CHAAR 2010-11 Statistical Tables Template
British Columbia

Registered Persons					
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
1. Number as of March 31st (#).	4,279,734	4,335,676	4,402,540	4,469,177	4,521,503

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
2. Number (#).	120 [1]	120 [1]	119 [1]	119 [1]	119 [1]
3. Payments for insured health services ($) [2]	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2006-2007**	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**
4. Number of private for-profit facilities providing insured health services (#).	22	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services($).	not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
6. Total number of claims, in-patient (#).	7,172	7,160	7,102	6,846	5,909
7. Total payments, in-patient ($).	65,678,542	55,309,733	64,550,692	64,655,739	67,078,612
8. Total number of claims, out-patient (#).	81,878	95,677	95,326	87,948	78,075
9. Total payments, out-patient ($).	17,937,647	19,088,368	24,262,195	24,188,890	21,830,298
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	1,858	1,603	1,963	3,056	2,469
11. Total payments, in-patient ($).	3,452,739	14,486,341	11,811,654	6,058,867	4,452,628
12. Total number of claims, out-patient (#).	960	1,215	1,630	1,920	1,940
13. Total payments, out-patient ($).	453,698	553,661	967,704	1,174,112	999,733

General information for statistical indicators 1-2: Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year. The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the Societies Act because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

[1] As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

[2] BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $7.1 billion in 2006–2007, $7.64 billion in 2007–2008, $8.2 billion in 2008–2009, $8.6 billion in 2009–2010, and $8.94 billion in 2010–2011.

Insured Physician Services Within Own Province or Territory					
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
14. Number of participating physicians (#).	8,626 [3]	8,772 [3]	8,986 [3]	9,201 [3]	9,417 [3]
15. Number of opted-out physicians (#).	5	5	5	5	5
16. Number of not participating physicians (#).	1	2	2	2	not available [4]
17. Total payments for services provided by physicians paid through all payment methods ($)	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service	2,136,478,686 [5]	2,234,652,895 [5]	2,334,513,866 [5]	2,460,945,514 [5]	2,541,920,220 [5]

Insured Physician Services Provided to Residents in Another Province or Territory					
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
19. Number of services (#).	869,076	724,900	735,829	622,229	624,569
20. Total payments ($).	27,402,618	26,464,075	28,703,587	29,591,572	30,719,900
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	80,810	84,204	82,654	75,190	41,369
22. Total payments ($).	3,739,839	4,379,977	4,528,057	3,880,760	2,151,509

Insured Surgical-Dental Services Within Own Province or Territory					
	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
23. Number of participating dentists (#).	234	245	249	243	236
24. Number of services provided (#).	44,015	43,262	46,736	50,341	51,036
25. Total payments ($).	6,087,395	6,305,343	7,289,302	8,093,266	7,991,262

[3] The number of participating physicians in item 14 is for physicians who received payments through Fee-For-Service.

[4] Based on reclassification of information and corresponding data, BC does not track non-participating physicians. Data for item number 16 is not available.

[5] The MSP Fee-For-Service payments in item 18 are restated to include medical services referred to medical practitioners by midwives or nurse practitioners.

British Columbia

Introduction

The British Columbia health system is one of our most valued social programs; virtually every person in the province will access some level of health care or health service during their lives. British Columbia has a progressive and integrated health system that includes insured services funded under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded by, government. The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, and timely health services are available to all British Columbians.

The Ministry works with health authorities, care providers, agencies, and other groups to guide and enhance the province's health services, provide access to care, and ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction, and support to these service delivery partners and sets province-wide goals, standards, and expectations for health service delivery by health authorities. The Ministry directly manages a number of provincial programs and services. These programs include: the Medical Services Plan, which covers most physician services; PharmaCare, which provides prescription drug insurance for British Columbians; the BC Vital Statistics Agency, which registers and reports on vital events such as a birth, death or marriage; and HealthLink BC, a confidential, non-emergency health information, advice, and health system navigation platform providing multi-disciplinary comprehensive self-care service. It is available 24/7 by telephone (8-1-1), on the web (www.healthlinkbc.ca), and in print resources (BC HealthGuide Handbook).

The province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of services and province-wide health programs. These include the specialized programs and services provided through the following agencies: Emergency and Health Services Commission which operates both BC Ambulance Service and BC Bedline, the provincial acute bed management system; BC Cancer Agency; BC Centre for Disease Control; BC Children's Hospital and Sunny Hill Health Centre for Children; BC Women's Hospital and Health Centre; BC Provincial Renal Agency; BC Transplant Society; Cardiac Services BC; BC Mental Health and Addiction Services including Riverview Hospital and the Forensic Psychiatric Services Commission; and Perinatal Services BC.

In 2010–2011, the Government of British Columbia invested $16.15 billion to meet the health needs of British Columbians. This expenditure was made across a wide spectrum of programs and services aligned with the Ministry's goals. The delivery of health services and the health of the population are monitored by the Ministry on an ongoing basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health information

and services continue to meet the needs of British Columbians.

The following section highlights significant achievements in 2010–2011 in areas relevant to the Canada Health Act Annual Report: providing increased access to care, innovation in health care, and health human resources.

Access to care:

- Opened the $9.4 million renal unit at Nanaimo Regional General Hospital, benefitting kidney patients across Central and Northern Vancouver Island, and opened the $349 million Patient Care Centre at Royal Jubilee Hospital in Victoria.
- Completed the $4.3 million newly redeveloped Invermere and District Hospital emergency department, doubling the size of the emergency department and improving patient flow, and completed the $24.7 million Shuswap Lake General Hospital redevelopment.
- Began construction on the new $36.9 million emergency department at Nanaimo Regional General Hospital, and worked with Canuck Place, the Provincial Health Services Authority, the Ministry of Children and Family Development, and the Fraser Health Authority to guide the expansion of hospice services for children in British Columbia.
- Increased investment in cancer care and control through the BC Cancer Agency by 151 percent since 2000–2001. Began construction on the $106 million BC Cancer Agency for the North, which will eliminate the need for northern residents to travel south for treatment.
- Reached a new agreement with emergency room physicians, providing an increase to the number of doctors in 19 emergency departments across the province. Over the 2010–2011 and 2011–2012 fiscal years, the Province's funding commitment will increase by up to $12 million for physician services in the affected hospitals over the two years.
- Continued to close the gap in health status between Aboriginal peoples and the rest of the British Columbia population by negotiating the BC Framework Agreement on First Nations Health Governance, which outlines the transfer of health resources to First Nations, to enable and empower First Nations people to better govern their own health and well-being.
- Launched a new surgical wait times website, which helps patients work with their general practitioners to decide whether there is a faster or more appropriate treatment available, and helps health authorities and the Province make decisions about funding and surgical resource allocation.
- Increased guideline-based care by family physicians; for example, planned chronic disease or complex care was provided to 575,894 patients as at February 2011, which is ten percent higher than at February 2010.

Innovation in health care:

In early 2010, British Columbia embarked on an innovation and change agenda, which is based on two key actions: 1) Where possible and appropriate, British Columbia can lower cost, improve patient outcomes, and improve patient experience by moving patient care from high cost, high intensity services such as hospital care to lower cost services within the community, and 2) Improve the efficiency of the system and drive innovation while continuing to meet the needs of the British Columbia population.

The innovation and change agenda is showing results:

- Patient-focused funding was introduced in April 2010 to provide quicker emergency department care, reduce surgery wait times, and increase the number of same-day surgical procedures where appropriate. With 2010–2011 patient-focused funding, an additional 36,000 patients received surgeries and diagnostic care and an additional 67,000 emergency department patients were seen within the targeted wait times.
- More than 125 Lean events were held across the province aimed at improving workflow and efficiency, improving services to patients, and reducing costs in the health system.
- Through initiatives such as active waitlist management and Activity-Based Funding, British Columbia has increased the number of hip replacements from 4,478 in 2009–2010 to 4,600 in 2010–2011. Over 400 more knee joint replacements were completed from the previous fiscal year and the 90th percentile wait time dropped by 3.7 weeks.
- The Province is providing help to British Columbia smokers who want to quit as part of its prevention initiative. The Prescription for Health program helps primary care providers give British Columbia doctors additional tools to help support those patients who smoke, are physically inactive, obese, or have unhealthy eating practices. QuitNow Services offers free smoking cessation supports 24 hours a day through web, text, and telephone services.
- The Province negotiated an agreement with the community pharmacy sector that will reduce the price of generic drugs in British Columbia, and save the British Columbia health system tens of millions of dollars per year.

Health human resources:

- Since 2004, the University of British Columbia (UBC) medical school has more than doubled the number of first-year seats for undergraduate medical students to 256, and distributed training programs outside the Lower Mainland to the Northern Medical Program in Prince George, the Island Medical Program in Victoria, and the Southern Medical Program which opened in the Okanagan in September 2011. By 2015, approximately 1,150 medical students are expected to be in training at any one time in BC.
- Growth in postgraduate medical education (residencies) has kept pace with undergraduate expansion. Since 2004, British Columbia has more than doubled the number of first-year residencies for Canadian medical graduates to 256, and tripled the number for international medical graduates (IMG) to 19.
- Starting in 2011, the IMG-BC Program is expected to expand and distribute its program by an additional 40 first-year residencies in family medicine over the next five years. By

2015, 1,200 residents are expected to be in training at any one time, and by 2020, over 300 new physicians are expected to be ready to enter practice each year.

- The College of Physicians and Surgeons of British Columbia reported 10,726 professionally active physicians in British Columbia in 2010.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The British Columbia Medical Services Plan (MSP) is administered by the British Columbia Ministry of Health. MSP insures medically required services provided by physicians and supplementary health care practitioners, laboratory services, and diagnostic procedures. The Ministry of Health sets goals, standards and performance agreements for health service delivery and works with the six health authorities to provide quality, appropriate and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages MSP on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose is to preserve a publicly-managed and fiscally sustainable health care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function and mandate of the MSC is to facilitate, under MSP, reasonable access to quality medical care, health care, and diagnostic services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of British Columbia, three representatives from the British Columbia Medical Association (BCMA), and three members from the public jointly nominated by the BCMA and government.

1.2 Reporting Relationship

The Medical Services Commission (MSC) is accountable to the Government of British Columbia through the Minister of Health; a report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees and other delegated bodies. In addition, the MSC Financial Statement is published annually: it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

The Ministry of Health (the Ministry) provides extensive information in the Annual Service Plan Report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act* (2000).

In addition to the Annual Service Plan Report, the Ministry reports through various publications, including:
• Vital Statistics Annual Report;
• Health Authority Government Letters of Expectations and Reports;
• Provincial Health Officer's Annual Report (on the health of the population);
• Nationally Comparable Indicators Report (Canadian Institute for Health Information); and
• Medical Services Commission Annual Report.

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

• The Office of the Comptroller General's Internal Audit and Advisory Services, the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry.

• The Office of the Auditor General (OAG) of British Columbia is responsible for conducting audits and reporting its findings to the Legislative Assembly. The OAG initiates its own audits and the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines when the Ministry has complied with the audit recommendations.

1.4 Designated Agency

The MSP of British Columbia requires premiums to be paid by eligible residents. The monies were collected by the Ministry of Finance during the 2010–2011 fiscal year. Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance and collection, on behalf of the Province of British Columbia (Ministry of Finance). The Province remains responsible for, retains control of, and performs all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:
• *Ombudsman Act* (British Columbia)
• *Business Practices and Consumer Protection Act* (British Columbia)
• *Financial Administration Act* (British Columbia)
• Freedom of Information Legislation: i.e., *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

In 2005, the Ministry of Health contracted with MAXIMUS BC to deliver the operations of the Medical Services Plan and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). The new organization is called Health Insurance BC (HIBC). Policy and decision-making functions remain with the Ministry of Health (the Ministry).

• HIBC submits monthly reports to the Ministry, reporting performance on service levels to the public and health care providers. HIBC also posts reports on its website on performance of key service levels.

