In the telling, the story of Duddy Kravitz has much in common with *Room at the Top*. Both stories tell of a young man on the make, energetic, impatient, regretfully smashing other human beings on his way up. Neither is devoid of human feeling: but the dynamo of success hunger drives both of them to sacrifice, in spite of their feelings, anyone, however dear, who stands between them and their goal.

This is where the comparison ends, for the context of the Kravitz tale is a world away from Braine and the north of England. In the Jewish boy's progress towards riches there is a shiny-eyed dedication which Anglo-Saxons reserve for good causes and the Holy Grail. Money is an ideal, a golden key to a romantic dream. Once he owns the lake and its surrounding land, he will give a farm to his Grandfather, who taught him that "a man without land is nobody."

If he uses and damages friends on the way, never mind. He will make it up to them. The end will justify the means — that's his view, and it's treachery in them to think otherwise.

The American actor Richard Dreyfuss, who made his name in *American Graffiti*, plays the 19-year-old Duddy with a virtuosity that makes him by turns appealing and sickening, powerful and ridiculous, vulnerable and hard as old flint. He dreams up projects, wheels and deals, flinches at failure and swaggers over success, throwing himself against obstacles in the belief that they have just gotta give way. He's wild, he's funny, he's terrifying from sheer force of explosive energy seeking an outlet.

"I need a stake," he says. "I've got a lot of ideas. Jeeze, somebody else has already thought of Kleenex!"

"Why did you never like me?" he asks a dying uncle, who paid his brother's college fees.

His uncle, surrounded by restrained ostentation, a success in business but childless and impotent, replies "Because you're a pusher, a little Jew-boy on the make and you make me sick." Yes, he is — but against this lifeless backdrop one's sympathies are with Duddy, eager, randy, grabbing life with greedy hands. The pity of it is that to get what he wants he must take decisions which destroy his own humanity. That is his bitter apprenticeship, spelt out to him in the steamy heat of a Turkish bath by a successful business man who doesn't want to see Duddy get too human and chicken out. In a hushed voice the older man confesses, by way of encouragement, how he dodged prison after a man was killed on his building site — letting his weaker partner pay the penalty instead.

It is a story with roots buried deep in human experience and literature. One recalls the Devil tempting Dr. Faustus in Marlowe's play some 470 years ago. That was a great hit. It still plays, from time to time.

# *Health care for all needs*

## By J. M. Greene

A comparison between Canada's health care arrangements and the National Health Service in Britain makes a fascinating study, in many ways revealing of the political and social differences between the two countries. Both are part of a wider trend among the developed nations of the world towards collective responsibility for the health of individuals. The end product is roughly the same in both countries: free medical care both in and out of hospital is available to all citizens. But the way this state of affairs came about and the way it is currently administered in Canada differs radically from the British pattern.

In Britain, the 1948 National Health Act was a markedly political event, still celebrated as the great achievement of the late Aneurin Bevan and the postwar Labour government. Although no political party would dare challenge its existence today, debate has continued to rumble around the edges of the National Health Service, over details like subscription charges, spectacles and teeth — the general pattern being for one party to reintroduce odd charges and the other, in due course, to repeal them.

### Class thinking

The recent battle over private beds in National Health hospitals is typical of the very emotive and doctrinaire thinking that surrounds the subject of health in Britain, and understandably so. In a class-conscious society, private and public health are bound to be equated with the other divisive categories: upper and lower class, priviledge and non-priviledge, rich and poor — with the implication that on one network you get quicker and better treatment than on the other. In simple terms, a parent whose child had waited eight months for a tonsilectomy on the National Health could until recently be by-passed by a child whose parents could pay for a private bed under the same surgeon in the same hospital within two weeks of diagnosis. This engendered a rage, fueled by ancient class feeling, which is the stuff Britain is made of: worse than irrelevant to mention that the middle-class parent of the child in the private bed might have gone without other things to subscribe to BUPA — the British United Provident Association — or some other independent form of hospital insurance.

By comparison with Britain, Canada has been slow in coming round to statutory provision of government-sponsored health care (though not so slow as the United States, which still has no National Health). The Canadian system came about gradually, with hospital and medicare "programmes" initiated by the federal government and spreading to acceptance by all the provincial governments. The hospital programme beeame universal in 1948 and the medicare programme not until 1971.

The system began, not with a centralized political movement but with the pragmatic discovery by isolated groups of people of the benefits of private health insurance. Historians of the Canadian health service are fond of pointing out that health insurance began there over 300 years ago, when a master surgeon in Ville Marie (which is now Montreal) offered a prepaid medical insurance plan for settlers and their families. For a premium of 100 sols per annum, he guaranteed to provide subscribers with free medical care — with certain prudent exceptions laid down with the contract. He did not, for example, guarantee treatment for the plague!

From that early start the idea snowballed, with significant developments as employers came round to taking a hand in insurance coverage for their workers. In the 1880s, Cape Breton miners and many lumbering camps developed a check-off system under which free hospital and medical services were financed from funds compounded of payroll deductions and employers' contributions. During the 1930s, when private health insurance was still uncommon, community hospitals in various parts of Canada offered prepaid hospital care to local residents in return for a few dollars a month. The hardship of the depression years made people very aware of the value of health insurance and lent fuel to the idea of universal coverage. Though this came late, by the time it did arrive all but 20 per cent of the population were already covered by some form of medical insurance.

### Based on insurance

The word "insurance" remains the key to understanding how the national scheme operates. Hospitals and doctors have not been reorganised under the employ of the state. They function much as they did before, with the difference that their bills are paid at standard rates out of insurance on which premiums are covered almost entirely by government funds.

The cost of this insurance is divided on a roughly equal basis between the federal government and the ten provincial govern-