medical services under other programs) and has paid, or has had paid on his behalf, the required premium is entitled to have payment made on his behalf from the Medical Care Insurance Fund for medical, surgical and obstetrical care, without limit, in his home, in the doctor's office and in hospital, from his physician-of-choice (including payment at specialists' rates for referred specialists' services). There are no restrictions relating to age or pre-existing conditions. Physicians may elect to receive payment in a number of ways; usually either they choose to receive direct payment from the Medical Care Insurance Commission at 85 p.c. of the 1959 Schedule of Minimum Fees of the College of Physicians and Surgeons of Saskatchewan (as amended) as payment in full, or their patients enrol voluntarily with an approved health agency, which pays the physician an amount equal to the amount paid to the agency by the Commission in respect of the physician's assessed account. In 1965, annual premiums of $12 for a single person and $24 for families accounted for 25 p.c. and general revenue contributions for 73 p.c. of the Commission's total receipts. There were more than 887,000 persons covered by the Saskatchewan Medical Care Insurance Act at the end of June 1965, or about 93 p.c. of the provincial population. Most of those not covered were protected under other public programs, federal or provincial.

Provincially Sponsored or Assisted Medical Care Programs.—Three provinces—Alberta, British Columbia and Ontario—have established provincially assisted voluntary medical care programs.

The Alberta Medical Plan, which became effective Oct. 1, 1963, is designed to help residents with low incomes who voluntarily purchase medical care insurance from approved non-profit and commercial agencies. The approved carriers must make available to all residents a program of insurance that provides the attendance of physicians in home, office or hospital, as well as surgical, specialist and general diagnostic services. Maximum premium rates set by the province must not be exceeded. The Plan is financed completely from personal premiums but there is provision for government subsidization of the premium costs of low-income persons to the extent of 80 p.c. for persons with no taxable income, 50 p.c. for persons with taxable income from $1 to $500, and 25 p.c. for persons with taxable income from $501 to $1,000. All residents may insure for medical services either through the doctor-sponsored Medical Services (Alberta) Incorporated or through approved agencies; doctors are reimbursed at 90 p.c. of their assessed fees by the former or at 100 p.c. by the latter. In October 1965, an estimated 850,000 persons were covered by the Plan, or 59 p.c. of the provincial population. Of these, about 187,000, or 13 p.c. of the provincial population, were covered by subsidized insurance contracts.

On July 1, 1966 the Alberta Health Program came into effect; it comprises the Alberta Medical Plan and the new Extended Health Benefits Plan. The latter makes available, through approved companies and with premium-subsidy rates equal to those under the Alberta Medical Plan, insurance for many additional health services, including prescribed drugs, optometry, physiotherapy, psychology, ambulance, osteopathy, chiropractic, podiatry, naturopathy, and various medical supplies and appliances. A deductible amount and a co-insurance charge or limited liability on some services apply to the new Plan.

The British Columbia Medical Plan took effect Sept. 1, 1965. The Plan, an agency directed by representatives of the government and the medical profession, makes available to all provincial residents insurance that provides most physician's services, as well as limited physiotherapy, special nursing, chiropractic and naturopathic services. To persons resident in the province for the preceding 12 months, the government offers subsidies of 90 p.c. of the premium for those with no taxable income and of 50 p.c. for those with taxable income from $1 to $1,000. Annual premiums are $60 for a single person, $120 for a family of two, and $150 for a family of three or more persons. The government pays $2,000,000 annually to a Medical Grant Stabilization Fund in order to cover any deficit. In February 1966, more than 198,000 persons were covered under the Plan and 67 p.c. of the insurance contracts were subsidized.

The Ontario Medical Services Insurance Plan began paying benefits July 1, 1966. The Plan offers to all Ontario residents insurance that covers most physician's services.