• HIBC applies payments against fee items approved by the Ministry. The Ministry approves all payments before they are released.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister of Health to designate facilities as hospitals, to license private residential care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* provides the authority for the Minister of Health to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital and are deemed medically required by the attending physician or midwife. These services are provided to beneficiaries without charge, with the exception of incremental charges for preferred, but not medically required, medical/surgical supplies, nonstandard accommodation when not medically required and, for residential care patients in extended care or general hospitals, a daily fee based on income.

General hospital services and the conditions under which they are provided are described in the Hospital Insurance Act Regulations and include the following for in-patients: accommodation and meals at the standard or public ward level; necessary nursing services; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury or disability; drugs, biological, and related preparations; routine surgical supplies; use of operating room and case room and anaesthetic facilities, including necessary equipment and supplies; use of radiotherapy and physiotherapy facilities, where available; and other services approved by the Minister.

The following out-patient general hospital services are also insured: day care surgical services; out-patient renal dialysis treatments in designated hospitals or other approved facilities; diabetic day-care services in designated hospitals; out-patient dietetic counselling services at hospitals with qualified staff dieticians; psychiatric out-patient and day-care services; rehabilitation out-patient services; cancer therapy and cytology services; out-patient psoriasis treatment; abortion services; and magnetic resonance imaging (MRI) services. In addition, a wide variety of out-

patient clinic services are insured when delivered in a hospital.

Insured services in rehabilitation hospitals include: accommodation and meals at the standard or public ward level; necessary nursing services; drugs, biologicals and related preparations; use of physiotherapy and occupational therapy facilities; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease, and helping diagnose and treat illness, injury, or disability; and other services approved by the Minister.

Insured services in extended care hospitals include: accommodation and meals at the standard ward level; necessary nursing services; drugs, biologicals, and related preparations; laboratory and radiological procedures and necessary interpretations together with such other diagnostic procedures as approved by the Minister in a particular hospital with the necessary interpretations, for maintaining health, preventing disease and helping diagnose and treat illness, injury, or disability; and other services approved by the Minister.

Insured hospital services do not include: transportation to and from hospital (however, ambulance transfers are insured under another Ministry program, with a small user charge); services or treatment that the Minister, or a person designated by the Minister, determines, on a review of the medical evidence, the beneficiary does not require; services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council; and services provided to non-beneficiaries.

No new hospital services were added during the 2010–2011 fiscal year. There is no regular process to review insured hospital services, as the list of insured services included in the regulations is intended to be both comprehensive and generic and does not require routine review and updating. There is a formal process to add specific medical services (physician fee items) to the list of services insured under the *Medicare Protection Act,* and this process is described in Section 2.2 of this report.

2.2 Insured Physician Services

The range of insured physician services covered by the Medical Services Plan (MSP) includes all medically necessary diagnostic and treatment services. Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care practitioners, such as midwives) who are enrolled and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA in accordance with the *Canada Health Act*:
- medically required services provided to "beneficiaries" (residents of British Columbia) by a medical practitioner enrolled with MSP; and
- medically required services performed in an approved diagnostic facility under the supervision

of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In the fiscal year 2010–2011, 9,417 physicians (includes only general practitioners and medical specialists who billed fee-for-service (FFS) in 2010–2011) were enrolled with MSP and billed FFS. In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) with the health authorities. Physicians paid by these alternative mechanisms may also practice on a FFS basis. Non-physician healthcare practitioners who may be enrolled to provide insured services under MSP are midwives and supplementary benefit practitioners (dental surgeons, optometrists, osteopaths, surgical podiatrists, and acupuncture practitioners). Only those MSP beneficiaries with premium assistance status qualify for MSP coverage of physiotherapy, massage therapy, chiropractic, naturopathy, acupuncture, and non-surgical podiatry services. In 2010–2011, there were 180 midwives and 6,071 supplementary benefits practitioners paid FFS through MSP.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission (MSC). Enrolled physicians may cancel their enrolment by giving 30 days written notice to MSC. Patients are responsible for the full cost of services provided by non-enrolled physicians. In 2010–2011, MSP had 5 opted-out physicians. Based on reclassification of information and corresponding data, British Columbia does not track non-participating physicians.

Enrolled physicians can elect to be paid directly by patients by giving written notice to MSC. MSC will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered.

Under the Master Agreement between the government, MSC, and the British Columbia Medical Association (BCMA), modifications to the Payment Schedule such as additions, deletions or fee changes are made by MSC, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2010–2011, physician services which were added as MSP insured benefits included 116 new fee items which reflect current practice standards, for example:

- Obstetrical B scan >14 weeks with Nuchal translucency measurement;
- General Surgery lysis of intra-abdominal adhesions;
- Specialist group medical visits; and
- Cardiovascular risk assessment.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by the Medical Services Plan (MSP) when hospitalization is medically required for the safe and proper completion of surgery and when they are listed in the

Dental Payment Schedule. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction. No new insured surgical-dental services were added during the fiscal year 2010–2011. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the Medical Services Commission.

Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in MSP may provide insured surgical-dental services in hospital. There were 236 dentists (includes only oral surgeons, dental surgeons, oral medicine, and orthodontists) enrolled with MSP and billing FFS in 2010–2011.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Medical necessity, as determined by the attending physician and hospital, is the basis for access to hospital and medical services.

For out-patients, take-home drugs and certain hospital drugs are not insured, except those provided under the provincial PharmaCare program. Other procedures not insured under the *Hospital Insurance Act* include: services of medical personnel not employed by the hospital; treatment for which Worksafe BC, the Department of Veterans Affairs, or any other agency is responsible; services solely for the alteration of appearance; and reversal of sterilization procedures. Uninsured hospital services also include: preferred accommodation at the patient's request; televisions, telephones, and private nursing services; preferred medical/surgical supplies; dental care that could be provided in a dental office including prosthetic and orthodontic services; and, preferred services provided to patients of extended care units or hospitals.

Services not insured under the Medical Services Plan include: those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; telephone advice unrelated to insured visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic, or other place or for any other matters that relate to the rendering of a benefit."

The Ministry of Health (the Ministry) responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry. The MSC determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure

services must be made to MSC. Consultation may take place through a sub-committee of MSC and usually includes a review by the BCMA's Tariff Committee. In 2010–2011, 65 obsolete fee items were removed from the Fee Schedule. The fee items which were removed included those for out-dated technology in the Laboratory, Ophthalmology, and Orthopaedic Sections, amongst others.

3.0 Universality

3.1 Eligibility

Section 7 of the *Medicare Protection Act* (MPA) defines the eligibility and enrolment of beneficiaries for insured services. Under the MPA, Part 2 of the Medical and Health Care Services Regulation details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits.

Section 1 of the MPA, defines a resident as a person who:
- is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- makes his or her home in British Columbia;
- is physically present in British Columbia at least six months in a calendar year; and
- is deemed under the regulations to be a resident.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see Section 3.2 of this report), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces, appointed members of the Royal Canadian Mounted Police (RCMP), or serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance. The Medical Services Plan (MSP) provides first-day coverage to discharged members of the RCMP and the Canadian Forces, and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

The number of residents registered with MSP as of March 31, 2011, was 4,521,503.

3.2 Other Categories of Individual

Holders of Minister's Permits, Temporary Resident Permits, study permits, and work permits are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section

2 of the Medical and Health Care Services Regulation.

3.3 Premiums

The enabling legislation is:
- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8; and
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums.

Enrolment in MSP is mandatory and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for MSP since January 1, 2011, are $60.50 for one person, $109 for a family of two, and $121 for a family of three or more.

Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or holder of permanent resident (landed immigrant) status under the (federal) *Immigration and Refugee Protection Act*.

4.0 Portability

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage during Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulation of the *Medicare Protection Act* define portability provisions for persons temporarily absent from British Columbia with regard to insured services. In 2010–2011, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 months. Approval is limited to once in five years for absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. When a beneficiary stays outside British Columbia longer than the approved period, they will be required to fulfill a waiting period upon returning to the province before coverage

can be renewed. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to interprovincial and interterritorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, upon presentation of a valid MSP CareCard. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved by the Assistant Deputy Minister Policy Advisory Committee for each hospital. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and inter-territorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from MSP.

British Columbia pays host provincial rates for insured services according to rates established by the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, section 24; the Hospital Insurance Act Regulations, Division 6; the *Medicare Protection Act*, section 51; and the Medical and Health Care Service Regulation, sections 3, 4, 5. The Medical and Health Care Services Regulation was amended by British Columbia Regulation 111/2005. The relevant issues addressed by the amendments are as follows:

Residents who leave British Columbia temporarily to attend school or university may be eligible for MSP coverage for the duration of their studies, provided they are in full-time attendance at a recognized educational facility and are enrolled in a program which leads to a degree or certificate recognized in Canada. Generally, beneficiaries who have been studying outside BC must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe, and who has been away for less than 24 months, should contact MSP.

Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. However, because of increasing demand for a specialized and mobile work force employed for short-term contracts and assignments, exceptions may be made to enable coverage for up to 24 consecutive months of absence while temporarily outside British Columbia. Approval is limited to once in five years for absences that exceed six months in a calendar year. In addition, if a person's employment requires them to routinely travel outside

British Columbia for more than six months per calendar year they can apply for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances are deemed residents for an additional 12 months if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are: surgery for alteration of appearance (cosmetic surgery); gender reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies (e.g., RCMP, Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada); services requested by a "third party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make inquiries of that home province after direct payment to the British Columbia physician. Some treatments (e.g., treatment for anorexia) may require the approval of the Health Authorities Division of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the MSC before the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

Beneficiaries in British Columbia, as defined in section 1 of the *Medicare Protection Act*, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

Access to Insured Physician and Dental-Surgical Services:

In 2010–2011, approximately 3,000 general practitioners (GPs) and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to hire salaried physicians or contract with physicians, in order to deliver insured clinical services.

The Ministry implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice, which were continued in the Physician Master Agreements (PMA) to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. These programs include:

- Rural Retention Program, which provides eligible physicians (estimated at 1,300) with fee premiums. It is available to resident and visiting physicians and locums, and also provides a flat fee sum for eligible physicians who reside and practice in a rural community.

- Northern and Isolation Travel Assistance Outreach Program, which provides funding support for approved physicians who visit rural and isolated communities to provide medical service(s).

- Rural General Practitioner Locum Program, which assists rural general practitioners in taking reasonable periods of leave from their practices by providing up to 43 days of paid locum coverage per year. This program assisted physicians in approximately 56 small communities to attend continuing medical education and also provided vacation relief.

- Rural Specialist Locum Program, which assists rural specialists in taking vacations and continuing medical education by providing paid locum support. The program provided locum support for core specialists in 10 rural communities to provide vacation relief and assistance while physician recruitment efforts were underway.

- Rural Education Action Plan, which supports the training needs of physicians in rural practice. This program supports training in physicians' rural practices through several components, including rural practice experience for medical students and enhanced skills for practicing physicians.

- Isolation Allowance Fund, which provides funding to communities with fewer than four physicians and no hospital, and where the Medical On-Call/Availability Program, call-back, or Doctor of the Day payments is not available.

- Rural Loan Forgiveness Program, which decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives, and pharmacists.

The Full-Service Family Practice Incentive Program has been expanded as the Ministry of Health and physicians continue to work together to develop incentives aimed at helping to

support and sustain full service family practice. In 2010–2011, further new and revised fees were in place to support general practitioners in providing primary care to their patients. As of March 31, 2011, 2,689 general practitioners (GPs) billed the Annual Complex Care fee (14033) for 141,838 patients, and 2,302 GPs participated in the Mental Health Planning Fee, developing a mental health plan for 77,273 patients. There were eight conferencing and planning fees available and billed for 12,429 patients in facilities, acute care, or palliative care.

