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IMPLEMENTING THE CANADIAN HEALTH INSURANCE PROGRAM WITH EMPHASIS ON A COMPARISON OF THE ONTARIO AND QUEBEC HEALTH INSURANCE PROGRAMS

Howard A. Palley

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IMPLEMENTING THE CANADIAN HEALTH INSURANCE PROGRAM WITH EMPHASIS ON A COMPARISON OF THE ONTARIO AND QUEBEC HEALTH INSURANCE PROGRAMS*

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Abstract

During a stay as a visiting scholar at the Brookdale Institute, the author prepared this summary of Canadian health insurance programs in order to explore some of the lessons for other countries.

Canadian law allows for a great deal of freedom among local health care systems while at the same time assuring basic adherence to national guidelines. The Israeli health system, consisting of more pluralistic and independent institutions, lacks the same degrees of coordination, accountability, equity, and adequacy as its Canadian counterpart.

Among the aspects of the Canadian system discussed are federal requirements regarding public administration, comprehensiveness, universality, portability, and accessability. The health services in two provinces - Quebec and Ontario - are described in detail.

TABLE OF CONTENTS

LIST OF TABLES

PREFACE

The Significance of the Canadian Health Act for Reform of the Israeli Health System

Canada's national law allows insurance protection of Canadian citizens while also allowing the provinces a great deal of freedom in the implementation of a health care delivery system. The mechanism utilized by the national government to secure basic adherence to national criteria is federal financial reimbursement. Other than a national guarantee of coverage by a Sick Fund, Israel has no national health insurance plan. This is due to the pluralism and independence of a variety of Israeli health care institutions. A National Health Reform which demands adherence to basic requirements in return for national funding might be both salutory in achieving coordination, accountability, equity and adequacy of health services in Israel while also being politically feasible.

The basic program criteria of the Canada Health Act passed in April, 1984, are requirements of:

a) public administration

b) comprehensiveness

c) universality

d) portability

e) accessibility

In addition, the law contains strong federal language forbidding additional billing of patients by physicians beyond insured payment levels (extra-billing) and prohibitions against user charges for "ordinary" insured coverage. It also establishes a process of negotiation between medical and dental practitioners and the provinces

in determining "reasonable compensation".

Such a model seems primae facie to represent an approach to the development of Israeli health system reform which is worth trying and which would represent an improvement over the current state of the Israeli health insurance system and health care delivery system.

THE CANADIAN HEALTH INSURANCE PROGRAM:

SOME GENERAL OBSERVATIONS

Canada's health insurance program is organized on a federal basis. Within nationally determined parameters which provides federal funding in return for provincial meeting of certain stipulations, a great deal of the formulation, organization and implementation of the program takes place at the provincial level.

The Nature of the Canadian System: Structure and Problems

Canada is a relatively loose federation of 10 provinces and 2 territories. The 50 states of the United States of America generally have less authority than the Canadian provinces. The British North American Act of 1867, which was the Canadian constitution until 1982, fixed responsibility for health care at the provincial level. The recent Canadian constitution does nothing to discontinue this provincial responsibility for health care.[1] Direct national authority in health care services is limited to residual areas and includes quarantines, and health services for Indians, Inuit, and aliens. However, the national government currently spends a considerable amount of its budget on payments to the provinces to finance provincial health care schemes. It also finances most medical and health care research in Canada.

In 1958, the National Hospital and Diagnostic Services Act was enacted, providing 50 percent federal cost-sharing for hospital-based services. Such payments led to all of the provinces providing hospital insurance; however, the Act did not mandate an organizational framework suitable for dealing with problems of efficiency or duplication of services. With the Medical Care Act of 1968, similar

federal-provincial cost sharing was provided for physician services.

Under these statutes, in order to qualify for federal-provincial cost-sharing of hospital and medical services, the provinces were required to meet certain stipulations:

"1. Universal hospital and medical coverage on uniform terms and conditions (95 percent of the population, without exclusions, had to be covered within two years of provincial adoption of the plan).

2. Portability of benefits from province to province.

3. Insurance of all medically necessary services.

4. A publicly administered non-profit plan."[2]

These two basic acts increased availability of health care without financial risk to the Canadian citizenry. With the 1958 Act, however, generous federal subsidies encouraged intensive hospital practice and high rates of surgery. The 1968 Act allowed the provinces open-ended national subsidies. This situation encouraged provincial policies which increased the volume of physician services and further encouraged elective surgery. Complementing health insurance, Canada also had passed a means-tested Medicaid Program. In 1965, this plan known as the Canadian Assistance Plan (CAP) was implemented. It allowed the federal government for the first time to share in the costs of medical care for welfare assistance recipients.

While the federal government had a strong preference for a universal comprehensive insurance scheme, it accepted inclusion of a categorical program as an interim measure. CAP allowed federal participation in providing health care services such as dental care, optical care, prescribed drugs and prosthetic appliances to the poor - services for which there was little or no public insurance for the rest of the population. Since its enactment, there has been some

increased general public provision of dental care and pharmaceuticals by provincial health insurance plans.

Within the insurance framework, federal-provincial cost-sharing, while it served as a stimulus to the provinces to adopt universal health insurance, utilized payment formulas which served to redistribute income from wealthier to poorer provinces. Wealthier provinces (i.e. Ontario) which have higher per capita health expenditure levels received less than 50 percent of their revenues from the federal government and poorer provinces (i.e. Newfoundland) received considerably more than 50 percent of their revenues from the federal government. This pattern of essentially "open-ended" federal matching was paralleled by a high level of health care expenditures. A concern with the resulting inflation ultimately led to greater limitations on national contributions for health care being incorporated in the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act of 1977. This act, which aimed at discouraging inflationary practices on the part of provinces, reduced overall federal contributions in relation to provincial expenditures and held further direct federal increases to the growth of the gross national product. The law's financial constraints discouraged both the development of new hospital beds and the training of an increased number of health professionals. It also has resulted in tighter provincial scrutiny of physicians fees.

Canada's provinces' universal medical and hospital insurance programs generally (until recently) have lacked the steep deductibles or co-insurance payments which characterize the Medicare Program in the United States. Hospitals receive payments based on negotiated-in-

advance budgets which the Canadians term "balloon budgets". Physicians are generally paid on a "fixed" fee for service basis with negotiated schedules. Ninety percent of Canada's physicians are "opted into" the provincial plans. Since physicians generally have accepted the negotiated fee as full payment, they do not ordinarily "extra bill" patients and they are therefore generally paid by the provincial government and not the patient. Federal funding for the program is provided by general taxation; the provinces have, in the past, used some premiums, special taxes, and general revenues. As of 1984, insured persons paid a fixed premium amount only in Ontario, Alberta and British Columbia. No other provinces financed insurance through subscriber premiums. Employers pay a payroll tax of 3 percent in Quebec.[3]

Current concerns in Canada with cost containment have led the provinces to increase their efforts to decentralize health service delivery within the provinces on a regional basis as well as to emphasize greater coordination and integration of related health and social services (i.e. Quebec's integrated local community service centers).

The considerable administrative and regulatory responsibility which is given to the Canadian provinces might very well prove to be a politically feasible model for national health insurance reform in the United States in that the role of the states would be emphasized. Such decentralization would provide the states with opportunities to experience different insurance schemes and a variety of health service delivery arrangements. I will suggest in this paper, that such decentralization also would provide a useful model for seeking compliance to national norms by Israel's sick funds.

Also, the Canadian model is useful for isolating potential problems. It appears that the Canadian provinces' often weak regulatory provisions and a vendor payment system model of health insurance initially led to hospital intensive practices as well as a very high rate of elective surgical practice. This situation ultimately was remedied, to some extent, by the 1977 Federal-Provincial Fiscal Arrangements and Established Programs Financing Act.

As has been noted, under the 1977 Act, national government makes equal per capita grants to each province. The amount of these grants is fixed, independent of actual provincial expenditures. Such per capita grants increase annually in line with the trend rate of increase in the gross national product per capita (provincial governments meet administrative costs).

This formula provides additional federal dollars each year for higher prices of health inputs and possibly for some expansion of health services. Thus, the formula gives the provinces more discretion in use of funds; formerly, federal payments were linked to provincial spending only on hospital and physician services. Such specification may have interfered with lower cost substitutes for hospitalization. Federal dollars are no longer directly tied to provincial spending for particular services as long as provincial programs continue to meet federal standards.

