helps pay for it, but the maintenance of public health care is the provinces' bailiwick. As might be expected in Canada, there are differences between the provinces in services covered, cost to the patient, and methods of financing. The widest is between Ontario and the others.

Federal hospital insurance was begun in 1958, at a time when the public was increasingly unable to afford hospital care on an individual basis. The federal government pays roughly half the cost and the provinces raise the rest. All raise their share at least partly from general revenues. Some charge direct premiums or special taxes. Ontario, for example, bills residents $132 a year for families. Manitoba and Saskatchewan tax up to $45 a year for families. Some provinces add "co-insurance" or "utilization" fees — that is, patients pay from $1 to $2.50 a day for hospitalization. Generally, you're covered even if you don't pay the premiums. You're just breaking the law.

Coverage is adequate but not posh and is determined by federal law. You stay in a ward, and all services normally provided are covered. Outpatient services are at the provinces' discretion, but most provinces provide virtually anything that is available to in-patients.

Help in paying the doctors' fees came later. Medical care insurance was started by several provinces in the early 1960's, Saskatchewan being first, in 1962. These plans likewise varied greatly in costs and coverage.

In 1968 Federal medicare began, amid rumblings from the medical profession. In a more flexible financing arrangement than with hospital insurance, the federal government pays half the cost of provincial plans, provided they meet several requirements, including:

They cover ninety-five per cent of insurable residents within three years.

They are publicly operated and non-profit. (This has virtually eliminated private insurance plans, except for special ones for drugs, ambulance service, and a few other things not always covered.)

Under medicare law, provinces can finance their share any way they wish, provided no insured person goes without care because of cost. The maritime provinces have devised a system where essential medical care is free to the patient. The government pays ninety per cent of the local medical association fee schedule, and, in general, doctors accept this as payment in full. Quebec charges premiums based on income, with a ceiling of $125 a year. Ontario charges up to $14.75 a month for families and recently has forbidden doctors to charge patients the percentage the government doesn't cover.

Going west, the coverage gets wider. In Manitoba a family pays about a dollar a month, and doctors accept the eighty-five per cent the government pays them. Saskatchewan and Alberta also charge small premiums, with wide coverage. Alberta pays for optometrists, chiropractors, podiatrists and special shoes, and osteopaths, for example. British Columbia does more, prompting MacLean's magazine to call it the hypochrondriacs Valhalla. Premiums of up to $12.50 a month per family cover most medical services.

When medicare was first proposed, doctors were generally stern towards it, and a vision of MDs fleeing the country was not uncommon. Recent studies show, though, that doctors' incomes have risen substantially since medicare. Newfoundland had the most spectacular rise, where doctors went from the lowest to the highest paid profession. Doctors are making more money for two reasons: first, they collect one hundred per cent of their bills — even if only at eighty-five or ninety per cent of par. Second, their fees have, in some cases, risen.

In the past several years, numerous professional committees have recommended ways to cut down on the cost to the government and to improve the general delivery of health care in the bargain.

Among the most frequent suggestions — which this year have become the policy of the government to encourage — are:

1. More non-MD "para-medical" attention, where appropriate.

2. Community health clinics instead of general purpose hospitals. Open twenty-four hours a day, these would serve as the patient's family health center, whether GP or specialist, or nurse.

3. New ways to tell how intelligently hospitals are spending their money. A cost-analysis system like this could help set up standards of operation that would determine federal aid.

It is expected Minister of National Health and Welfare John Munro will put forth new recommendations on these and other cost saving methods this fall. The actual implementation is the job of the provinces, and none would be instituted without provincial assent, but the federal government can lay on healthy encouragements. It can stop making grants to general hospitals and concentrate on community health care centers, should they appear, for example.

The next step will be extensive federal-provincial-professional conferences on the recommendations, and then, taking this input, the government probably will offer legislation.

Undoubtedly the new ideas will be met with much debate, as was medicare. Whatever happens, it is likely that individual Canadians will continue for the forseeable future, to get sick with only their pain to fret over.