Infrastructure and Capital Planning:

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry of Health invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry is developing a ten year capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

As noted in the Introduction section of the report, the Ministry has committed to a significant number of major capital projects at hospitals in locations including Victoria, Surrey, Abbotsford, Vancouver, Prince George, Vernon, Kelowna, and Fort St. John, developed as public-private partnerships. Major capital projects are overseen by Project Boards comprised of senior executives from health authorities and government to ensure projects are appropriately defined and stay within their approved scope, cost, and completion schedules.

The province is nearing completion of the construction on a new cancer treatment centre in Prince George and is in the process of procurement for a new cardiac care centre in Kelowna. These projects represent an extension of strategic health services and reduce the need for patients to travel to the Vancouver area for treatment. British Columbia has also started construction on a new Critical Care Tower at Surrey Memorial Hospital to accommodate an expanded emergency department, neonatal intensive care beds, and acute care beds.

5.2 Physician Compensation

Through negotiations with the British Columbia Medical Association (BCMA), British Columbia established the compensation and benefit structure for physicians who perform publicly funded medical procedures. In 2007, as provided for by the 2006 Letter of Agreement, the Province and the BCMA concluded negotiations for a Physician Master Agreement (PMA). The PMA remains in effect until 2012. In addition to the PMA, the Province and the BCMA also have five subsidiary agreements: General Practitioners Subsidiary Agreement; Specialists Subsidiary Agreement; Rural Practice Subsidiary Agreement; Alternative Payments Subsidiary Agreement; and Benefits Subsidiary Agreement. These agreements address matters unique to each aspect of medicine addressed by an individual subsidiary agreement. All five subsidiary agreements terminate in 2012 along with the PMA.

Being long-term, the PMA provides support for a more structured relationship between the BCMA and the Province than had been in place previously. Health authorities have a larger role

in making decisions which affect health care in their respective regions. A main focus of the PMA is the establishment of mechanisms which promote enhanced collaboration and accountabilities between the province and the BCMA. Key to the success of these mechanisms is a strengthened conflict resolution process.

British Columbia anticipates additional benefits from the new PMA structure including: efficiencies stemming from the amalgamation of most agreements with the BCMA into a single agreement framework; streamlining committee structure and communication; providing a formal conflict management process which addresses issues at both the local and provincial levels; limiting physician service withdrawals; and establishing a structured process for physicians wishing to change their method of compensation to better align with strategies and priorities of the Province and of health authorities.

Effective April 1, 2009, physician compensation rates were increased by 3 percent. Over the life of the PMA, the province also provides financial support targeted towards: increasing rural physician incentive programs; providing for new fee items; increasing physician benefit programs; supporting full service family practices; and improving information technology and promoting eHealth initiatives.

Medical practitioners are licensed under the *Health Professions Act.* A Payment Schedule for medical practitioners is established under section 26 of the *Medicare Protection Act* and is referred to in the Second Master Agreement between the Government of British Columbia, the Medical Services Commission, and the British Columbia Medical Association.

Dentists are licensed under the *Health Professions Act.* The province and the British Columbia Dental Association (BCDA) negotiated a Memorandum of Understanding in 2007 that is effective through March 2012 and covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; and dental technical procedures. Both the Province and the BCDA agree to meet through a Joint Dental Surgery Policy Committee for the duration of the Agreement.

Compensation Methods for Physicians and Dentists:

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the APP to health authorities for physicians' services. Over 74 percent of medical expenditures were distributed as fee-for-service and 11 percent were distributed as alternative payments. Of the alternative payments, 77 percent were distributed through contracts, 21 percent as sessions (3.5-hour units of service), and 2 percent as salaried arrangements. The government funds health authorities for alternative payments; it does not pay physicians directly. In British Columbia, for dentistry services, MSP pays for medically required dental services and medically required dental surgical services performed in a hospital; the rest is self-pay.

5.3 Payments to Hospitals

Funding for hospital services is included in the annual funding allocation and payments made to regional health authorities. This funding allocation is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. The *Hospital Insurance Act* and its related regulations govern payments made by the health care plan to health authorities. This statute establishes the authority of the Minister to make payments to hospitals, and specifies in broad terms what services are insured when provided within a hospital.

The hospitals' portion of the funding allocation is not specified; however the exception to this rule is funding targeted for specific priority projects (e.g., reduction in wait times for hips and knees, and patient-focused funding). For these types of initiatives, funding is provided to health authorities rather than hospitals and it is specifically earmarked and must be reported on separately.

As noted in the Introduction of this report, in April 2010, the Ministry of Health (the Ministry) introduced patient-focused funding under which a significant portion of eligible acute care funding is based on actual workload performed. By 2013, it is expected that around 20 percent of acute care funding (or ten percent of total funding to health authorities) will be allocated using the patient-focused funding methodology.

Annual funding allocations to health authorities are determined as part of the Ministry of Health's annual budget process in consultation with the Ministry of Finance and Treasury Board. The final funding amount is conveyed to health authorities by means of an annual funding letter. Insured hospital services are included within the annual funding allocations to health authorities, as well as specific targeted funding from time to time. Incremental funding is allocated to health authorities using the Ministry of Health's Population Needs-Based Funding Formula and other funding allocation methodologies (e.g. to reflect targeted funding allocations directed to specific health authorities). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry of Health, such as the payments to physicians and payments for prescription drugs covered under PharmaCare.

The accountability mechanisms associated with government funding for hospitals is part of several comprehensive documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual Government Letters of Expectations. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations. In 2010–2011, a full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions programs, etc.) was provided.

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2010–2011, these documents included:

• 2010–2011 Third Quarterly Report, available at:
http://www.fin.gov.bc.ca/qrt-rpt/qr10/Q3_10.pdf

• Estimates, Fiscal Year Ending March 31, 2011, available at:
http://www.bcbudget.gov.bc.ca/2010/estimates/2010_Estimates.pdf

• 2010–2011 Budget and Fiscal Plan, available at:
http://www.bcbudget.gov.bc.ca/2010/bfp/2010_Budget_Fiscal_Plan.pdf

• Public Accounts 2010–2011, available at:
http://www.fin.gov.bc.ca/OCG/pa/10_11/Pa10_11.htm

CHAAR 2011-12 Statistical Tables Template
British Columbia
Final

Registered Persons					
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
1. Number as of March 31st (#).	4,335,676	4,402,540	4,469,177	4,521,503	4,565,864

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
2. Number (#).[1]	120 [1]	119 [1]	119 [1]	119 [1]	120 [1]
3. Payments for insured health services ($).[2]	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2007-2008**	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
4. Number of private for-profit facilities providing insured health services (#).	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services($).	not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
6. Total number of claims, in-patient (#).	7,160	7,102	6,846	5,909	6,551
7. Total payments, in-patient ($).	55,309,733	64,550,692	64,655,739	67,078,612	69,785,313
8. Total number of claims, out-patient (#).	95,677	95,326	87,948	78,075	86,544
9. Total payments, out-patient ($).	19,088,368	24,262,195	24,188,890	21,830,298	25,327,347
Insured Hospital Services Provided Outside Canada					
10. Total number of claims, in-patient (#).	1,603	1,963	3,056	2,469	2,961
11. Total payments, in-patient ($).	14,486,341	11,811,654	6,058,867	4,452,628	4,152,060
12. Total number of claims,	1,215	1,630	1,920	1,940	2,468
13. Total payments, out-patient ($).	553,661	967,704	1,174,112	999,733	1,301,179

General information for statistical indicators 1-2: Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year. The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the Societies Act because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

[1] As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

[2] BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $7.1 billion in 2006–2007, $7.6 billion in 2007–2008, $8.2 billion in 2008–2009, $8.6 billion in 2009–2010, $9.2 billion in 2010–2011, and $9.7 billion in 2011-12.

Insured Physician Services Within Own Province or Territory					
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
14. Number of participating physicians as of March 31st (#).	8,772 [3]	8,986 [3]	9,201 [3]	9,417 [3]	9,628 [3]
15. Number of opted-out physicians as of March 31st (#).	5	5	5	5	5
16. Number of not participating physicians as of March 31st (#).	2	2	2	not available [4]	not available [4]
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).	2,234,652,895 [5]	2,334,513,866 [5]	2,460,935,638 [5]	2,541,874,909 [5]	2,619,943,719 [5]

Insured Physician Services Provided to Residents in Another Province or Territory					
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
19. Number of services (#).	725,130	736,007	622,390	626,034	651,682
20. Total payments ($).	26,465,248	28,703,587	29,591,918	30,779,981	32,421,561
Insured Physician Services Provided Outside Canada					
21. Number of services (#).	84,204	82,654	75,909	82,076	66,506
22. Total payments ($).	4,379,977	4,528,521	4,014,813	4,119,511	3,592,313

Insured Surgical-Dental Services Within Own Province or Territory					
	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012
23. Number of participating dentists as of March 31st (#).	245	249	243	236	218
24. Number of services provided as of March 31st (#).	43,262	46,736	50,341	51,036	52,047
25. Total payments as of March 31st ($).	6,305,343	7,289,302	8,093,266	7,991,262	8,130,009

[3] The number of participating physicians in item 14 is for physicians who received payments through Fee-For-Service.

[4] Based on reclassification of information and corresponding data, BC does not track non-participating physicians. Data for item number 16 is not available.

[5] The MSP Fee-For-Service payments in item 18 are restated to include medical services referred to medical practitioners by midwives or nurse practitioners.

British Columbia

Introduction

British Columbia has a progressive and integrated health system that includes insured services funded under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, and timely health services are available to all British Columbians.

The Ministry works with health authorities, care providers, agencies, and other groups to guide and enhance the province's health services, provide access to care, and ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction, and support to these service delivery partners and sets province-wide goals, standards, and expectations for health service delivery by health authorities. The province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of services and province-wide health programs.

The delivery of health services and the health of the population are monitored by the Ministry on an ongoing basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health information and services continue to meet the needs of British Columbians. To read more about British Columbia's publicly funded health system, please refer to the BC Ministry of Health 2011-12 Annual Service Plan Report: www.bcbudget.gov.bc.ca/Annual_Reports/2011_2012/pdf/hlth.pdf.

1.0 Public Administration

1.1 Health Care Insurance Plan and Public Authority

The British Columbia Medical Services Plan (MSP) is administered by the British Columbia Ministry of Health (the Ministry). MSP insures medically required services provided by physicians and supplementary health care practitioners, laboratory services, and diagnostic procedures. The Ministry sets goals, standards, and performance agreements for health service delivery and works with the six health authorities to provide quality, appropriate, and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages MSP on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose is to preserve a publicly-managed and fiscally sustainable health care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function

and mandate of the MSC is to facilitate reasonable access to quality medical care, health care, and diagnostic facility services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of British Columbia, three representatives from the British Columbia Medical Association (BCMA), and three members from the public jointly nominated by the BCMA and government.

In 2011-12, the *Medicare Protection Act* was amended to support the introduction of a more secure care card, designed to improve patient safety and reduce fraud. Further, the Medical and Health Care Services Regulation was amended to bring into force this amendment to the *Medicare Protection Act* and to detail the framework of the requirement for enrolment and renewal of enrolment in MSP.

1.2 Reporting Relationship

The Medical Services Commission (MSC) is accountable to the Government of British Columbia through the Minister of Health; a report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees, and other delegated bodies. In addition, the MSC Financial Statement is published annually: it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

The Ministry provides extensive information in the Annual Service Plan Report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act* (2000).

In addition to the Annual Service Plan Report, the Ministry reports through various publications, including:

- Vital Statistics Annual Report;
- Provincial Health Officer's Annual Report (on the health of the population);
- Canadian Institute for Health Information reports; and
- Medical Services Commission Annual Report.

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- The Office of the Comptroller General (OCG) Internal Audit and Advisory Services, the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry. The OCG reports can be located on the following website link: http://www.fin.gov.bc.ca/ocg/ias/Audit_Reports.htm

- The Office of the Auditor General (OAG) of British Columbia is responsible for conducting annual audits as well as special audits/reports. The OAG reports its findings to the Legislative Assembly. The OAG initiates its own audits and determines the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines if and when the Ministry has complied with the audit recommendations.

