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 p.c. 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 for 85 p.c. of the approved amount from the public 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.

Alberta.—The Alberta Medical Plan introduced in October 1963 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 exclusions because of age, pre-existing health conditions, or a previous record of high utilization. The plan was financed from personal premiums alone. The government contributed, as a subsidy, 80 p.c. of the premium for persons with no taxable income, 50 p.c. for persons with annual taxable incomes from $1 to $500, and 25 p.c. for those with taxable incomes from $501 to $1,000. On July 1, 1966, this plan was supplemented, for an additional premium, by other benefits including prescribed drugs, optometry, physiotherapy, ambulance service, osteopathy, chiropractic, podiatry, naturopathy and certain medical supplies and appliances. A deductible amount, co-insurance charges, and limited liability on some services applied to the extended plan.

On July 1, 1967, these plans were superseded by the Alberta Health Plan, to be operated by the Department of Health for all residents voluntarily seeking individual and family enrolment. The new plan is divided into two parts—Basic Health Services and Optional Health Services, the latter being subdivided into Options A, B and C. The Basic Plan covers all services of physicians with payment of 100 p.c. of the tariff, special dental surgery, limited optometric services, and podiatric and osteopathic services up to $100 annually. Option A offers as additional benefits certain services not insured under the provincial hospital plan, including hospital admission charge, daily co-insurance charge in a standard ward (limited to 180 days a year in a chronic hospital), differential charge for a semi-private room, certain hospital out-patient charges, and ambulance benefits up to $100 a year. Option B covers 80 p.c. of the cost of prescribed drugs and prosthetic appliances; the subscriber pays 20 p.c. Purchase and repair of artificial limbs, eyes and braces, prescribed by a physician, are also covered up to $300 a year. Option C offers chiropractic and naturopathic services up to $100 a year.

Premium rates for the Basic Plan are $60 a year for single-person families, $120 for families of two persons and $160 for families of three or more. Each Option costs an additional $12, $24 and $36 a year, respectively. For individuals or families with little or no taxable income, premiums for both the Basic Plan and the Options may be reduced by means of subsidies from the province.

British Columbia—The British Columbia medical plan took effect in September 1965. As of mid-1967 it was administered by an agency directed by representatives of government and the medical profession. The benefits provided were comprehensive and included most physicians' services as well as limited physiotherapy, special nursing, chiropractic and naturopathy. For eligible residents, the government offered subsidies totalling 90 p.c. of the premium for persons with no taxable income and 50 p.c. of the premium for persons with taxable income from $1 to $1,000. A medical grant stabilization fund was established, initially of $2,000,000, to cover possible deficits.