As of F.Y. 1980, in the four Atlantic Provinces - New Foundland, Prince Edward Island, Nova Scotia and New Brunswick - the federal contribution exceeded 50 percent of provincial health expenditures; in all others it was less than 50 percent.[4] So-called "have not" provinces object that block grant funding still does not provide them

with the resources to adequately develop their health care systems. (The federal government is considering cost-sharing additional insured services in such provinces.)

In April 1984, Canada passed the Canada Health Act which recodified and changed to some extent the basic national law regarding health insurance and services. The act replaced the Health Insurance and Diagnostic Services Act and the Medical Care Act. The Canada Health Act lists a number of program criteria and conditions of payment for federal cash contributions made to the provinces for "insured health services" and payments made to the provinces for extended health services. Basic insured health services which are covered are all necessary hospital services, physician services and surgical dental services performed in a hospital; extended health services are defined as nursing home care, intermediate care, adult residential care, home care, and ambulatory health care.[5]

To achieve the full federal contribution and payment a provincial program must meet for "insured health services" the criteria of:

1) Public and administration: "The health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province..."

2) Comprehensiveness: "...the health insurance plan of the province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permit, similar or additional services rendered by other health practitioners."

3) Universality: "... the health insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."

4) Portability: "... the health insurance plan of a province ... must not impose any minimum period of residence, or waiting period in excess of three months before residents of the province are eligible for or are entitled to insured health services... [W]here insured health services are provided in Canada,

payment... is [generally] at a rate... approved by the health care insurance plan of the province in which the services are provided..."

5) Accessibility: "... the health care insurance plan of the province... must provide for insured health services on uniform terms and conditions and on a basis which does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."[6]

In addition conditions of payment for health services that provinces must comply with in order to meet requirements for a full federal revenue contribution to the province include:

Provision of information:

That is, reasonable information on the implementation of the program is to be provided by the provinces to the Minister of National Health and Welfare;

Visibility:

Federal contributions to the health insurance program are to be given significant visibility; and extra-billing and user changes are not permitted.[7]

The new act thus increases federal regulatory obligations with regard to the stipulations listed. That is, the level of federal funding is contingent upon provincial compliance with regulations. It is conceivable that a wealthier province such as Ontario might forego some federal support rather than forego such procedures as extra-billing. This is an unlikely option for the poorer provinces.

Canada Today

While Canada's expenditures for health care have experienced growth in the early eighties, they have not been as explosive as the growth of U.S. expenditures. In fiscal year 1982, the portion of Canada's GNP devoted to health care grew from 7.9 percent to 8.4

percent. (In fiscal year 1982 the United States spent 10.5 percent of its GNP on health care.)

Provincial health program increases in cost, in part, represent an effort to increase provision of health care services. The Canadian Medical Association has conducted a random survey of hospitals which has indicated that 158,000 persons on waiting lists for specified elective surgical procedures waited for as long as six to eight months for care. Many hospitals also lack the level of technological "hardware" which is taken for granted in American (U.S.) hospitals. Also, Canadian physicians often express the belief that their incomes are too low - citing the disparity between Canadian physician income and American (U.S.) physician income.

According to an Ontario Medical Association spokesman in 1982, the average net physician salary was about $53,000 (U.S.) a year. In addition to comparing poorly with American physician incomes, the spokesman indicated the Ontario Medical Association believed that physician incomes in Ontario were lagging in comparison to the incomes of Canadian lawyers, dentists, and accountants.[8] One observer has commented that doctors sometimes seek to compensate for what they view as low fees by extending office hours and crowding large numbers of patients into the day's schedule.[9]

Rising costs which are greater than the amount covered by national and provincial budgets resulted by 1983 in many provinces (8 of Canada's 12 provinces) allowing physicians to bill patients more than Canada's Medicare programs pay and to permit hospitals to levy user charges (7 provinces). (Extra billing remained "banned" in the provinces of Quebec and British Columbia.) Such extra billing provided $70 million (U.S.) in additional revenues in 1982, $49

million (U.S.) in the province of Ontario.[10]

The national government in Ottawa in the early 1980's began to view these practices with alarm. In 1983, Maureen Law, Associate Deputy Minister of the National Department of Health and Welfare commented that such charges represent a barrier to access to health care services - as while those who can afford service would not be deterred from seeking services, the poor often would be so constrained. In a position paper, the National Health and Welfare Minister Monique Begin complained that "through a cumulation of direct charges on the sick - each one possibly not a big increase in itself - the goal of complete insurance, fully prepaid, is being abandoned."[11] Substantial concern was expressed by the then Liberal Government that if the practice of extra billing continue to spread, the result would be the emergence of a private health insurance system which the current system had successfully outlawed. This concern ultimately led to the passage of the Canada Health Act in 1984 which prohibits such extra-billing as a condition of full participation in receipt of federal revenues.

Fiscal Federalism

The relationship between the national government and the provinces in health care is significantly shaped by federal fiscal statutes. Under the Federal Provincial Fiscal Arrangements and Established Programs Financing Act, starting April 1977, federal contributions to hospital insurance were made partly (as has already been noted) through a transfer of taxing power to the provinces and partly by per capita grants tied to the growth of the Gross National

Product.

The total of federal contributions for these programs is tied to the value of 1975-76 federal contributions to three stipulated programs. Calculation of federal transfers was based on a complex formula. This formula consisted of 6 elements:

1) A base equal to the national average per capita of federal contributions to the provinces for the established programs in 1975-76;

2) An escalator based on the three-year compound moving average of the annual rate of growth of nominal Gross National Product per capita;

3) The total provincial population;

4) The equalized value for 13.5 personal and 1.0 corporate income tax points;

5) Cash payments to provinces equal to the difference between the value of the federal entitlement and the value of the equalized tax transfer;

6) A special abatement of 8.5 personal income tax points for the province of Quebec.[12]

Under the Act, the Minister of Finance allocates the federal contribution to each program according to the national proportion obtaining in the base year. That allocation is:

50.5% - Hospital Insurance

17.4% - Medical Insurance

32.1% - Post-Secondary Education[13]

Such cash contributions for the health care area are considered contributions payable under the Hospital Insurance and Diagnostic Services Act and the Medical Care Act respectively. The cash contributions are paid by the Ministry of National Health and Welfare. Such payments are conditional on the provincial hospital and medical care insurance programs continuing to meet program criteria of the federal health insurance legislation.

The federal estimates of the Hospital Insurance and Medical Care Programs contributions to the provinces, consisting of cash payments and transfer programs are noted in Table 1:

Table 1: Estimated Federal Direct and Indirect Contributions under the EHCS Program Since April 1, 1977, and up to Fiscal Year 1984

Fiscal Years	Contributions* (cash payments and tax transfers) $ millions (Canadian)	Increase over Previous Year
1977-78	4,207.7	-
1978-79	4,824.6	14.3%
1979-80	5,512.4	14.3%
1980-81	6,167.5	11.9%
1981-82	6,907.7	12.0%
1982-83	7,696.8	11.4%
1983-84	8,457.5	9.9%

* Excludes compensation for termination of the 1972 Revenue Guarantee.

Source: Health Services and Promotion Branch, Department of National Health and Welfare, "Established Programs Financial Arrangements for Hospital Insurance, Medical Care and Extended Health Care Services Programs," Ottawa, Ontario, Canada, July 1983, p. 5.

Federal programs under the EHCS Program since April 1977 and through fiscal year 1983-84 have shown a steady increase in direct federal contributions. These are noted in Table 2.