The OAG's annual audit of the Ministry's accounts and financial transactions are reflected in the OAG's overall review and opinion related to the BC Public Accounts, which can be found at the following website link: http://www.bcauditor.com/pubs/2012/special/auditor-generals-opinions-summary-financial-statements-an .

Finally, the OAG's special audits/reports can be located the following link: http://www.bcauditor.com/pubs

1.4 Designated Agency

The MSP of British Columbia requires premiums to be paid by eligible residents. The monies were collected by the Ministry of Finance during the 2011–2012 fiscal year. Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance, and collection on behalf of the Province of British Columbia (Ministry of Finance). The province remains responsible for, retains control of, and performs all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:

- *Ombudsman Act* (British Columbia)
- *Business Practices and Consumer Protection Act* (British Columbia)
- *Financial Administration Act* (British Columbia)
- Freedom of Information Legislation: i.e., *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

Since 2005, the Ministry has contracted with MAXIMUS Canada to deliver the operations of the Medical Services Plan and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). MAXIMUS Canada administers the province's medical and drug insurance plans under the Health Insurance BC (HIBC) program. Policy and decision-making functions remain with the Ministry.

- HIBC submits monthly reports to the Ministry, reporting performance on service levels to the public and health care providers. HIBC also posts reports on its website on the performance of key service levels.

- HIBC applies payments against fee items approved by the Ministry. The Ministry approves all payments before they are released.

2.0 Comprehensiveness

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister of Health to designate facilities as hospitals, to license private residential care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* and the Hospital Insurance Act Regulations provide the authority for the Minister of Health to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital, and are deemed medically required by the attending physician or midwife. There is no scheduled or regular process to review insured hospital services, as the insured services included in the regulations are intended to be comprehensive/inclusive ~~and do not require routine updating~~. Uninsured services are referred to in Section 2.4 of this report.

When medically required, the following are provided to beneficiaries who are inpatients in an acute or rehabilitation hospital:

- accommodation and meals at the standard level.
- necessary nursing service.
- drugs, biologicals, and related preparations which are required by the patient and administered in hospital.
- laboratory and radiological procedures and related interpretations.
- diagnostic procedures and the necessary interpretations, as approved by the Minister.
- use of operating room, caseroom, anaesthetic facilities, routine surgical supplies, and other necessary equipment and supplies.
- use of radiotherapy facilities.
- use of physiotherapy facilities.
- services of a social worker.
- rehabilitation services including occupational and speech therapy.
- other required services approved by the Minister, provided by persons who receive remuneration from the hospital.

When medically required, the following are provided as benefits under the *Hospital Insurance Act* or the *Medicare Protection Act* to outpatients who are beneficiaries:

- emergency department services.
- diagnostic services (e.g. laboratory or radiological procedures).

- use of operating room facilities.
- equipment and supplies used in medically necessary services provided to the beneficiary, including anaesthetics, sterile supplies, dressings, casts, splints, or immobilizers and bandages.
- meals required during diagnosis and treatment.
- drugs and medications administered in a medically-necessary service provided to the beneficiary.
- any service provided by an employee of the hospital that is approved by the Minister.

The services are provided to beneficiaries without charge, with a few exceptions, such as incremental charges for preferred (but not medically required) medical/surgical supplies and nonstandard accommodation, and daily fees for residential care patients in extended care or general hospitals.

Some facilities providing residential care services (in this case, the term "extended care" is often used) are regulated under the *Hospital Act*. Health authorities/hospital societies are required to follow Home and Community Care policies to determine benefits in such cases.

2.2 Insured Physician Services

The range of insured physician services covered by the Medical Services Plan (MSP) includes all medically necessary diagnostic and treatment services. Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care professionals, such as midwives) who are enrolled with MSP and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA in accordance with the *Canada Health Act*:

- medically required services provided to "beneficiaries" (residents of British Columbia that are enrolled in MSP in accordance with section 7 of the *MPA*) by a medical practitioner enrolled with MSP; and

- medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In the fiscal year 2011–2012, 9,628 physicians were enrolled with MSP and billed fee-for-service (FFS) (includes only general practitioners and medical specialists who billed FFS in 2011–2012). In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) with the health authorities. Physicians paid by these alternative mechanisms may also practice on a FFS basis.

Practitioners other than physicians and dentists who may enrol and provide benefits under MSP include midwives, optometrists, and supplementary benefit practitioners. The Supplementary Benefits Program

assists premium assistance beneficiaries to access the following services: acupuncturist, massage therapist, physiotherapist, chiropractor, naturopath, and podiatrist (non-surgical services). The program contributes $23.00 towards the cost of each patient visit to a maximum of ten visits per patient per annum summed across the six types of providers.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission (MSC). Enrolled physicians may cancel their enrolment by giving 30 days written notice to the MSC. Patients are responsible for the full cost of services provided by non-enrolled physicians. In 2011–2012, MSP had 5 opted-out physicians. Based on reclassification of information and corresponding data, British Columbia does not track non-participating physicians.

Enrolled physicians can elect to be paid directly by patients by giving written notice to the MSC. The MSC will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered.

Under the Physician Master Agreement between the government, the MSC, and the British Columbia Medical Association (BCMA), modifications to the Payment Schedule such as additions, deletions, or fee changes are made by the MSC, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by the MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2011–2012, physician services which were added as MSP insured benefits included 106 new fee items which reflect current practice standards, for example, 34 new fee items were in the Section of General Surgery; 21 new fee items were in the Section of General Practice; and eight new fee items were in the Section of Plastic surgery.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by the Medical Services Plan (MSP) when hospitalization is medically required for the safe and proper completion of surgery and when they are listed in the Dental Payment Schedule. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the MSC.

Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in MSP may provide insured surgical-dental services in hospital. There were 218 dentists enrolled with MSP and billing FFS in 2011–2012 (includes only oral surgeons, dental surgeons, oral medicine, and orthodontists).

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Medical necessity, as determined by the attending physician and hospital, is the criterion for public funding of hospital and medical services.

Inpatient and outpatient take-home drugs and any drugs not clinically approved by the hospital are excluded from coverage.

Procedures not insured under the *Hospital Insurance Act* and its regulations include: services of medical personnel not employed by the hospital; treatment for which WorkSafeBC, the Department of Veterans Affairs, or any other agency is responsible; services or treatment that the Minister, or a person designated by the Minister, determines on a review of the medical evidence, that the beneficiary does not require; and excluded illnesses or conditions (i.e. in vitro fertilization; cosmetic service solely for the alteration of appearance; and reversal of previous sterilization procedures except when sterilization was originally caused by trauma). Uninsured hospital services also include: preferred accommodation at the patient's request; preferred medical/surgical supplies; televisions, telephones, and private nursing services; and dental care that could safely be provided in a dental office including prosthetic and orthodontic services. Insured hospital services do not include transportation between place of residence and hospital (however, health authorities are required to fund some of these services by Ministry policy, with a small user charge).

Services not insured under the Medical Services Plan include: those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; telephone advice unrelated to insured visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic, or other place or for any other matters that relate to the rendering of a benefit."

The Ministry responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry. The MSC determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the MSC. Consultation may take place through a sub-committee of the MSC and usually includes a review by the BCMA's Tariff Committee. In 2011–2012, 11 obsolete fee items were removed from the Fee Schedule. The fee items removed were from the Section of the General Surgery for procedures which are now obsolete.

3.0 Universality

3.1 Eligibility

Section 7 of the *Medicare Protection Act* (MPA) defines the eligibility and enrolment of beneficiaries for insured services. Under the MPA, Part 2 of the Medical and Health Care Services Regulation details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits.

Section 1 of the MPA, defines a resident as a person who:

- is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- makes his or her home in British Columbia;
- is physically present in British Columbia at least six months in a calendar year; and
- is deemed under the regulations to be a resident.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see Section 3.2 of this report), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces, appointed members of the Royal Canadian Mounted Police (RCMP)[1], or serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance. The Medical Services Plan (MSP) provides first-day coverage to discharged members of the RCMP and the Canadian Forces, and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

The number of residents registered with MSP as of March 31, 2012, was 4,565,864.

3.2 Other Categories of Individual

Holders of Minister's Permits, Temporary Resident Permits, study permits, and work permits are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section 2 of the Medical and Health Care Services Regulation.

[1] "Although outside the 2011-12 fiscal year reporting period, for clarity purposes Health Canada notes that "On June 29, 2012, as a result of the federal Bill C-38 *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans."

3.3 Premiums

The enabling legislation is:

- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8; and
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums.

Enrolment in MSP is mandatory and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for MSP since January 1, 2012, are $64.00 for one person, $116.00 for a family of two, and $128.00 for a family of three or more.

Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or a holder of permanent resident (landed immigrant) status under the federal *Immigration and Refugee Protection Act*.

4.0 Portability

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage during Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulation of the *Medicare Protection Act* define portability provisions for persons temporarily absent from British Columbia with regard to insured services. In 2011–2012, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 months. Approval is limited to once in five years for absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. When a beneficiary stays outside British Columbia longer than the approved period, they will be required to fulfill a waiting period upon returning to the province before coverage can be renewed. Students attending a recognized school in

another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to interprovincial and interterritorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible British Columbia residents, upon presentation of a valid MSP CareCard. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved for each hospital by the Assistant Deputy Ministers Policy Advisory Committee. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from MSP.

British Columbia pays host provincial rates for insured services according to rates established by the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, section 24; the Hospital Insurance Act Regulations, Division 6; the *Medicare Protection Act*, section 51; and the Medical and Health Care Service Regulation, sections 3, 4, 5.

Residents who leave British Columbia temporarily to attend school or university may be eligible for MSP coverage for the duration of their studies, provided they are in full-time attendance at a recognized educational facility and are enrolled in a program which leads to a degree or certificate recognized in Canada. Generally, beneficiaries who have been studying outside of BC must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe, and who has been away for less than 24 months, should contact MSP.

Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. However, because of the increasing demand for a specialized and mobile work force employed for short-term contracts and assignments, exceptions may be made to enable coverage for up to 24 consecutive months of absence while temporarily outside British Columbia. Approval is limited to once in five years for absences that exceed six months in a calendar year. In addition, if a person's employment requires them to routinely travel outside of British Columbia for more than six months per calendar year they can apply for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances are deemed residents for an additional 12 months if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission is required for procedures that are not covered under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are: surgery for alteration of appearance (cosmetic surgery); gender reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies (e.g., RCMP, Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada); services requested by a "third party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make inquiries of that home province after direct payment to the British Columbia physician. Some treatments (e.g., treatment services in not-for-profit residential facilities) may require the recommendation of the Health Authorities Division of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the MSC before the procedure.

5.0 Accessibility

5.1 Access to Insured Health Services

Beneficiaries in British Columbia, as defined in section 1 of the *Medicare Protection Act*, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

Access to Insured Physician and Dental-Surgical Services:

Access to insured services continues to be enhanced:

- In 2011–2012, approximately 3,000 general practitioners (GPs) and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to contract with or hire physicians, in order to deliver insured clinical services.

- The Full-Service Family Practice Incentive Program has been expanded as the Ministry of Health (the Ministry) and physicians continue to work together to develop incentives aimed at helping to support and sustain full service family practice.

- The Ministry provides funding through the Medical On-Call Availability Program to health authorities to enable them to contract with groups of physicians to provide "on-call" coverage necessary for hospitals to deliver emergency health care services to unassigned patients in a reliable, effective, and efficient manner.

