By the end of 1968, basic medical or surgical coverage, or both, were being provided to about 17.2 million Canadians, representing 82 per cent of the total population. Of these, the voluntary plans operating purely in the private sector provided coverage for about 10.9 million persons, or 52 per cent, and public plans of various kinds covered 6.3 million persons, or 30 per cent.

Early in 1971, with public medical-care programs implemented in all ten provinces and the Northwest Territories, insurance for physicians' services covered in most provinces virtually the entire eligible population, or slightly over 21 million persons.

The four criteria for acceptability set out in the federal legislation leave each province with substantial flexibility in determining the administrative arrangements for the operation of its medical-care insurance plan and in choosing the way in which its plan will be financed, e.g., through premiums, sales tax, other provincial revenues or by a combination of methods.

In addition to the comprehensive physicians' services which must be provided as insured benefits by participating provinces, most plans also make provision for other health-care benefits that are part of the basic contract but towards the cost of which the Federal Government does not contribute. Refraction services by optometrists are included in the majority of provincial plans. A restricted volume of services provided by such practitioners as chiropractors, podiatrists, osteopaths, and naturopaths is also insured by some provinces. Residents may, if they wish, continue to seek insurance protection, generally from private voluntary agencies, for such additional services as dental care, special duty nursing, and prescribed drugs.

Five of the 11 provincial and territorial medical plans finance their portion of total costs from general taxation revenues only and there is thus virtually no direct cost to families apart from additional billing that doctors may in some instances impose. Five of the plans employ premium levies to help finance their share of costs, and one employs a payroll tax. Typically, premiums are paid for welfare recipients, and various devices are used to keep the financial burden low for families that are poor but just above the poverty-line entitling them to welfare assistance.

Each of the 11 plans in operation is described briefly in the paragraphs that follow, in chronological order of entry into the national program. It must be noted that, although most doctors are paid on a fee-for-service basis, alternative or additional arrangements include salary, sessional payments, contract service, capitation, and incentive pay.

Saskatchewan

This program, which was introduced in July 1962, requires enrolment of the entire eligible population. The premiums are compulsory and amount to $24 a year for a family, or $12 a year for a single person. These premiums cover only a small portion of the costs of the program. Welfare recipients are automatically covered, and no premium payment is required for them.