Table 2: Estimated Federal Contributions under the EHCS Program Since April 1, 1977, and up to Fiscal Year 1984

Fiscal Years	Contributions $ millions (Canadian)	Increase Over Previous Year
1977-78	465.2	-
1978-79	520.3	11.8%
1979-80	581.2	11.7%
1980-81	650.4	11.9%
1981-82	730.7	12.4%
1982-83	829.2	13.5%
1983-84	914.6	10.3%

Source: Health Serivces and Promotion Branch, Department of National Health and Welfare, "Established Programs and Financial Arrangements for Health Insurances, Medical Care and Extended Health Care Service Programs," Ottawa, Ontario, Canada, July, 1983, p.5

For fiscal year 1983-84, these figures break down in the following manner (see Table 3):

Table 3: Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977

Province	Contributions (1983-84): All Health Care Service programs in thousands of dollars (Canadian)*	
	Cash Payments	Tax Transfers
Newfoundland	134,510	87,095
Prince Edward Island	28,907	18,717
Nova Scotia	200,295	129,693
New Brunswick	164,675	106,628
Quebec	1,058,122	1,447,712
Ontario	1,959,600	1,426,204
Manitoba	243,982	157,981
Saskatchewan	238,646	142,616
Alberta	400,392	501,585
British Columbia	575,036	508,219
Northwest Territories	11,308	7,358
Yukon	3,330	5,235
CANADA	5,018,803	4,539,043

Source: Health Services and Promotion Branch Financial Management Department of Finance, August 26, 1983, "Total Provincial E.P.F. Entitlements Under Part VI of the Fiscal Arrangements Act, 1977, as amended, 1982," Ottawa, Ontario, Canada, September 1983, p.6.

* Slight differences may appear in and between totals due to rounding differences.

Thus, federal contributions in terms of cash payments and tax transfers, while limited, have expanded considerably during the late 1970's and early 1980's. A significant issue which has arisen in the Canadian federal system from the viewpoint of the provinces has been the growing gap between federal regulations and requirements upon the provinces and the availability of new federal revenue resources to enable the provinces to carry out such obligations.

THE CANADIAN NATIONAL HEALTH INSURANCE SYSTEM: ITS OPERATION IN TWO PROVINCES - QUEBEC AND ONTARIO

Introductory Statement: Contrasting Ontario and Quebec

This study will examine the way in which two provinces - Ontario and Quebec - seek to carry out the national government mandate that comprehensive services be "accessible" on a universal basis. The study will focus on the criteria of accessibility. This measure of assessment has been defined by Monique Begin, Canada's former health and Welfare Minister, in the following terms:

"All residents of Canada should be entitled to

- a sufficient quantity of insured services;
- an equitable geographic distribution of insured services;
- availability of insured services;
- delivery of insured health services without financial barriers."[14]

Expected levels of care include hospital benefits such as standard ward care, in-hospital medical treatment, surgery, necessary nursing, pharmaceuticals, diagnostic services, and oral surgery in approved hospitals. Medical benefits include general medical and maternity care, surgical, specialist, and laboratory services, and

dental care for children and pensioners in some provinces. Health insurance plans also include sometimes limited provision for osteopaths, chiropractors and optometrists.[15] On a needs or means test basis, welfare recipients and those over age 65 are eligible for free drugs, eye-glasses, nursing home care, and dental care.[16]

How these goals are sought by two provinces: The Progressive Conservative dominated "Tory" province of Ontario and the reformist socialist and French nationalist regime of the Parti Quebecois will be examined in different sections of this paper. Contrasting styles as well as substance will be reviewed.

HEALTH INSURANCE AND HEALTH SERVICE IN QUEBEC

The Political Culture of Quebec

In Quebec since 1950, the expansion of the state power in the health area was accompanied by statements of social democratic ideology emphasizing such goals as consumer participation in social and health care decision-making, decentralization and regionalization of decision-making power, comprehensive health care services and equal educational opportunity. The advancement of such goals was achieved by the passage of statutes without prolonged public debate or inductive experiments. Accompanying regulations have been laid out in great detail in the manner of the Code Napoleon.[17]

Since 1970 Quebec's political culture has witnessed the rise of the Parti Quebecois. By 1976 this political party had taken over the reins of government in Quebec. It particularly espouses a nationalist and egalitarian philosophy. In contrast to Ontario, Quebec's provincial government is much more ideological regarding health and education programs and there is a much more activist, more

centralized role by the provincial government in program development.[18]

The goal of equal access to health care is a goal clearly articulated ideologically in the program of the governing party of Quebec, the Parti Quebecois, than in the dominant party of Ontario, the Progressive Conservative Party. A 1984 presentation by Guy Rivard, Deputy Minister in Quebec's Minister of Social Affairs dealt with the issue of inequality. It is worthwhile to elaborate on his discussion of equity because the "esprit" of the Parti Quebecois articulates a clearer concern on inequality-related issues than one finds in Ontario - although both provinces are committed to comprehensiveness and universality of health care services.

Rivard states that "equity is of more than critical importance in the decision-making of the Ministry of Social Affairs. Such equity is defined in terms of persons, programs and regions."[19] With respect to equity between individuals, Rivard notes that the development of vital statistics which point out differences between the health of different groups is necessary in order to reduce such differences.[20] Regionally, he observes that the area of Northern Quebec reveals a life expectancy three years lower than in the regions of Southern Quebec. Also noted is that generally studies (not governmental studies) show that socio-economic status exerts a negative influence on levels of health at all ages, on general mortality rates and on specific illness rates.[21]

Moreover, the concerns expressed by Rivard are mirrored in the earlier actions of Quebec governments. As early as 1962, Saskatschewan had developed the first Canadian provincial

comprehensive medical care benefit program. Earlier, in June 1961, the Royal Commission on Health Services had been appointed "to inquire into and report upon the existing facilities and the future need for health services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians."[22] The Commission's actions ultimately led to the federal Medical Care Act of 1966 under which provisions the federal government shared the costs of public medical care insurance with the provinces. In Quebec, the Union Nationale government of Daniel Johnson appointed the Castonguay Commission in 1966, under the chairmanship of Claude Castonguay to inquire into the entire field of health and welfare in the province.

Historically statements by Quebec officials concerned with health care have set as significant goals the removal of inequity whether regionally, occupationally or class-based. In 1967, the Castonguay Commission's first volume, Health Insurance, recommended "a complete and universal health insurance plan be established in Quebec."[23] It further advocated a broad range of initial benefits to be subsequently expanded gradually to include dental care, prescribed drugs and prosthetic devices. It further proposed that this plan be directly administered by a Health Insurance Commission with no fiscal intermediary; and that it be financed through an income-related tax. Uniform fee schedules were to be developed for payments to physicians and no "extra-billing" was to be allowed for payments to health care providers. A salary scale would be negotiated with professional associations - with exceptionally able physicians authorized to claim higher fees - the excess being paid by patients - a scheme which

mirrored France's health insurance system.

Volume IV of the Castonguay Commission, entitled Health was published in 1970. It provided a detailed review of Quebec's existing health services and proposed extensive reorganization of these services. An important recommendation of the Commission was that the Quebec health plan be regionalized and decentralized. Quebec would have been divided into three regions - each directed by a Regional Health Office (RHO) which would have possessed autonomous legal status and broad powers of direction, organization and administration.

The regions proposed were the Quebec region encompassing Quebec City and the areas north and east of Quebec; the Sherbrook region - including the regions of Trois Rivieres and the Eastern Townships, and the Montreal region - including Montreal, the Ottawa Valley and the northwest. Such RHOs were to develop modern integrated networks of health care and social care service which would provide universal accessibility of such care and allocate resources equitably and efficiently. The Quebec provincial government would retain the ultimate authority over the health care system and the control of public operating and capital expenditures. Health care was to be provided by health care teams operating out of Local Health Centers (LHCs). Such teams were to be staffed by physicians, nurses, social workers and other health care providers - serving defined units of the population. Such teams would provide complete family and personal health care. The LHCs would generally have community boards of directors or in some instances community advisory boards (when the LHC was organized by autonomous professionals). Furthermore, such LHCs would be linked to general hospitals - renamed Community Health

Centers (CHCs) - which generally would serve populations of from 100,000 to 150,000. The report reflected a deductive, idealistic approach often taken by governments in Quebec to health care reform.

Castonguay was replaced as Committee Chairman in April, 1970 upon his election as a Liberal Party representative to the Quebec National Assembly and his designation of Minister of Health and of Family and Social Welfare, which was later consolidated into the Ministry of Social Affairs. He was succeeded by Gerard Nepreu.

As Minister, Castonguay cancelled a number of new hospital projects which were felt to be duplicative and health care facilities which were viewed as creating an unduly hospital-based system. He proceeded with the development of a number of local health centers. He also proceeded with the development of the Health Insurance Act.