- The Ministry continued and implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice, which were continued in the Physician Master Agreement (PMA) to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. These programs include:
    - Rural Retention Program- provides eligible physicians (estimated at 1,800) with fee premiums. It is available to resident and visiting physicians and locums, and also provides a flat fee sum for eligible physicians who reside and practice in a rural community.
    - Isolation Allowance Fund- provides funding to communities with fewer than four physicians and no hospital, and where the Medical On-Call Availability Program, Call-back, or Doctor of the Day payments is not available.
    - Northern and Isolation Travel Assistance Outreach Program- provides funding support for approved physicians who visit rural and isolated communities to provide medical service(s).
    - Rural General Practitioner Locum Program- assists rural general practitioners in taking reasonable periods of leave from their practices by providing up to 43 days of paid locum coverage per year. This program assisted physicians in approximately 56 small communities to attend continuing medical education and also provided vacation relief.
    - Rural Specialist Locum Program- assists rural specialists in taking vacations and continuing medical education by providing paid locum support. The program provided locum support for core specialists in 10 rural communities to provide vacation relief and assistance while physician recruitment efforts were underway.
    - Rural Emergency Enhancement Fund- provides funding to support eligible rural communities for physician groups that commit to work as a team to maintain public access to Emergency Department services in rural hospitals.
    - Rural Education Action Plan- supports the training needs of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practicing physicians.
    - Rural Continuing Medical Education- offers eligible rural physicians funding support to acquire and maintain medical skills and expertise for rural practice. The amount is dependent

upon the designation of the community and the length of time the physician has practiced in the community.

- Recruitment Incentive Fund- provides an incentive to physicians to fill vacancies that are part of the Physician Supply Plan in eligible rural communities.
- Rural Loan Forgiveness Program- decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives, and pharmacists.

Infrastructure and Capital Planning:

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry has developed a ten year capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

The Ministry has committed to a significant number of major capital projects at hospitals in locations including Surrey, Victoria, Abbotsford, Vancouver, Prince George, Vernon, Kelowna, Courtenay/Comox, Campbell River, and Fort St. John, developed as public-private partnerships. Major capital projects are overseen by Project Boards comprised of senior executives from health authorities and government to ensure projects are appropriately defined and stay within their approved scope, cost, and completion schedules.

5.2 Physician Compensation

The Physician Master Agreement (PMA) is a formal agreement signed by the Government of British Columbia, the British Columbia Medical Association (BCMA), and the Medical Services Commission (MSC). As of March 31, 2012 (the fiscal year deadline for the 2011/12 Canada Health Act report submission), the province and the BCMA were in negotiations regarding the ratification of the renewal of the PMA*.

[Health Canada to place as a footnote at the end of section 5.2: *Although outside the scope of the 2011/12 fiscal year reporting period, British Columbia notes that in July 2012, doctors in BC ratified a new four-year agreement that will support ongoing efforts to recruit and retain physicians, while also improving access to specialists and care in rural and remote communities. For further information, please see the Government of British Columbia News Release: http://www2.news.gov.bc.ca/news_releases_2009-2013/2012HLTH0077-001081.htm]

In general terms, the PMA provides the framework for managing the ongoing relationship between the government, health authorities, physicians, and the BCMA. Its Subsidiary Agreements provide additional detail related to:

- Physician benefits (the Benefits Subsidiary Agreement) – outlines programs that provide contractually negotiated benefits.

- Rural programs (the Rural Practice Subsidiary Agreement) – provides financial incentives for physicians to locate to and establish their practice in rural and remote communities.

- Alternative Payment programs (The Alternative Payments Subsidiary Agreement) – outlines the specific terms and conditions applicable to alternative payment agreements.

- Programs specific to General Practitioners (General Practitioner Subsidiary Agreement) and Specialists (Specialist Subsidiary Agreement)- establishes the General Practitioners Services Committee, the Specialist Services Committee, and the Shared Care Committee.

The PMA gives the BCMA exclusive right to represent the interests of all physicians who receive payment for the medical services they provide to persons insured through the Medical Services Plan. The PMA establishes mechanisms which promote enhanced collaboration and accountabilities between the province and the BCMA through various joint committees. It also provides formal conflict management process at both the local and provincial levels and language limiting physician service withdrawals. The role of health authorities in the planning and delivery of health care services are reinforced in the PMA.

The PMA establishes the compensation and benefit structure for physicians who provide publicly funded medical services whether on a fee-for-service or alternate funding methods (service contracts, salaries, and sessional arrangements). Through the PMA, the province also provides targeted financial support for such areas as: rural physician incentive programs; access to specialist services; supporting full service family practices; and shared care models involving GPs, specialists, and other healthcare professions.

Physicians are licensed under the *Health Professions Act* with their Payment Schedule established under section 26 of the *Medicare Protection Act.* The agreement provides processes for monitoring and managing the funding established by the MSC for allocation under section 25 of the *Medicare Protection Act* for insured medical services provided by physicians on a fee-for-service basis. Mechanisms for revisions to the Payment Schedule and for the payment of physicians are detailed in the PMA.

Dentists are licensed under the *Health Professions Act*. The province and the British Columbia Dental Association (BCDA) negotiated a Memorandum of Understanding in 2010 that is effective through March 2012 and covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; and dental technical procedures. Both the province and the BCDA agree to meet through a Joint Dental Surgery Policy Committee for the duration of the agreement.

Compensation Methods for Physicians and Dentists:

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payment Program (APP) to health authorities for physicians' services. In 2011-12, over 73 percent of medical expenditures were distributed as fee-for-service and 11 percent were distributed as alternative payments. Of the alternative payments, 78 percent were distributed through contracts, 20 percent as sessions (3.5-hour units of service), and two percent as salaried arrangements. The government funds health authorities for alternative payments- it does not pay physicians directly. In British Columbia, for dentistry services,

MSP pays for medically required dental services and medically required dental surgical services performed in a hospital; the rest is self-pay.

5.3 Payments to Hospitals

Funding for hospital services is included in the annual funding allocation and payments made to regional health authorities. This funding allocation is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. The *Hospital Insurance Act* and its related regulations govern payments made by the health care plan to health authorities. This statute establishes the authority of the Minister to make payments to hospitals, and specifies in broad terms what services are insured when provided within a hospital.

The hospitals' portion of the funding allocation is not specified; however, the exception to this rule is funding targeted for specific priority projects (e.g., reduction in wait times for hips and knees, and patient-focused funding). For these types of initiatives, funding is provided to health authorities rather than hospitals and it is specifically earmarked and must be reported on separately.

The Ministry of Health (the Ministry) introduced patient-focused funding in 2010/11 under which a significant portion of eligible acute care funding is based on actual workload performed. The Ministry continued the Patient-Focused Funding (PFF) initiative in 2011/12 and health authorities participated in the PFF initiatives, such as Emergency Department Pay-for-Performance; Procedural Care Programs (e.g. Magnetic Resource Imaging); Community Programs; Activity Based Funding; and National Surgical Quality Improvement.

Annual funding allocations to health authorities are determined as part of the Ministry's annual budget process in consultation with the Ministry of Finance and Treasury Board. The final funding amount is conveyed to health authorities by means of an annual funding letter.

Insured hospital services are included within the annual funding allocations to health authorities, as well as specific targeted funding from time to time. Incremental funding is allocated to health authorities using the Ministry's Population Needs-Based Funding Formula and other funding allocation methodologies (e.g. to reflect targeted funding allocations directed to specific health authorities). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry, such as the payments to physicians and payments for prescription drugs covered under PharmaCare.

The accountability mechanisms associated with government funding for hospitals is part of several comprehensive documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual Government Letters of Expectations. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations. In 2011–2012, a full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions

programs, etc.) was provided through five regional health authorities and the Provincial Health Services Authority (responsible for province-wide programs).

6.0 Recognition Given to Federal Transfers

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2011–2012, these documents included:

- Estimates, Fiscal Year Ending March 31, 2012, available at: http://www.bcbudget.gov.bc.ca/2012/estimates/2012_Estimates.pdf
- 2011–2012 Budget and Fiscal Plan, which includes the 2011 – 2012 Third Quarterly Report, available at: http://www.bcbudget.gov.bc.ca/2011/bfp/2011_Budget_Fiscal_Plan.pdf
- Public Accounts 2011–2012, available at: http://www.fin.gov.bc.ca/ocg/pa/11_12/Pa11_12.htm

BRITISH COLUMBIA

2012 - 2013 CANADA HEALTH ACT ANNUAL REPORT

INTRODUCTION

British Columbia has a progressive and integrated health system that includes insured services funded under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, and timely health services are available to all British Columbians.

The Ministry works with health authorities, care providers, agencies, and other groups to guide and enhance the province's health services, provide access to care, and ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction, and support to these service delivery partners and sets province-wide goals, standards, and expectations for health service delivery by health authorities. The province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of services and province-wide health programs.

The delivery of health services and the health of the population are monitored by the Ministry on an ongoing basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health information and services continue to meet the needs of British Columbians. To read more about British Columbia's publicly funded health system, please refer to the BC Ministry of Health 2012–2013 Annual Service Plan Report:
http://www.bcbudget.gov.bc.ca/Annual_Reports/2012_2013/pdf/ministry/hlth.pdf

1.0 PUBLIC ADMINISTRATION

1.1 HEALTH CARE INSURANCE PLAN AND PUBLIC AUTHORITY

The British Columbia Medical Services Plan (MSP) is administered by the British Columbia Ministry of Health (the Ministry). MSP insures medically required services provided by physicians and supplementary health care practitioners, laboratory services, and diagnostic procedures. The Ministry sets goals, standards, and performance agreements for health service delivery and works with the six health authorities to provide quality, appropriate, and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages the MSP on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose is to preserve a publicly-managed and fiscally sustainable health care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function and mandate of the MSC is to facilitate reasonable access to quality medical care, health care, and diagnostic facility services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of

British Columbia, three representatives from the British Columbia Medical Association (BCMA), and three members from the public jointly nominated by the BCMA and government.

In 2012-2013, the *Medicare Protection Act* and the Medical and Health Care Services Regulation were amended to permit British Columbians to be absent from the province for up to seven months in a year, an increase from six months, for vacation purposes. This change allows BC residents who are outside the province for vacation purposes for six months, to qualify for an additional one month absence per calendar year for a total of up to seven months and still remain eligible for MSP coverage.

The Medical and Health Care Services Regulation was also amended to:

- clarify that the MSP is not obligated to pay for diagnostic services that are conducted pursuant to a referral from a practitioner who is not enrolled in the MSP;
- remove the exclusion of members of the RCMP from the MSP; and
- clarify that only net income shown on a Notice of Assessment or Notice of Re-assessment from the Canada Revenue Agency may be used for calculating income for the purpose of applying for premium assistance.

1.2 Reporting Relationship

The Medical Services Commission is accountable to the Government of British Columbia through the Minister of Health; a report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees, and other delegated bodies. In addition, the MSC Financial Statement is published annually; it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

The Ministry provides extensive information in the Annual Service Plan Report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act* (2000).

In addition to the Annual Service Plan Report, the Ministry reports through various publications, including:

- Vital Statistics Annual Report;
- Provincial Health Officer's Annual Report (on the health of the population);
- Canadian Institute for Health Information reports; and
- Medical Services Commission Annual Report.

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- The Office of the Comptroller General (OCG) Internal Audit and Advisory Services; the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry. The OCG reports can be located on the following website link: http://www.fin.gov.bc.ca/ocg/ias/Audit_Reports.htm
- The Office of the Auditor General (OAG) of British Columbia is responsible for conducting annual audits as well as special audits/reports. The OAG reports its findings to the Legislative Assembly. The

OAG initiates its own audits and determines the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines if and when the Ministry has complied with the audit recommendations.

