as defined by a simple test of income adequacy, are subsidized from general tax revenues.

Saskatchewan - Only Saskatchewan has a universal-coverage medical care program. This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory. The premium for a family is $24 a year; for a single person, $12. The premiums cover approximately 25 per cent of the costs of the program.

In 1968 small co-charges to be paid by the beneficiary at the time of receiving service were imposed with respect to certain services. The fees are $1.50 a visit to a physician's office and $2 a visit by a physician with respect to home, emergency, and hospital out-patient services. Fees are waived for welfare recipients and patients under the separate cancer program, and levels of maximum family liability are scheduled to be established in 1969.

Among the medical services covered are home, office and hospital visits, surgery, obstetrics, psychiatric care, anaesthesia, laboratory and radiological services, preventive medicine, and certain services provided by dentists. There are no waiting periods for benefits and no exclusions for reasons of age or pre-existing health conditions.

Physicians may elect to receive payment in four ways. First, the physician may receive payment of 85 per cent of the tariffs in the current schedule of fees of the organized profession, directly from the public administering authority, and accept this payment as payment in full. Secondly, patients and physicians may enrol voluntarily with an "approved health agency" that serves as intermediary, with respect to payment, between the public authority and the physicians; here also, the physician receives 85 per cent of the tariff as payment in full. Thirdly, a physician may elect to submit his bill directly to the patient who pays him and seeks reimbursement authority; the physician may bill the patient directly for amounts over and above what the public authority has paid. Fourthly, patient and physician may, if they agree, settle their accounts privately without involving any public authority or approved health agency. With respect to items of service on which a utilization fee must be paid, the 85 per cent applies to the balance after this fee has been paid.

Alberta - The Alberta Medical Plan was introduced in October 1963. It provided for public regulation of approved voluntary plans with regard to minimum benefits and maximum premiums, and was primarily designed to help residents having poor health or low income to purchase voluntary medical care insurance from approved non-profit and commercial agencies. It was required that the benefits provided be comprehensive and that there could be no exclusion because of age, pre-existing health conditions, or a previous record of high utilization. The government contributed premium subsidies for persons with little or no taxable income.

On July 1, 1966, this plan was supplemented by an extended health-benefit plan which, for an additional premium, made available many other benefits, including prescribed drugs, optometry, physiotherapy, ambulance service, osteopathy, chiropractic, podiatry, naturopathy, and certain other medical supplies and appliances. A deductible amount, co-insurance charges, and limited liability on some services applied to the extended plan.