As Malcolm S. Taylor observed, the major impact of the Castonguay Report was:

> to make even stronger the case for medicare in Quebec. The major arguments were : (1) Health indices gave a picture of greater need and lesser access to health services than in most other provinces. For example, the infant mortality rate was much higher than the average and life expectancy was lower. (2) A higher proportion of the population were in low income categories. Because of the well-known circular relationship between illness and poverty, only extraordinary governmental initiatives could hope to break the links. (3) The high unemployment rates not only reduced incomes for expenditure on health services but also, in many cases, resulted in family heads and single wage earners losing their group insurance coverage when they became jobless. (4) A relatively low proportion of the population carried any form or private insurance. Despite an increase of over 50 per cent in the number insured in the preceding 10 years, the 1964 total represented only 43.1 per cent of the population and, as in other provinces, left out the older citizens, rural groups and people with low incomes who do not have insurance but whose need for health services is greater. (5) The shortage of general practitioners and health facilities combined with a maldistribution of both facilities and personnel.
>
> ... [Thus]... the Castonguay Commission recommended... that a complete and universal health insurance plan be established in

Quebec. And, then, of no small consequence and a constant factor in the background was the federal offer of half the cost of a program that met its four principles - an amount which continued to grow - estimated at $212 million lost to Quebec in the first eighteen months. The humanitarian idealism, the social and economic rationale, the obvious public demand, the political rivalry, and half the finances - all were there. It was, indeed, an almost overwhelming case for action.[24]

Quebec's Health Insurance and Health Services System

The Castonguay Commission's recommendations were essentially adapted in the subsequent Quebec Health Insurance Plan legislation. The law was to provide universal coverage; initial financing was to be through a combination of a new payroll tax plus provincial general revenues; practitioners would have the right to opt out - however, in such cases patients could not be reimbursed; the province would proceed with regionalization and the development of local health centers.[25]

Regarding regionalization, the final statute did not conform to the Castonguay Commission recommendations. It established twelve regional bodies with little administrative power thus leaving the provincial government with the main authority for health planning and regulation. The chief functions of the regional bodies were to be "advising and assisting the health establishments in the preparation of their programs, to develop and operate health services and of assuming any duties assigned by the minister... (and) sending recommendations to the Minister once a year."[26]

Under Quebec's health legislation, local Health Centers (LHC) were termed local community service centers (CLSCs). These centers were to bring together primary health services, social services, and community action projects. Such centers were to be established

through local initiative which would apply directly to the Ministry of Social Affairs for financial support. Rather than Community Health Centers, Hospital Centers were to be developed with broad community board composition including elected patient users. Also 32 hospital-based Departments of Community Health (DSCs - Departements de Sante Communautaire) were instituted. Local and district health departments and staff were transferred to these centers. Such DSCs were responsible for preventive, therapeutic, and rehabilitative services for about 200,000 people in defined districts. The DSC director would be responsible for ambulatory services in the base hospital. DSCs would be concerned with analysis and evaluation of health problems, would evaluate the population's state of health and coordinate community resources. DSCs would also seek to coordinate their efforts with those of local community service centers (CLSCs).[27]

Subsequently, the CLSCs have undergone considerable development. Currently, 81 local community service centers (CLSCs) exist in Quebec. With subcenters they account for 124 "points de service".

They are located as follows in Table 4.

Table 4: Number of CLSCs by Public Health Region

Bas-Saint-Laurent-Gaspesie	8
Saguennay-Lac-Saint-Tean	3
Quebec	11
Trois Rivieres	4
Cantons-de-l'Est	4
Montreal metropolitain	18
Laurentides-Lanaudiere	4
Sud de Montreal	13
Outaouais	10
Nord-Ouest	3
Cote-Nord	3
Nouveau-Quebec	-
Total	81

Source: Gouvernment du Quebec. Les Affaires Sociales au Quebec. Quebec City, Quebec, Canada, 1980, p.124.

Fifty-seven CLSCs have both day and early evening hours and forty-four offer both medical and social services in the evening. Eight-eight percent of CLSCs offer psychological and social counselling, 83 percent offer medical consultation; 67 percent offer preventive services, while 38 percent offer diagnostic service; 30 percent offer radiology; 87 percent offer group counselling; 83 percent offer community action assistance to aid in the mobilization of local communities and 78 percent provide support for self-help groups.[28]

Thus, the goals of the Castonguay Report regarding decentralization and local area-based provision of integrated health and social services have made some visible progress. Nevertheless, integration of medical and social services is often not fully realized. Also decisions regarding resource allocation to the CLSCs ultimately lie at the provincial, not the local level.

Provincial Authority and the Nature of the Health Care System in Quebec

Provincial authority in Quebec vis-a-vis the health care professions, hospital administrations and regional authorities is quite strong in Quebec. This centralized power influences regulatory and planning developments. Once a direction is provincially determined regarding health care policy, interest groups are usually unable to block provincial action. This is in sharp contrast to developments in Ontario.

Quebec provincial law regarding physician reimbursement and the placement of hospitals and other health care facilities is quite regulatory. It concentrates authority at the provincial level. Budgets for hospitals and physician fee levels are developed after regional health councils and physician organizations make recommendations to Le Conseil de la Recherche en Sante (CRES).

At the provincial level, CRES makes advisory recommendations based on hospital growth, equipment and health service development to the Minister of Social Affairs. Where possible the Minister will seek to utilize these recommendations as a buffer between the decision of the province of Quebec and local feelings. Nevertheless, authority regarding budget decisions is highly concentrated at the provincial

level. Regarding Quebec Bill 27 passed in 1982 which regulates health and social services, Dr. Augustin Roy, president of the Corporation of Physicians of Quebec complained that "Hospital boards and administrators have little power. They must obey the Minister. They do not negotiate labour agreements and 80 percent of hospital budgets are represented by salaries. Hospitals are asked to cut costs but are hampered by collective agreements over which they have no control."[29] The high degree of acceptance of provincial political authority by Quebec citizens has allowed a more direct approach by the province to regulation of hospital location and capital equipment as well as the levels and modalities of physician reimbursement.

While the federal medical care insurance program was passed July 1, 1968, the Quebec Medicare Plan was passed only in July 1970. This statute provided for governmentally enforced "lids" on physician reimbursement and temporarily led to a strike by Quebec's physicians.[30]

The results of this legislation was the total removal of financial barriers between the medical needs of Quebec residents and their access to care. In the short run there was a decline of 7.5 percent in the frequency of home, office, clinic and hospital calls.[31] Home visits declined significantly, while office visits increased by about one-third. A considerable increase was observed in the utilization of physician services by lower-income patients.[32] Moreover, the removal of income barriers led to greater patient follow-up of important medical symptoms. In spite of some initial loss of specialists in Quebec, the physician-population ratio has improved continually since 1971.[33]

Quebec divides health related insurance coverage between the Quebec Health Insurance Plan administered by the Quebec Regie de l'Assurance Maladie du Quebec (RAMQ), which is responsible to the Minister of Social Affairs and the Quebec Hospital Insurance Plan which is directly administered by the Department of Social Affairs - with the Regie processing the claims of other provinces. Neither plan requires premiums of qualified Quebec residents.[34] Quebec's Health Insurance Plan provides for medically required services of physicians - both general and specialists, for visits, consultations, psychiatric treatment, diagnostic and therapeutic procedures, surgery, anesthesia and x-ray services to all residents of Quebec. Dental, optometric, prosthetic and pharmaceutical services are covered to a more limited extent under different programs of the Health Insurance Plan. General dental care services are provided for children up to age 15; optometric services are generally provided; there is a drug program for the elderly and social assistance recipients; also dental services including dentures are provided to social assistance beneficiaries. Other, more general programs include a program for provision of prostheses and orthopedic appliances, a breast prosthesis grant program; aids for the visually handicapped and an auditory aids program. In addition, ostomy appliances and occular prosthesis are provided under the Quebec Hospital Insurance Plan. Also, the Department of Social Affairs provides for the supplying of special drugs at reduced cost for the use of ambulatory patients afflicted with chronic diseases, and a program of home care services including renal dialysis and parenteral nutrition services. In addition, free ambulance care is provided for those persons 65 years of age and over. Under Quebec's Health Insurance Plan some medically-related long term

care benefits may be reimbursed by insurance; other maintenance benefits may be either privately paid or available through the Department of Social Affairs.