The OAG's annual audit of the Ministry's accounts and financial transactions are reflected in the OAG's overall review and opinion related to the BC Public Accounts, which can be found at the following website link: http://www.bcauditor.com/pubs/2013/special/audit-opinions-are-important-discussion-qualified-audit-o

The OAG's special audits/reports can be located at the following link: http://www.bcauditor.com/pubs

1.4 Designated Agency

The MSP of British Columbia requires premiums to be paid by eligible residents. The monies were collected by the Ministry of Finance during the 2012–2013 fiscal year. Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance, and collection on behalf of the Province of British Columbia (Ministry of Finance). The province remains responsible for and retains control of all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:

- *Ombudsman Act* (British Columbia).
- *Business Practices and Consumer Protection Act* (British Columbia).
- *Financial Administration Act* (British Columbia).
- Freedom of Information Legislation: i.e., *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

Since 2005, the Ministry has contracted with MAXIMUS Canada to deliver the operations of the MSP and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). MAXIMUS Canada administers the province's medical and drug insurance plans under the Health Insurance BC (HIBC) program. Policy and decision-making functions remain with the Ministry.

- HIBC submits monthly reports to the Ministry, reporting performance on service levels to the public and health care providers. HIBC also posts reports on its website on the performance of key service levels.
- HIBC applies payments against fee items approved by the Ministry. The Ministry approves all payments before they are released.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister of Health to designate facilities as hospitals, to license private residential care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* and the Hospital Insurance Act Regulations provide the authority for the

Minister of Health to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

In 2012-2013, the Hospital Act Regulation and the Hospital Insurance Act Regulation were amended to permit nurse practitioners and dental surgeons to admit and discharge from hospital.

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital, and are deemed medically required by the attending physician, midwife, or nurse practitioner. There is no scheduled or regular process to review insured hospital services as the insured services included in the regulations are intended to be inclusive. As per the report guidelines, uninsured services are referred to in Section 2.4 of this report.

When medically required, the following are provided to beneficiaries who are in-patients in an acute or rehabilitation hospital:

- accommodation and meals at the standard level;
- necessary nursing service;
- drugs, biologicals, and related preparations which are required by the patient and administered in hospital;
- laboratory and radiological procedures and related interpretations;
- diagnostic procedures and the necessary interpretations, as approved by the Minister;
- use of operating room, caseroom, anaesthetic facilities, routine surgical supplies, and other necessary equipment and supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities;
- services of a social worker;
- rehabilitation services including occupational and speech therapy; and
- other required services approved by the Minister, provided by persons who receive remuneration from the hospital.

When medically required, the following are provided as benefits under the *Hospital Insurance Act* or the *Medicare Protection Act* to out-patients who are beneficiaries:

- emergency department services;
- diagnostic services (e.g., laboratory or radiological procedures);
- use of operating room facilities;
- equipment and supplies used in medically necessary services provided to the beneficiary, including anaesthetics, sterile supplies, dressings, casts, splints, or immobilizers and bandages;
- meals required during diagnosis and treatment;
- drugs and medications administered in a medically-necessary service provided to the beneficiary; and
- any service provided by an employee of the hospital that is approved by the Minister.

The services are provided to beneficiaries without charge, with a few exceptions, such as incremental charges for preferred (but not medically required) medical/surgical supplies and nonstandard

accommodation, and daily fees for residential care patients in extended care or general hospitals.

Some facilities providing residential care services (in this case, the term "extended care" is often used) are regulated under the *Hospital Act*. Health authorities/hospital societies are required to follow Home and Community Care policies to determine benefits in such cases.

2.2 Insured Physician Services

The range of insured physician services covered by the Medical Services Plan (MSP) includes all medically necessary diagnostic and treatment services. Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care professionals, such as midwives) who are enrolled with MSP and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA in accordance with the *Canada Health Act*:

- medically required services provided to "beneficiaries" (residents of British Columbia who are enrolled in MSP in accordance with section 7 of the MPA) by a medical practitioner enrolled with MSP; and
- medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In the fiscal year 2012–2013, 9,947 physicians were enrolled with MSP and received payments through fee-for-service (FFS). In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) with the health authorities. Physicians paid by these alternative mechanisms may also practice on a FFS basis.

Practitioners other than physicians and dentists who may enrol and provide benefits under MSP include midwives, optometrists, and supplementary benefit practitioners. The Supplementary Benefits Program assists premium assistance beneficiaries to access the following services: acupuncturist, massage therapist, physiotherapist, chiropractor, naturopath, and podiatrist (non-surgical services). The program contributes $23.00 towards the cost of each patient visit to a maximum of ten visits per patient per annum summed across the six types of providers.

Physicians enrolled in MSP may choose to be opted-in or opted-out. Opted-in physicians are physicians who are enroled in MSP under Section 13 of the *Medicare Protection Act* and who elect to bill MSP directly for insured services provided to MSP beneficiaries. An opted in physician may not bill a patient directly for an insured benefit. Opted-out physicians are physicians who are enroled in MSP under Section 13 of the *Medicare Protection Act* and who elect to opt out and bill patients directly for insured benefits. Physicians wishing to opt out of MSP must give written notice to the Medical Services Commission (MSC). In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered. By law, an opted-out physician may not charge a patient more for an insured benefit than the prescribed MSP amount. In 2012–2013, MSP had 4 opted out physicians. Based on reclassification of information and corresponding data, British Columbia does not track non-participating physicians.

Under the Physician Master Agreement between the government, the MSC, and the British Columbia Medical Association (BCMA), modifications to the Payment Schedule such as additions, deletions, or fee changes are made by the MSC, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by the MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2012–2013, physician services which were added as MSP insured benefits included 34 new fee items which reflect current practice standards, for example: 13 new fee items were introduced for the Section of Cardiac Surgery, and eight new fee items were introduced for the Section of Orthopaedics.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by the Medical Services Plan (MSP) when hospitalization is medically required for the safe and proper completion of surgery and when they are listed in the Dental Payment Schedule. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the MSC. Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in MSP may provide insured surgical-dental services in hospital.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Medical necessity, as determined by the attending physician and hospital, is the criterion for public funding of hospital and medical services.

In-patient and out-patient take-home drugs and any drugs not clinically approved by the hospital are excluded from coverage.

Procedures not insured under the *Hospital Insurance Act* and its regulations include: services of medical personnel not employed by the hospital; treatment for which WorkSafeBC, the Department of Veterans Affairs, or any other agency is responsible; services or treatment that the Minister, or a person designated by the Minister, determines, on a review of the medical evidence, that the beneficiary does not require; and excluded illnesses or conditions (i.e., in vitro fertilization; cosmetic service solely for the alteration of appearance; and reversal of previous sterilization procedures except when sterilization was originally caused by trauma). Uninsured hospital services also include: preferred accommodation at the patient's request; preferred medical/surgical supplies; televisions, telephones, and private nursing services; and dental care that could safely be provided in a dental office including prosthetic and orthodontic services. Insured hospital services do not include transportation between place of residence and hospital (however, health authorities are required to fund some of these services by Ministry policy, with a small user charge).

Services not insured under the MSP include: those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; telephone advice unrelated to insured visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic, or other place or for any other matters that relate to the rendering of a benefit."

The Ministry responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry. The MSC determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the MSC. Consultation may take place through a sub-committee of the MSC and usually includes a review by the BCMA's Tariff Committee. In 2012-2013, three fee items from the Section of Cardiac Surgery were removed from the Fee Schedule; two of the fee items were for procedures which are now obsolete and one fee item was redundant.

3.0 UNIVERSALITY

3.1 Eligibility

Section 7 of the *Medicare Protection Act* (MPA) defines the eligibility and enrolment of beneficiaries for insured services. Under the MPA, Part 2 of the Medical and Health Care Services Regulation details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits.

In 2012-2013, the *Medicare Protection Act* and the Medical and Health Care Services Regulation were amended to permit British Columbians to be absent from the province for seven months in a year, an increase from six months, for vacation purposes.

Section 1 of the MPA, defines a resident as a person who:

- is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- makes his or her home in British Columbia, and
- is physically present in British Columbia for at least six months in a calendar year, or for a prescribed shorter period of time, and
- includes a person who is deemed under the regulations to be a resident, but does not include a tourist or visitor to British Columbia.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see Section 3.2 of this report), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces and those serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance. The Medical Services Plan (MSP) provides first-day coverage to discharged members of the Canadian Forces, and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

The number of residents registered with MSP as of March 31, 2013, was 4,594,940.

3.2 Other Categories of Individual

Some holders of Minister's Permits, Temporary Resident Permits, study permits, work permits and applicants for permanent resident status who are the spouse or child of an eligible resident are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section 2 of the Medical and Health Care Services Regulation.

3.3 Premiums

The enabling legislation is:

- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8; and
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums.

Enrolment in MSP is mandatory and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for MSP since January 1, 2013, are $66.50 for one person, $120.50 for a family of two, and $133.00 for a family of three or more.

MSP has two programs that offer assistance with the payment of premiums based on financial need. Regular premium assistance has five levels of assistance and is based on a person's net income for the preceding tax year, combined with that of the person's spouse if applicable, less MSP deductions. A short term, 100 percent subsidy is offered under the temporary premium assistance program based on current, unexpected financial hardship. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or a holder of permanent resident (landed immigrant) status under the federal *Immigration and Refugee Protection Act.*

4.0 PORTABILITY

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month residence is established plus two additional months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage during Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulation of the *Medicare Protection Act* define portability provisions for persons temporarily absent from British Columbia with regard to insured services.

Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. As of January 1, 2013, longer term vacationers who are deemed residents may qualify for a total absence of up to seven months per calendar year for vacation purposes; in 2012-2013, the Medical and Health Care Services Regulation was amended to permit residents of British Columbia to be

absent from the province for up to seven months in a calendar year for vacation purposes.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 consecutive months. Approval is limited to once in five years for absences exceeding six months in a calendar year. When a beneficiary stays outside British Columbia longer than the approved period, they will be required to fulfill a waiting period upon re-establishing residence in the province before coverage can be renewed. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to interprovincial and interterritorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible Medical Services Plan (MSP) British Columbia residents, upon presentation of a valid CareCard or BC Services Card. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved for each hospital by the Assistant Deputy Ministers Policy Advisory Committee. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from MSP.

British Columbia pays host provincial rates for insured services according to rates established by the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, section 24; the Hospital Insurance Act Regulations, Division 6; the *Medicare Protection Act*, section 51; and the Medical and Health Care Service Regulation, sections 3, 4, 5.

Residents who leave British Columbia temporarily to attend school or university may be eligible for MSP coverage for the duration of their studies, provided they were physically present in Canada for 6 of the 12 months immediately preceding departure and are in full-time attendance at a recognized educational facility. Beneficiaries who have been studying outside British Columbia must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe should contact MSP.

Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. As of January 1, 2013, longer term vacationers who are deemed residents may qualify for a total absence of up to seven months per calendar year; in 2012-2013, the Medical and Health Care Services Regulation was amended to permit residents of British Columbia to be absent from the province for up to seven months in a calendar year for vacation purposes.

