage for drugs, dental services, special nurses, allied health professionals, prosthetic appliances, or the cost of extended care accommodation. However, most commercial carriers have displayed a reluctance to market coverage on a non-group basis, and most of the above benefits have been included under "major medical" contracts.

In all provinces, provision has been made for physicians to "opt out" of the medical care plan and to bill their patients directly, rather than through the public authority. Opted-out doctors are generally required to inform their patients of their intention before treating them and they usually charge more than the benefits payable by the provincial plan for their services. This means that their patients are not usually reimbursed for the full amount when they submit their bills to the provincial medical care plan for payment. Opting out by physicians is not a particularly widespread phenomenon in most provinces, being limited to less than 10% of all doctors, and in some provinces there are no opted-out doctors. Many of the non-participating doctors, however, do not in practice bill for a fee higher than the benefits available under the plan if they are aware of an individual's financial difficulties.

6.2.6 Emergency health services

The Emergency Health Services Division, established in 1959 within the federal Department of National Health and Welfare, encourages the provinces, with the support of an advisory committee, to develop their own emergency health services divisions. These are organized under a provincial director who is generally assisted by a health-supplies officer and