Quebec residents pay no health insurance premium for the aforementioned care which have been described. Under Quebec's provincial law, physicians choosing to participate in the provincial plan are not permitted to bill patients beyond provincial plan benefit levels. Only a very few bill patients at all. Participating physicians usually preferring to bill the Health Insurance Plan directly. The small minority of participating physicians who charge as they see fit may not, except in emergency situations, be reimbursed by Quebec's Regie de l'Assurance-Maladie .

Quebec's Hospital Insurance Plan is also funded by general revenues without premium payments. It provides residents with standard ward accomodations (three or more beds), nursing care, laboratory tests, x-rays and other diagnostic procedures, drugs and other hospital administered preparations, operating, recovery and delivery services - including anesthesia, surgical supplies, radiotherapy, physiotherapy, and services rendered by the hospital staff; plus provision of pacemakers and steel plates.

The province will pay the approved rate for insured services provided in other provinces. Outside of Canada, it pays for acute episodes of illness, emergency care and within 24 hours of an accident, it will pay for full coverage at the lowest rate charged by the hospital. In other cases, it will pay 75% of the daily hospital rate for hospital care outside of Canada. For hospital ward care in Quebec there is no charge to the patient. Nevertheless, the patient

is responsible for differential charges for occupation of a private or semi-private room and for standard room charges in an extended care facility.

The hospitals are paid in 26 instalments a year based on an approved expense budget. Adjustment may be made in emergency circumstances. As a control, admission discharge forms and long term (30 days) reports are required for every hospitalization. Operating costs of the hospital are controlled by means of a budget determined in advance. Also, all public hospitals must file quarterly financial reports.

In Quebec patient payment for chronic care involved some patient co-payments. In 1981, patients were charged $10.05 per day for chronic care in extended care hospitals or in the extended care units of general care hospitals. Exemptions included children less than 18 years of age, low income individuals who benefit from total or partial exemption depending on family or financial considerations. (Home care is authorized by the Department of Social Affairs, supervised by the Regional Health and Social Services Councils, and usually implemented by local Community Service Centers).

As we have noted earlier, local community service centers serve as primary care providers for many individuals in the fields of health and social services. Such centers also are responsible for coordinating the provision of home care services. In addition "centres d'accueil" (reception centers) are utilized as child day care centers, short-term rehabilitation centers, or centers coordinating longer term rehabilitation.

Given the Ministry of Social Affairs' concern with eliminating regional inequities, regional differences between the state of health

of various areas is a significant programmatic focus. The Ministry has attempted to equalize regional resources: A number of incentives are provided for getting physicians and other health personnel to practise in outlying areas. The ministry provides a 15 percent bonus for the general practitioner and 20 percent bonus for the specialist who will work in the northern coast area where 25 percent of the population is concentrated. (In contrast, in "overdoctored areas" for the first three years of practice physicians receive 20 percent less than the regular fee.) This has proved a sufficient inducement for generalists but not a sufficient inducement for specialists. Specialists often will only go to the northern peripheral areas for periods of a few weeks and for urgent treatment patients are brought to lower Quebec.

Quebec's ratio of population per physician in 1977 was slightly lower than that of Canada overall - 543 persons per physician in Quebec as compared to 563 persons per thousand in Canada and 595 in the United States.[35] Nevertheless in examining regional differences in spite of incentives, differences regarding availability of both generalist physicians and specialist physicians persist (see Table 5).

Table 5: Number of General Physicians, Social-Health Regions, Quebec 1972, 1980 and 1982

		General Physicians (1)				
		1972	1980	1982	1972 - 1982	
	Regions				Absolute increase	% increase
01	Bas-St.-Laurent-Gaspesie	94	164	188	94	100.0
02	Saguenay-Lac-St. Jean	97	185	190	93	95.9
03	Quebec	497	970	1013	516	103.8
04	Trois Rivieres	170	278	308	138	81.2
05	Estrie	100	234	252	152	152.0
06	Montreal (greater)	1847	3331	3552	1705	92.3
06A	Metropolitan Montreal and Laval	1247	2248	2339	1092	87.6
06B	Laurentides-Lanaudiere	175	351	384	209	119.4
06C	Monteregie	425	732	829	404	95.1
07	Outaouais	86	172	202	116	134.9
08	Nord-Ouest	46	92	109	63	137.0
09 10	Cote-Nord and Nouveau-Quebec	42	79	93	51	121.4
TOTAL		2979	5505	5907	2928	98.3

Source: Regie de l'assurance-maladie du Quebec, Troisieme rapport 1971-1972, Tableau K.
Regie de l'assurance-maladie du Quebec, Statistiques annuelles 1980, pp. 90-91.
Regie de l'assurance-maladie du Quebec, Statistiques annuelles 1982, pp. 138.
Ministere des Affaires Sociales, Super-Pop. March 1976; Fertility rate and migration = Hypothesis B (for 1972).
Ministere des Affaires socialies, Super-Pop, Resultats Revise du Modele Super-Pop, July 1980; Fertility rate and Census 1981.

(1) Comprehensive data all general physicians and residents paid by R.A.M.Q.

Conclusion

The province of Quebec has been concerned with and has acted to provide universal, comprehensive accessible insured health care - without barriers of employee premium requirements or patient coinsurance and deductible charges in insured areas. In so doing it has encourage integration of health and social services through regional centers. It has developed a financial incentive system to try to increase generalist and specialist physician participation in providing services for outlying areas. It has sought to encourage local participation in the development of health care service recommendations. Also, it has retained substantial power at the level of the provincial Ministry of Social Affairs.

HEALTH INSURANCE AND HEALTH SERVICE IN ONTARIO

The Political Culture of Ontario

In Ontario, since 1943, the dominant political party has been the Progressive Conservative Party. The opposition has been essentially split between the Liberal Party and the New Democratic Party. The Progressive Conservative party is viewed as "reformist" or cautiously progressive.[36]. The development of the health care system in Ontario has also followed a reformist, pragmatic and essentially non-ideological bent.

Ontario also has an ethnically pluralistic subculture. Toronto has a substantial Italo-Canadian population (25% of the City of Toronto) and substantial Greek, Chinese and Southeast Asian Indian populations. Similar ethnic enclaves of Finnish, Ukranian and Italian descent exist in Northern Ontario. Thus, substantial numbers of

Ontarians are of neither British or French descent. There are multi-ethnic subcultures and often an attenuated sense of Canadian or Ontarian political culture among a substantial segment of the population. This pluralist subculture has perhaps contributed to the inductive nature of political reforms in Ontario.[37]

Ontario's Health Insurance and Health Services System

In contrast to Quebec, health service reform in Ontario has been more incremental both in terms of the substance of reform and the process by which reforms have been attained. On April 12, 1957, the federal Hospital Insurance and Diagnostic Services Act was passed. On July 9 of the same year, Ontario's Blue Cross Plan, the Ontario Hospital Association (OHA) passed a resolution requiring that "...the OHA confine itself to the offering of Supplementary Hospital Coverage, that a plan for the takeover of its OHA staff and equipment" by the Ontario Hospital Services Commission be prepared and submitted to the OHA's Board of Directors. All Blue Cross employees who did not remain to administer a new Blue Cross Supplementary Benefits Program were transferred to the Ontario Hospital Services Commission.[37]

The development of a health insurance mechanism in the province of Ontario emerged in the 1950's. In 1955, the Progressive Conservative Premier of Ontario Leslie Frost appealed for a national health insurance program. This appeal was described by Maxwell Taylor, one of the architects of Canadian national health policy, as emerging from an amalgam of financial realities, organizational limitations, interest group pressures, political rivalry, federal political gamesmanship, and perhaps most important, as the concept of

what Mr. Frost called, simply human betterment.[38]

In order to understand the development of the Ontario Health Insurance Plan (OHIP), it is necessary to review Ontario's experience.[39] In 1947, the province of Ontario established a system of funding hospital beds which amounted to a grant of $1,000 per bed. This grant raised to a level of $1,500 was eventually matched by a federal grant for each hospital bed.

In 1958, as noted previously, the federal government was willing to subsidize provincial hospital insurance plans which met federal stipulations. With this background Ontario, along with Nova Scotia, and New Brunswick, introduced their plans on January 1, 1959. Earlier Newfoundland and Manitoba had introduced programs. By 1961 all of the provinces had joined the national hospital insurance program of utilizing "50 cent dollars" - based on federal cost sharing.[40] By the 1970's the same principle had been extended to national medical insurance.