In some circumstances, while temporarily outside the province for work or vacation, an individual may be deemed an eligible resident during an 'extended absence' of up to 24 consecutive months, once in a

five year period. To qualify, they must continue to maintain their home in British Columbia, be physically present in Canada for six of the twelve months immediately preceding departure and have not been granted an extended absence in the previous five calendar years. In addition, they must not have taken advantage of the additional one month absence available to vacationers, during the year the extended absence begins or during the calendar year prior to the start of the extended absence. In certain situations, if a person's employment requires them to routinely travel outside of British Columbia for more than six months per calendar year, they can apply to the Medical Services Commission for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances may be deemed residents for up to an additional 12 months if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

4.4 Prior Approval Requirement

No prior approval is required for medically required procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services Commission (MSC) is required for procedures that are excluded under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are: surgery for alteration of appearance (cosmetic surgery); gender reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies (e.g. Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada); services requested by a "third party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make inquiries of that home province after direct payment to the British Columbia physician. Some treatments (e.g., treatment services in not-for-profit residential facilities) may require the recommendation of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the MSC before the procedure.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Beneficiaries in British Columbia, as defined in section 1 of the *Medicare Protection Act*, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

Access to Insured Physician and Surgical-Dental Services

Access to insured services continues to be enhanced:

- In 2012–2013, approximately 3,000 general practitioners (GPs) and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to contract with or hire physicians, in order to deliver insured clinical services.
- The Full-Service Family Practice Incentive Program has been expanded as the Ministry of Health (the Ministry) and physicians continue to work together to develop incentives aimed at helping to support and sustain full service family practice.
- The Ministry provides funding through the Medical On-Call Availability Program to health authorities to enable them to contract with groups of physicians to provide "on-call" coverage necessary for hospitals to deliver emergency health care services to unassigned patients in a reliable, effective, and efficient manner.
- The Ministry continued and implemented several programs under the 2012 Rural Practice Subsidiary Agreement, which were continued in the Physician Master Agreement (PMA) to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. These programs include:
  - Rural Retention Program — provides eligible physicians (estimated at 1,800) with fee premiums. It is available to resident and visiting physicians and locums, and also provides a flat fee sum for eligible physicians who reside and practice in a rural community.
  - Isolation Allowance Fund — provides funding to communities with fewer than four physicians and no hospital, and where the Medical On-Call Availability Program, Call-back, or Doctor of the Day payments is not available.
  - Northern and Isolation Travel Assistance Outreach Program — provides funding support for approved physicians who visit rural and isolated communities to provide medical service(s).
  - Rural General Practitioner Locum Program — assists rural general practitioners in taking reasonable periods of leave from their practices by providing up to 43 days of paid locum coverage per year. This program assisted physicians in approximately 63 small communities to attend continuing medical education and also provided vacation relief.
  - Rural Specialist Locum Program — assists rural specialists in taking vacations and continuing medical education by providing paid locum support. The program provided locum support for core specialists in 18 rural communities to provide vacation relief and assistance while physician recruitment efforts were underway.
  - Rural Emergency Enhancement Fund — provides funding to support eligible rural communities for physician groups that commit to work as a team to maintain public access to Emergency Department services in rural hospitals.
  - Rural Education Action Plan — supports the training needs of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practicing physicians.
  - Rural Continuing Medical Education — offers eligible rural physicians funding support to acquire and maintain medical skills and expertise for rural practice. The amount is dependent upon the designation of the community and the length of time the physician has practiced in the community.
  - Recruitment Incentive Fund — provides an incentive to physicians to fill vacancies that are part of the Physician Supply Plan in eligible rural communities.
  - Rural Loan Forgiveness Program — decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives, and pharmacists.

Infrastructure and Capital Planning

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry has developed a ten year capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

The Ministry has committed to a significant number of major capital projects at hospitals in locations including Surrey, Vancouver, Vernon, Kelowna, Courtenay/Comox, and Campbell River, developed as public-private partnerships. Major capital projects are overseen by Project Boards comprised of senior executives from health authorities and government to ensure projects are appropriately defined and stay within their approved scope, cost, and completion schedules.

5.2 Physician Compensation

The Physician Master Agreement (PMA) is a formal agreement signed by the Government of British Columbia, the British Columbia Medical Association (BCMA), and the Medical Services Commission (MSC). In July 2012, doctors in BC ratified a new four-year agreement that supports ongoing efforts to recruit and retain physicians, while also improving access to specialists and care in rural and remote communities.

In general terms, the PMA provides the framework for managing the ongoing relationship between the government, health authorities, physicians, and the BCMA. Its Subsidiary Agreements and Appendices provide additional detail related to:

- Physician benefits (the Benefits Subsidiary Agreement) — outlines programs that provide contractually negotiated benefits.
- Rural programs (the Rural Practice Subsidiary Agreement) — provides financial incentives for physicians to locate to and establish their practice in rural and remote communities.
- Alternative Payment Programs (The Alternative Payments Subsidiary Agreement) — outlines the specific terms and conditions applicable to alternative payment agreements.
- Programs specific to GPs (General Practitioner Subsidiary Agreement) and Specialists (Specialist Subsidiary Agreement) — establishes the General Practitioners Services Committee, the Specialist Services Committee, and the Shared Care Committee.
- Appendix G - Medical On-Call/Availability Program (MOCAP) provides payments to physicians and physician groups who provide coverage for patients, other than their own or their call groups', which includes funding for Doctor of the Day payments. This provides greater flexibility for health authorities in purchasing MOCAP coverage and Doctor of the Day services.
- Appendix J – Laboratory Medicine Fee Agreement establishes targets for the total annual outpatient laboratory expenditures and agreed to the formation of the Laboratory Reform Committee.

The PMA gives the BCMA exclusive right to represent the interests of all physicians who receive payment for the medical services they provide to persons insured through the Medical Services Plan (MSP). The PMA establishes mechanisms which promote enhanced collaboration and accountabilities between the province and the BCMA through various joint committees. It also provides formal conflict management process at both the local and provincial levels and language limiting physician service

withdrawals. The role of health authorities in the planning and delivery of health care services are reinforced in the PMA.

The PMA establishes the compensation and benefit structure for physicians who provide publicly funded medical services whether on a fee-for-service or alternate funding methods (service contracts, salaries, and sessional arrangements). Through the PMA, the province also provides targeted financial support for such areas as: rural physician incentive programs; access to specialist services; supporting full service family practices; and shared care models involving GPs, specialists, and other healthcare professions.

Physicians are licensed under the *Health Professions Act* with their Payment Schedule established under section 26 of the *Medicare Protection Act*. The agreement provides processes for monitoring and managing the funding established by the MSC for allocation under section 25 of the *Medicare Protection Act* for insured medical services provided by physicians on a fee-for-service basis. Mechanisms for revisions to the Payment Schedule and for the payment of physicians are detailed in the PMA.

Dentists are licensed under the *Health Professions Act*. The province and the British Columbia Dental Association (BCDA) negotiated a Memorandum of Understanding that is effective from April 1, 2012 to March 31, 2014 and covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; and dental technical procedures. Both the province and the BCDA agree to meet through a Joint Dental Surgery Policy Committee for the duration of the agreement.

Compensation Methods for Physicians and Dentists

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payment Program (APP) to health authorities for physicians' services. In 2012–2013, approximately 72 percent of medical expenditures were distributed as fee-for-service and 11 percent were distributed as alternative payments. Of the alternative payments, approximately 79.5 percent were distributed through contracts, 19 percent as sessions (3.5-hour units of service), and 1.5 percent as salaried arrangements. The government funds health authorities for alternative payments; it does not pay physicians directly. In British Columbia, for dentistry services, MSP pays for medically required dental services and medically required dental surgical services performed in a hospital; the rest is self-pay.

5.3 Payments to Hospitals

Funding for hospital services is included in the annual funding allocation and payments made to health authorities. This funding allocation is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. The *Hospital Insurance Act* and its related regulations and the *Health Authorities Act* govern payments made by government to health authorities. These statutes establish the authority of the Minister to: make payments to hospitals, regional health authorities, the Provincial Health Services Authority and the Nisga'a Nation, and specifies in broad terms what services are insured when provided within a hospital and to deliver regional health care services.

The Ministry of Health does not specifically fund hospitals directly – instead health authorities are funded and provide operating budgets to hospitals within their control to deliver specified services. There is an exception to this wherein funding targeted for specific priority projects (e.g., reduction in wait times for hips and knees, and patient-focused funding) is provided to health authorities (again not directly to hospitals) and since it is specifically earmarked, it must be reported on separately.

The Ministry of Health introduced patient-focused funding in 2010–2011 under which a portion of eligible acute care funding was based on actual workload performed. The Ministry continued the Patient-Focused Funding (PFF) initiative in 2011–2012 and 2012-2013, and health authorities participated in the PFF initiatives, such as Emergency Department Pay-for-Performance; Procedural Care Programs (e.g., Magnetic Resource Imaging); Community Programs; Activity Based Funding; and National Surgical Quality Improvement). The Ministry continues to examine alternative funding methodologies including the use of pay-for-performance and activity-based funding.

Annual funding allocations to health authorities are determined as part of the Ministry's annual budget process in consultation with the Ministry of Finance and Treasury Board. The final funding amount is conveyed to health authorities by means of an annual funding letter.

Insured hospital services are included within the annual funding allocations to health authorities, as well as specifically targeted funding from time to time. Incremental funding is allocated to health authorities using the Ministry's Population Needs-Based Funding Formula and other funding allocation methodologies (e.g. to reflect targeted funding allocations directed to specific health authorities). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry, such as the payments to physicians and payments for prescription drugs covered under PharmaCare.

The accountability mechanisms associated with government funding for hospitals is part of several comprehensive documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual Government Letters of Expectations. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations. In 2012–2013, a full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions programs, etc.) was provided through five regional health authorities and the Provincial Health Services Authority (responsible for province-wide programs).

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2012–2013, these documents included:

- Estimates, Fiscal Year Ending March 31, 2013, available at:
  http://www.bcbudget.gov.bc.ca/2012/estimates/2012_Estimates.pdf
- Budget and Fiscal Plan 2012-2013 and 2014-2015, which includes the 2012–2013 Third Quarterly Report, available at: http://www.bcbudget.gov.bc.ca/2012/bfp/2012_Budget_Fiscal_Plan.pdf
- Public Accounts 2012–2013, available at: http://www.fin.gov.bc.ca/ocg/pa/12_13/Pa12_13.htm

Registered Persons					
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
1. Number as of March 31st (#).	4,402,540	4,469,177	4,521,503	4,565,864	4,594,940

Insured Hospital Services Within Own Province or Territory					
Public Facilities	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**
2. Number (#).[1]	119	119	119	120	120
3. Payments for insured health services ($).[2]	not available	not available	not available	not available	not available
Private For-Profit Facilities	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**
4. Number of private for-profit facilities providing insured health services (#).	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services($).	not available	not available	not available	not available	not available

Insured Hospital Services Provided to Residents in Another Province or Territory					
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013

6.	Total number of claims, in-patient (#).	7,102	6,846	5,909	6,551	6,886
7.	Total payments, in-patient ($).	64,550,692	64,655,739	67,078,612	69,785,313	68,904,638
8.	Total number of claims, out-patient (#).	95,326	87,948	78,075	86,544	97,088
9.	Total payments, out-patient ($).	24,262,195	24,188,890	21,830,298	25,327,347	28,643,797
Insured Hospital Services Provided Outside Canada						
10.	Total number of claims, in-patient (#).	1,963	3,056	2,469	2,961	4,091
11.	Total payments, in-patient ($).	11,811,654	6,058,867	4,452,628	4,152,060	4,520,778
12.	Total number of claims, out-patient (#).	1,630	1,920	1,940	2,468	2,915
13.	Total payments, out-patient ($).	967,704	1,174,112	999,733	1,301,179	1,646,810

General information for statistical indicators 1-2: Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year. The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the Societies Act because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

[1] As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

[2] BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $7.1 billion in 2006–2007, $7.6 billion in 2007–2008, $8.2 billion in 2008–2009, $8.6 billion in 2009–2010, $9.2 billion in 2010–2011, $9.7 billion in 2011-12, and $10.1 billion in 2012-2013.

Insured Physician Services Within Own Province or Territory					
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
14. Number of participating physicians as of March 31st (#).	8,986 [3]	9,201 [3]	9,417 [3]	9,628 [3]	9,947 [3]
15. Number of opted-out physicians as of March 31st (#).	5	5	5	5	4
16. Number of not participating physicians as of March 31st (#).	2	2	not available [4]	not available [4]	not available [4]
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).	2,334,513,866	2,460,943,779	2,541,874,909	2,619,943,719	2,656,938,267

Insured Physician Services Provided to Residents in Another Province or Territory					
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
19. Number of services (#).	735,928	622,277	625,981	653,387	628,705
20. Total payments ($).	28,686,013	29,560,007	30,698,752	32,453,109	32,502,933

Insured Physician Services Provided Outside Canada					
21. Number of services (#).	82,628	75,910	82,247	91,026	83,050
22. Total payments ($).	4,524,790	4,013,791	4,240,090	4,869,497	4,340,034

Insured Surgical-Dental Services Within Own Province or Territory					
	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
23. Number of participating dentists as of March 31st (#).	249	243	236	218	217
24. Number of services provided as of March 31st (#).	46,736	50,341	51,036	52,047	50,813
25. Total payments as of March 31st ($).	7,289,302	8,093,266	7,991,262	8,130,009	7,903,742

[3] The number of participating physicians in item 14 is for physicians who received payments through Fee-For-Service.