The form of insurance which culminated in OHIP was shaped by a number of factors. In 1954, the Department of National Health and Welfare estimated that 6.8 million Canadians were covered by some form of prepaid hospital insurance, 40 percent of the Canadian population of that time. In Ontario during the 1960's, strong private sector involvement in hospital and health insurance was represented by Blue Cross (hospitals), Physicians Services Incorporated (a medical society related medical insurance program) and many private life insurance companies. Particular political pressure to maintain the role of private insurance was brought to bear by London Life, an insurance company headquartered in London, Ontario, Premier Roberts home constituency.[41] In March, 1956, the Ontario Medical Association

criticized proposals for assuming a program of mandatory hospital insurance for the employed. Rather, it advocated that government target individuals who either could not afford prepaid care or were uninsurable. Another pressure group influencing the development of the insurance system was the Ontario Hospital Association. The Ontario Hospital Association which operated the Blue Cross Plan of Ontario urged government to use Blue Cross to administer the hospital insurance program and "make full use of the experienced and trained personnel which could be invaluable, particularly in the initial stages of an overall plan."[42]

Following the advice of the insurance industry, Ontario adopted the Ontario Medical Services Insurance Plan (OMSIP) in 1966. It was a government-administered plan which covered persons lacking access to private insurance due to such reasons as unemployment, inability to pay premiums because of low income and uninsurability or because of prior medical conditions. A premium system was implemented with subsidies available to low income persons. Sadiq describes the resulting program as follows: "OMSIP did not meet the federal government's cost-sharing conditions that the provincial health insurance program be universally accessible on uniform terms and conditions, that it be portable from province to province and that it be publicly administered... Later, on October 1, 1969... Ontario attempted to meet these conditions by a ... combination of public and private enterprise [termed]... the Ontario Health Services Insurance Plan (OHSIP)... OHSIP administered the program through its own government agency with approximately 35 insurance companies also acting as agents. The result was an administrative nightmare in which

a resident of Ontario could be insured by any of 36 agencies, depending on the insuring agency selected by the employer."[51]

In 1972, the hospital and medical insurance programs were combined within an Ontarian provincial governmental organization known as the Ontario Health Insurance Plan (OHIP). This consolidation also was characterized by elimination of the private health insurance industry in the administration of the program. The system retained an employment related premium system which represented about 1.4 billion dollars (Canadian) in financial revenue collection.

Criticism of the premium system takes two forms. On the one hand, it is viewed as a "regressive tax" as the premium is equally applicable to all payees regardless of income levels. While a number of premium assistance programs are available to those with low income levels the case is made that often such programs are not well known and depend on initiatives by the applicant and submission to a degrading means test. Also, the premium system is administratively cumbersome and complex.

According to one OHIP official: "... OHIP has been placed in the position of a tax collection organization as well as requiring staff to perform means tests in the administration of premium assistance programs. Moreover, the need to make refunds, to administer assistance programs and to adjust coverage according to frequent status changes, not only adds to operational complexity but also results in friction with providers when claims are rejected on grounds of ineligibility. Lapses in coverage occur when employers fail to list new employees, when unemployed persons fail to register as individual subscribers, or when residents experiencing changes in family status fail to so advise. Rather than enhancing OHIP's primary

mandate of facilitating access to health services, the premium system continues to confuse and negate the public's perception of a social service function. A payable tax, as used in Quebec, would allow OHIP to concentrate on its social service mandate without any tax collection responsibilities."[44]

While hospital and medical benefits in Ontario are broadly available and comprehensive, the system utilizes means-testing regarding exemption from premium payments for OHIP coverage. Also, it has allowed physicians to over-bill, a privilege that skilled specialists have increasingly utilized. Moreover, as will be discussed later in this paper, in its hospital resource planning process, Ontario political culture utilizes more of an inductive, incremental political approach in contrast to Quebec's more deductive approach characterized by strongly provincial action which has not been seriously challenged by particular interests in Quebec.

A number of outcomes resulted from the Ontario government's decision to develop a hospital insurance plan and from the nature of the provisions of the plan instituted. The Government of Ontario instituted a program of largely universally available hospital insurance removing the economic threat to individuals needing prolonged hospital care. In response to opposition by the Ontario Medical Association, Ontario's government did not introduce out-patient diagnostic services as a benefit supplementing hospital insurance. Unlike Quebec, the medical society in Ontario was able to assert its influence in the polity and to bargain with some success with regard to its interests in shaping resultant provincial health policy. This decision resulted in an excessive utilization of beds

for in-patient care.[45] A similar tendency to over-utilize hospital beds resulted from a decision not to provide for home care benefits at that time.

The enactment of an Ontario Hospital Services Commission by the provincial legislature resulted in a degree of planfullness, although political bargaining does take place in Ontario regarding the positioning of hospital resources, and the development of a degree of provincial balance and integration of hospital facilities in Ontario. With the development of OHIP, the municipalities achieved major new revenue support in that there was a considerabe decline in non-insured indigent patients. Another effect was the loss of the field of coverage of standard hospital ward benefits by commercial insurance companies. However, Blue Cross continued the offering of semi-private hospital care benefits and added additional supplementary benefits - so that is operations continued to thrive.

Ontario's Health Insurance and Health Services Today

In spite of some limitations already noted regarding eligibility and coverage of costs, the Ontario Health Insurance Plan (OHIP) today provides coverage for a wide range of physician services with basic hospital benefits being paid for directly by the Ontario Ministry of Health. Insurance benefits include: physician services in the home, in a physician's office, or a hospital or other institution; specialist services where the specialist is certified by the Royal College of Physicians and Surgeons of Canada. Specifically covered are services related to the diagnosis of illness and injury, the treatment of fractures and dislocations, surgery, administration of anesthetics, x-rays for the purpose of diagnosis or treatment, obstetrical care - including the prenatal and postnatal periods;

laboratory and clinical pathology services.

The Ontario Health Insurance Plan (OHIP) pays physicians according to an OHIP schedule of benefits. Ontario statute allows the physician not to accept the plan payment as a total payment. In such cases, patients must pay the physician his full fee and are then allowed to recover the OHIP benefit from the Insurance Plan.[41]

Hospital service benefits are totally covered by OHIP when medically necessary in the diagnosis and treatment of illness or injury on an inpatient or outpatient basis. Among the hospital services provided for in Ontario are standard ward accommodations, necessary hospital-provided nursing servies, laboratory and x-ray diagnostic procedures, drugs provided by a physician - unless taking a pharmaceutical drug is the sole reason for the hospital visit; utilization of operating and delivery rooms, anesthetic and surgical supplies, as well as utilization of radiotherapy services. The use of home renal dialysis and home hyperailmentation equipment are included benefits. Other services which are reimbursed when prescribed by a physician under the administration of a hospital approved by the OHIP include occupational therapy, physiotherapy, speech therapy and out-patient diet counselling.[46]

OHIP also provides partial benefits for long-term care in a participating chronic care hospital or nursing home. This partial payment goes towards payment of approved standard ward costs. The degree of coverage is more comprehensive for lower income patients; higher income patients have "higher" co-insurance payments. Physician approved home care is also an approved benefit in circumstances where such "a professional health service" is needed. OHIP also provides

assistance for the services of optometrists, physiotherapists, and on a limited basis, for chiropractors, osteopaths, and chiropodists.

Services are generally underwritten by employment or income-related premium payments. In 1982, such payments were $27 monthly for an individual and $54 for a family of two or more persons. If your personal income was $3,000 or the income of husband and wife was under $3,500, no premium was required. Also, payments were reduced at a variety of percentage rates if under $4,500 for an individual or under $5,500 for a husband and wife. Also, premium-free OHIP coverage was available for individuals who qualified for public assistance payments or for those over 65 years of age. Those over 65 years of age were also entitled to pharmaceutical benefits.[47]

In Ontario, a person who occupies a chronic, rehabilitative or convalescent bed for more than 60 days is required to contribute to the cost of care, unless that patient financially qualifies for total or partial exemption. Chronic care payments are established quarterly. The maximum payment set by the Ministry of Health is $12.60 per day or 383.24 per month - as of August 1, 1981. Such payments may be waived on a means test basis. (Various home care programs are directly authorized by either the Ontario Ministry of Health or Ministry of Community and Social Services).