[4] Based on reclassification of information and corresponding data, BC does not track non-participating physicians. Data for item number 16 is not available.

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Postal Locator 0908C
Ottawa ON K1A 0K9

Dear Ms. Mandy:

I am writing to you further to my letter of November 18, 2013, regarding British Columbia's report on extra billing and user charges during the period of April 1, 2011, to March 31, 2012.

Following discussions you had with Ministry of Health staff, please find attached a revised 2011/12 report that includes an additional assessment by Health Canada based on specific findings in Cambie Surgery Centre and Specialist Referral Clinic audits, without extrapolation.

Please do not hesitate to contact me should you require further information.

Sincerely,

Steve Brown
Deputy Minister

Attachments

Ministry of Health Office of the Deputy Minister 5-3, 1515 Blanshard Street Victoria BC V8W 3C8

CONFIDENTIAL - Alleged Extra Billing/User Charges for 2011/12 - Revised

File #	Service / Procedure	D.O.S. (mm/dd/yy)	Facility	User Charge Clinics	Extra Billing Phys
	Colonoscopy		Private Surgery Centre	$ 1,924	
	Nasal Septal Reconstruction		Private Surgery Centre	$ 4,600	
	Anaesthesia Consultation and Back Surgery		Private Surgery Centre	$ 7,972.40	
	Right Shoulder Arthroscopy and Rotator Cuff Repair		Private Surgery Centre	$ 10,182	
	Independent Medical Assessment		Private Surgery Centre	$ 1,000	
	Independent Medical Assessment, Administration Fee, Inguinal Hernia Repair		Private Surgery Centre	$ 4,025	
S22	Cyst Removal (case was closed - no evidence of extra billing found)	S22	Physician's Private Office		$0
	Interspinous Implantation		Private Surgery Centre	$ 9,674	
	Lucentis Tray Fee		Physician's Private Office		$2,400
	Medical Assessment and Rotator Cuff Repair		Private Surgery Centre	$ 8,298	
Sub-Totals				**$47,675.40**	**$2,400**
Total Charges Based on Patient Complaints			**$50,075.40**		

CANADA HEALTH ACT

ACTUAL AMOUNTS OF EXTRA-BILLING AND USER CHARGES FOR THE PERIOD APRIL 1, 2011 TO MARCH 31, 2012

1. EXTRA-BILLING

Amount actually charged in the province through extra-billing by physicians and dentists in respect of insured services. $ 2,400.00

Explanatory Note:

AS PER ATTACHED SPREADSHEET (BASED ON PATIENT COMPLAINTS)

2. USER CHARGES (including FACILITY FEES)

a) Amount actually charged in the province in respect of user charges associated with insured hospital services, as per the definition of "hospital" and "hospital services" in the *Act*. $ Ø

N.B. Charges may be levied for accommodation and meal costs related to a patient who, in the opinion of the attending physician, is a permanent resident in a hospital or other chronic care institution as per the limitation of Section 19 (2). Charges related to this limitation should not be included in the financial statement.

b) Amount actually charged in the province in respect of user charges for insured services provided by a physician in a clinic, as defined by the federal private clinics policy. (BASED ON PATIENT COMPLAINTS) $ 47,675.40

Explanatory Note: c) ADDITIONAL HEALTH CANADA ASSESSMENT $ 174,493.00
AS PER ATTACHED SPREADSHEET BASED ON SPECIFIC FINDINGS IN CAMBIE SURGERY CENTRE / SRC AUDITS (WITHOUT EXTRAPOLATION)

TOTAL FOR EXTRA BILLING AND USER CHARGES $ 224,568.40

I certify that the above information is submitted in compliance with Sections 20(1) and 20(2) of the *Canada Health Act* and has been prepared in conformity with that Act and applicable provincial legislation.

Date: _____ **Signature:** _____

Name: STEPHEN BROWN

Title: DEPUTY MINISTER

Province/Territory: BRITISH COLUMBIA

Telephone: (250) 952-1911

BRITISH COLUMBIA

DEC - 5 2012

953815

Ms. Gigi Mandy
Director
Canada Health Act Division
Strategic Policy Branch
Health Canada
Jeanne Mance Building 6th Floor
200 Eglantine Driveway, Tunney's Pasture
Postal Locator 1906C
Ottawa ON K1A 0K9

Dear Ms. Mandy:

I am writing in response to the letter of November 15, 2012, from Ms. Glenda Yeates, Deputy Minister, Health Canada, addressed to Mr. Graham Whitmarsh, Deputy Minister, British Columbia Ministry of Health.

As requested, attached is a report from British Columbia on known amounts charged with respect to extra billing and user charges during the period April 1, 2010, to March 31, 2011, including an explanation of the method used to determine these amounts.

Please do not hesitate to contact me should you require further information.

Yours truly,

Nichola Manning
Assistant Deputy Minister

Ministry of Health

Office of the Assistant Deputy Minister
3-1, 1515 Blanshard Street
Medical Services and Health Human Resources Division

Victoria BC V8W 3C8
Tel: 250 952-3465
Fax: 250 952-3131

CANADA HEALTH ACT

ACTUAL AMOUNTS OF EXTRA-BILLING AND USER CHARGES FOR THE PERIOD APRIL 1, 2010 TO MARCH 31, 2011

1. EXTRA-BILLING

Amount actually charged in the province through extra-billing by physicians and dentists in respect of insured services. $ ∅

Explanatory Note:

2. USER CHARGES (including FACILITY FEES)

a) Amount actually charged in the province in respect of user charges associated with insured hospital services, as per the definition of "hospital" and "hospital services" in the *Act*. $ ∅

N.B. Charges may be levied for accommodation and meal costs related to a patient who, in the opinion of the attending physician, is a permanent resident in a hospital or other chronic care institution as per the limitation of Section 19 (2). Charges related to this limitation should not be included in the financial statement.

b) Amount actually charged in the province in respect of user charges for insured services provided by a physician in a clinic, as defined by the federal private clinics policy. $ 105,526.00

Explanatory Note:

TOTAL FOR EXTRA BILLING AND USER CHARGES $ 105,526.00

I certify that the above information is submitted in compliance with Sections 20(1) and 20(2) of the *Canada Health Act* and has been prepared in conformity with that Act and applicable provincial legislation.

Date: _____

Signature: _____

Name: NICHOLA MANNING

Title: ASSISTANT DEPUTY MINISTER

Province/Territory: BRITISH COLUMBIA

Telephone: (250) 952-3465

Alleged Extra Billing/User Charges for 2010/11

File #	Service / Procedure	D.O.S. (mm/dd/yy)	Facility	User Charge Clinics	Extra Billing Phys
	Laser Assisted Intrasomal Keratoplasty		Private Surgery Centre	$ 1,520	
	ACL Reconstruction		Private Surgery Centre	$ 7,000	
	Clinic Fee for Sigmoidoscopy		Private Surgery Centre	$ 100	
	Laminectomy		Private Surgery Centre	$ 10,000	
	Admin Fee, Disectomy, Foraminotomy		Private Surgery Centre	$ 5,632	
	Assessment and Arthroscopic Ankle Debridement		Private Surgery Centre	$ 7,624	
	Colonoscopy		Private Surgery Centre	$ 1,898	
S22	Knee Arthroscopy	S22	Private Surgery Centre	$ 5,848	
	Knee Surgery		Private Surgery Centre	$ 25,700	
	Orthopaedic Consultation		Private Surgery Centre	$ 500	
	Knee Surgery		Private Surgery Centre	$ 3,000	
	Assessment, Therapeutic Injections, Admin Fee, Disectomy		Private Surgery Centre	$ 8,533	
	Laminectomy and Bilateral Fusion		Private Surgery Centre	$ 11,500	
	Colonoscopy		Private Surgery Centre	$ 1,471	
	Rotator Cuff Surgery		Private Surgery Centre	$ 5,300	
	Rotator Cuff Surgery		Private Surgery Centre	$ 9,400	
TOTALS				**$105,526**	**$0**

BRITISH COLUMBIA

NOV 14 2011

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Ms. Gigi Mandy
Director, Strategic Policy Branch
Canada Health Act Division
Health Canada
6th Floor, Jeanne Mance Building
200 Eglantine Driveway, Tunney's Pasture
Postal Locator 1906C
Ottawa ON K1A 0K9

Dear Ms. Mandy:

I am writing in response to the letter of October 21, 2011, from Ms. Glenda Yeates, Deputy Minister, Health Canada, addressed to Mr. Graham Whitmarsh, Deputy Minister, British Columbia Ministry of Health.

As requested, attached is a report from British Columbia on known amounts charged with respect to extra billing and user charges during the period April 1, 2009, to March 31, 2010, including an explanation of the method used to determine these amounts.

Please do not hesitate to contact me should you require further information.

Yours truly,

Sheila A. Taylor
Assistant Deputy Minister

Attachment

Ministry of Health

Assistant Deputy Minister
Medical Services and Health Human Resources Division

3-1, 1515 Blanshard Street
Victoria BC V8W 3C8
Telephone: 250 952-3465
Facsimile: 250 952-3131

CANADA HEALTH ACT

ACTUAL AMOUNTS OF EXTRA-BILLING AND USER CHARGES FOR THE PERIOD APRIL 1, 2009 TO MARCH 31, 2010

1. EXTRA-BILLING

Amount actually charged in the province through extra-billing by physicians and dentists in respect of insured services. $ 40.00

Explanatory Note:

2. USER CHARGES (including FACILITY FEES)

a) Amount actually charged in the province in respect of user charges associated with insured hospital services, as per the definition of "hospital" and "hospital services" in the *Act*. $ Ø

N.B. Charges may be levied for accommodation and meal costs related to a patient who, in the opinion of the attending physician, is a permanent resident in a hospital or other chronic care institution as per the limitation of Section 19 (2). Charges related to this limitation should not be included in the financial statement.

b) Amount actually charged in the province in respect of user charges for insured services provided by a physician in a clinic, as defined by the federal private clinics policy. $ 33,179.00

Explanatory Note:

TOTAL FOR EXTRA BILLING AND USER CHARGES $ 33,219.00

I certify that the above information is submitted in compliance with Sections 20(1) and 20(2) of the *Canada Health Act* and has been prepared in conformity with that Act and applicable provincial legislation.

Date: Nov 14, 2011

Signature: Sheila Taylor

Name: Sheila Taylor

Title: Assistant Deputy Minister

Province/Territory: British Columbia

Telephone: 250-952-3405

STRICTLY CONFIDENTIAL
Alleged Extra Billing/User Charges for 2009/10

File #	Home HA	Service / Procedure	D.O.S. (yy/mm/dd)	Facility	User Charge Clinics	Extra Billing Phys
	NHA	Foot Surgery		Private Surgery Centre	3,800	
	FHA	Cataract Surgery		Private Surgery Centre	750	
	VCHA	Allergy Testing		Physician's Private Office		40
	IHA	Consultation and Knee Surgery		Private Surgery Centre	6,715	
					500	
	VCHA	Consultation and Duputyren's Contracture		Private Surgery Centre	1,610	
S22			S22		500	
	FHA	Knee Arthrsocopy		Private Surgery Centre	1,900	
	FHA	Rotator Cuff Repair		Private Surgery Centre	7,949	
	VCHA	Cataract Surgery		Private Surgery Centre	1,590	
	VCHA	Sinus Surgery (CASS+SMRIT)		Private Surgery Centre	6,415	
	IHA	Cataract Surgery		Physician's Private Office	1,450	
TOTAL					**$33,179**	**$40**