In addition to insurance coverage, Ontario's Ministry of Health provides an incentive grant program for family practitioners who will work in Northern Ontario. As of 1984, either an income tax-free grant of $40,000 Canadian ($10,000 a year over four years) or a contractual guarantee of $38,000 is provided for four years of service. In some areas of Southern Ontario, where it is difficult to attract family practitioners, a modified incentive scheme is also provided. In

addition, a travelling specialist program is provided.

Ontario has been more responsive to professional pressure in its health service decisionmaking, particularly in its permitting of physicians "opting out" of the OHIP system and "over-billing". As we have previously noted, in Ontario the physician may accept the negotiated fee as a full payment for a service and be paid directly by the province of Ontario with the patient paying nothing and receiving no bill - or the physician may "opt out" - billing the patient beyond the level of the provincial fee schedule. In this situation the plan pays a portion of the amount to the patient or the physician and the patient pays the remainder of the fee. Nevertheless "opted out" physicians do not always "overbill" so that the exact impact of overbilling is difficult to assess. The number of opted out physicians in Ontario in 1984 was estimated at about 15 percent.[49]

The provincial government of Ontario has also been less directive in its approach to policy decisions than that of Quebec. This approach is particularly illustrated by its utilization of an indirectly political process in seeking to control hospital costs - largely related to capital building and technology costs. In the face of percentage increases in provincial spending between 1972/1973 and 1982/1983 (see Table 8), the Government of Ontario sought to restrict hospital spending and close and consolidate "excess" hospitals. It has sought to utilize local advisory agencies called District Health Councils (DHCs) to recommend and implement such budget cuts. Deber and Vayda have referred to this process as the "buffering" of Ministerial authority.

Proposed new and expanded programs have to be sent to a DHC for

approval and prioritization before consideration by the Ministry. Twenty-five DHCs exist in Ontario. Such DHC recommendations are only advisory to the Ministry and not binding. However, DHCs have the potential - which they sometimes, but not always, wish to follow - to make so-called "hard decisions" insulating the Ministry of Health from politically difficult budget cutting decisions.[50]

Conclusion

While interest in providing equitable health care for all its citizens, Ontario has not been especially active in pursuing this goal beyond its assumption that structurally quality care is available for all its citizens. However, it has, through a Ministry of Health program, been active in seeking to increase regional accessibility of health care services throughout the province.

In its allowance of overbilling and its utilization of premiums, Ontario has also shown itself more ready than Quebec to negotiate with representatives of providers of health services in reaching decisions regarding delivery of health care services. Its use of DHCs to "buffer" provincial decisions regarding the control of hospital spending is another indication of Ontario's desire to use a more indirect negotiating process in reaching cost control decisions.

Table 6: Expenditures of the Government of Ontario, the Ministry of Health, and Payments to Hospitals for the Fiscal Years 1972/73 - 1982/83[1,2]

	Provincial Spending Ministry of Health					Provincial Spending Hospitals (corrected)[3]			
Year	% Incr Total Gov Exp (Actual)	% Incr Health Exp (Act)	% of Prov Budget (Est)	% of Prov Budget (Act)	% of Health Budget (Act)	$ (Est)	$ (Act)	% Incr (Est)	% Incr (Act)
1972-73	n/a	n/a	n/a	30.8	46.3	954.9	926.4	n/a	n/a
1973-74	12.7	7.9	30.1	29.5	45.6	1010.6	986.1	5.8	6.4
1974-75	20.8	17.3	27.7	28.7	49.6	1078.0	1256.5	6.7	27.4
1975-76	20.5	17.7	27.9	28.0	48.7	1377.9	1454.5	27.8	15.8
1976-77	12.1	13.8	27.9	28.5	50.9	1646.0	1730.7	19.5	19.0
1977-78	10.1	7.1	28.8	27.7	50.1	1887.2	1825.9	14.7	5.5
1978-79	7.8	8.6	27.6	27.9	49.0	1951.9	1938.0	3.4	6.1
1979-80	8.4	7.8	27.5	27.8	49.6	2072.6	2119.1	6.2	9.3
1980-81	9.7	13.7	28.0	28.8	48.5	2298.1	2355.3	10.9	11.1
1981-82	16.7	18.8	29.1	29.3	49.3	2641.2	2847.9	14.9	20.9
1982-83	n/a	n/a	29.6	n/a	n/a	3206.0	n/a	21.4	n/a

Source: Fiscal Resources Branch, Ontario Ministry of Health, Ottawa, Ontario, Canada, 1984.

n/a data not available
(ACT) actual expenditures as reported in Public Accounts
(EST) estimated expenditures as reported in Printed Estimates
EXP expenditures

1. Prior to 1972, only net funding of hospitals was reported as expenditures by Ministry of Health; consistent series for earlier years are therefore not available.
2. All figures prior to 1978-79 are adjusted to reflect change from calendar year to fiscal year reporting.
3. Payments to hospitals during fiscal years 1972-73 to 1977-78 included payments for clinical education which were subsequently reported separately; from 1972-73 for to 1979-80 included payments for Related Facilities; from 1972-73 to 1978-79 included payments for private physiotherapy and out of province care. Adjusted figures for hospital expenditures reflect these changes.

A COMPARISON OF HEALTH SERVICES IN QUEBEC AND ONTARIO: IN TERMS OF COVERAGE, COSTS, AND QUALITY

To some extent, social and political expenditures in the Ontario and Quebec systems reflect different social and political choices and priorities. In 1980, funding of overall health services in Quebec, both public and private, are slightly lower in Quebec than in Ontario, by an amount of $19.00 Canadian per capita or 2 percent. Public funding in Quebec is higher ($83.00 Canadian per capita or 13 percent. Quebec's public sector covers 81 percent of health care costs as compared with 70 percent in Ontario.[51] Recently, between 1977 and 1981, Quebec's "private" sector has grown from 6.7 percent to 10.1 percent.

Quebec, which utilizes a more direct degree of government regulation spends much less for services. Thus public expenditures for physician services is less than $21.00 Canadian per capita - partially because of set fees but also because out-patient care in Ontario is frequently provided by private offices.

Public costs for dental services in Quebec reflect generous coverage for child care and prevention. Also included are many beneficiaries of aide social. In 1976, 29 percent of the population of Ontario was covered by private dental insurance. In the area of coverage of drug costs - private costs for pharmaceuticals are lower than for other professional services.[2] The reason for these figures may be lower utilization of pharmaceuticals due to the fact that they were less often included under insured coverage than other health care services.

Excluding out-patient care, short term hospital care in Quebec is a significant concern. Quebec has less beds per 1,000 than Ontario

(4.54 versus 4.78 in 1981) and its rate of occupancy is 82.4 percent versus Ontario's 81 percent in fiscal year 1980-1981. Quebec provides a greater percentage number of days of hospitalization for long-term chronic care services - 20 percent for Quebec and 15 percent for Ontario in 1979-1980.

In Quebec a comparable lower number of days of hospitalization in comparison with Quebec must be compared with a higher cost per day of hospitalization. This cost is raised by a greater number of hours of hospital care reimbursed in each day of hospitalization (excluding out-patient services). This is due to greater personnel costs, more chronic care services, the costs of diagnostic and therapeutic services, and greater costs of administration and support services. In 1980-81, in Quebec the hours of remuneration increased for professional workers by 2 percent, by 12 percent for auxiliary personnel and by 118 percent for other aides and hospital help.

In comparing the number of hours worked per illness in Ontario and Quebec, Quebec's costs represented 77.8 percent of hours of remuneration paid per illness, as compared to remuneration on Ontario in 1979 and 79.3 percent in 1980.[53] A greater number of hours were spent on out-patient care in Quebec plus less care was provided by specialized physicians in Quebec than Ontario.

With respect to long term care and residential care, Quebec's costs are greater than those of Ontario. $53 (Canadian) more per inhabitant or 38 percent more was spent in Quebec as compared with Ontario and $70.00 (Canadian) more of public spending was spent in Quebec than in Ontario for long term care. Across the board, long term care and residential care for the elderly has been a priority in Quebec for a number of years,

while Ontario has only been directing attention to this problem since 1980. In meeting the needs of the elderly, Quebec has committed itself substantially to institutional resources directly financed by the province. It has supplemented long term care facility and residential care for the elderly with long-term care beds in short-term care hospitals. It had not sufficiently developed alternative community-based long term care resources.

Overall health levels in Quebec and Ontario do not show any significant differences.[54] In 1982, the death rate in Ontario of 7.3/1,000 was somewhat higher than Quebec's rate of 6.7 percent. Quebec's 1982 infant mortality rate of 8.8 was slightly higher than Ontario's rate of 8.3. The neo-natal (first 6 months of life) death rate for Quebec was 5.8 in comparison with Ontario's rate of 5.7. The perinatal death rate was 9.3/1,000 in Quebec and 10.2/1,000 in Ontario. Maternal mortality in both provinces is quite low - in 1981 there were .4 maternal deaths per 10,000 live births in Quebec in comparison with .8 maternal deaths per 10,000 live births in Ontario.[55]

In general, the vital statistics of both provinces exceed those of the poorer Canadian provinces, but are about comparable to national Canadian norms. For 1982 Canada's rate was 7.1, the general infant mortality rate was 9.1; the neonatal mortality rate was 5.9 and perinatal deaths were 11.6. The maternal mortality rate was .6.

Nevertheless, for Quebec, vital statistics represent a great improvement over the early 1970s. Since 1971, and particularly since 1976, mortality rates have declined in Quebec. In 1980, life expectancy for men stood at 70.31 years of age and at 78.23 years of

age for women.[56] Between 1971 and 1980, deaths due to heart disease dropped by 26 percent for men and 34 percent for women. Health costs involving 8.7 percent of Quebec's population represented 37.4 percent of health changes. 17.9 percent of such charges involved the treatment of mental illness.[57]

In viewing the dimension of revenue commitment to health care, in fiscal year 1979-1980, Quebec's per capita expenditure of $107.6 (Canadian) exceeded that of all provinces except Alberta.[58] Health expenditure in Quebec as a percentage of the provincial Gross Domestic Product was 6.5 percent. Ontario's level of health expenditures as a percentage of its Gross Domestic Product was 4.8 percent, lower than that of any other province except for Alberta. This is more a reflection of the extent of domestic spending in other areas in Ontario and Alberta rather than any lack of expenditure on health care.[59]

Quebec's strong provincial role in controlling costs has been effective in limiting hospital utilization. Nevertheless, Quebec has been less effective than Ontario in limiting the costs of administrative and support services in the health care delivery system. Quebec has also spent a greater proportion of its health care budget on institutional long-term care services than Ontario.

Since the Castonguay Commission Reports, Quebec has made a substantial revenue commitment to the provision of health care services. It also has consciously targeted resources on low-income and other specially vulnerable citizens. While the public expenditure level in Ontario for health care is lower than in Quebec relative to other government spending, Ontario also has made a major public commitment to the provision of insured health care services, although

it has not especially targeted the poor as a patient group. Quebec also has made a greater effort to target coverage in the area of prevention and out-patient care services. In contrast, in Ontario more care was provided by medical specialists than occurred in Quebec.

CONCLUSIONS

The Quebec and Ontario health insurance and health service delivery systems provide generally universal and comprehensive basic hospital and medical benefits and increasingly provide for the delivery of long-term care services. In viewing vital statistics, the health of Ontario and Quebec residents may be viewed as comparable.[60] In viewing expenditures, Quebec has a more clearly articulated plan of providing accessible services to low-income persons, and to integrating health and social services. Its plans of decentralized services are counterbalanced by a strong provincial role in health decision-making. Quebec's political culture also allows the province to play a stronger role in hospital planning and in the regulation of physician income. These political dynamics allow Quebec an advantage in control of costs. In Ontario, physician interests, and hospital interests play an active role in health system bargaining and are usually able to influence remuneration and resources allocation decisions.

The Canadian national health care legislation has allowed the provinces to evolve different health service institutions and styles of decisionmaking as long as they have fulfilled the stipulations of the national legislation regarding provision of insured services.

Federal funding allows the provinces great variability in the style and substance of implementation of health care services. As such it is at the national level a structurally minimalist intervention system which may serve as a model for the development of a truly accessible, comprehensive and universal system of health insurance in both the United States and the State of Israel.

The Canadian Health Care System: Its Lesson for the United States

The Canadian health system provides a useful model for the American health system in the following way: It would allow a great deal of variability among the states for the programmatic organization of a health care delivery system. Mechanisms of regulation and planning would be left for state development. As the price of accepting federal funding for "insured health service" state health insurance plans would have to agree to the maintenance of criteria of public administration; comprehensiveness of insured hospital and medical services, universality and portability of benefits and accessibility of services. Since federal funding is not open-ended, and as subscriber premiums would be prohibited, states would need to make serious efforts regarding health planning of resources and significant cost-controls. The federal government also would encourage through financial incentives, state development of extended health care services such as long term, chronic care services.

As covered medical practitioners and dentists would not be permitted to charge patients at all (no "extra-billing") and would have to accept negotiated fees or other negotiated remuneration, the states would, under federal law, need to develop a negotiating system

for settlement of compensation disputes. The model of decentralized "fiscal federalism" by leaving substantial state authority within presribed federal provisions, would allow local and regional political cultures to shape state plans while establishing for all American residents the right to adequate and accessible health care services.

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הפעלת תכניות ביטוח הבריאות של קבדה:
השוואה בין תכניות ביטוח הבריאות של קובק ואובטריו

הווארד ר. פאלי

פורום בינלאומי

פב-7-85

ג'וינט ישראל
מכון ברוקדייל לגרונטולוגיה
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המכון

הוא מכון ארצי למחקר, לניסוי ולחינוך בגרונטולוגיה והתפתחות אדם וחברה. הוא נוסד ב-1974 ופועל במסגרת הג'וינט האמריקאי (ועד הסיוע המאוחד של יהודי אמריקה), בעזרתן של קרן ברוקדייל בניו-יורק וממשלת ישראל.

בפעולתו מנסה המכון לזהות בעיות חברתיות ולהציב להן פתרונות חילופיים בשירותי הבריאות והשירותים הסוציאליים בכללם. אחד מיעדיו הוא להגביר שיתוף הפעולה של מומחים מהאקדמיות והממשלה, עובדי ציבור ופעילים בקהילה כדי לגשר בין מחקר לבין מימוש מסקנות מחקר הלכה למעשה.

סידרה בינלאומית

המאמרים מציגים מימצאי מחקר והשקפות מקצועיות של מלומדים אורחים מחו"ל, של אנשי אקדמיה בארץ ושל חברי סגל המכון. המאמרים בסידרה מציגים דיונים החורגים מעבר להקשר האמפירי הישראלי, או עוסקים בסוגיות מושגיות ומתודולוגיות בעלות ענין בינלאומי כללי. בכך משמשת הסידרה במה שבה נבחנים בפרספקטיבה בינלאומית ההלכה והמעשה של נושאי ההזדקנות.

הממצאים והמסקנות המוצגים הם של המחבר או המחברים וללא כוונה ליצג את אלה של המכון או של פרטים וגופים אחרים הקשורים למכון.

הפעלת תכניות ביטוח הבריאות של קנדה:

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ספטמבר, 1985

תקציר

מאמר זה הוכן בעת שהותו של המחבר כחוקר אורח במכון ברוקדייל. המאמר סוקר את התכניות השונות לביטוח רפואי בקנדה, במטרה לעמוד על השלכות אפשריות לגבי ארצות אחרות.

החוק הקנדי מאפשר למערכות הבריאות המקומיות חופש רב, אך בעת ובעונה אחת מבטיח הקפדה על קוי היסוד הבסיסיים. במערכת הבריאות בישראל, הכוללת מוסדות מגוונים ועצמאיים יותר, אין אותה מידה של תאום, אחריות, שוויון והלימה כפי שניתן למצוא במערכת המקבילה בקנדה.

היבטים אחרים של המערכת הקנדית הנדונים במאמר זה הינם הדרישות הפדרליות בנוגע לניהול ציבורי, כוללנות, אוניברסליות, ניידות ונגישות. שירותי הבריאות בשני מחוזות - קובק ואונטריו - מתוארים בפרוסרוט.

תוכן העניינים

רשימת לוחות