care programs. In provinces where provincially operated ambulance services are not available, ambulance services may be hospital based.

Non-hospital institutional care is provided by a variety of facilities including nursing homes, homes for the aged, homes for unmarried mothers, child care institutions, hostels and senior citizens' lodges. Insurance coverage does not extend to these institutions except in the three provinces noted below, but persons requiring care are eligible to apply for assistance through the Canada Assistance Plan.

Ontario provides extended health (nursing home) care benefits under its health insurance plan. Manitoba has a personal care home program covering extended treatment, personal care and hostel care, and Alberta has an insured nursing home program. Daily authorized charges to the patient applicable to these programs are: Ontario $5.45, Manitoba $4.50, Alberta $3.00.

In addition, some provincial insurance plans provide other services not eligible for cost-sharing under the federal Act including home renal dialysis and home hyperalimentation equipment, supplies and medication, essential ambulance services at modest cost, and occupational and speech therapy in non-hospital facilities in Ontario; physiotherapy services in non-hospital facilities and services in community health and social centres in Saskatchewan; care in senior citizens' lodges at modest cost in Alberta; and equipment, supplies and medication for home renal dialysis in British Columbia.

### 5.2.2 Medical care and related services

Before the establishment of government-administered medical insurance, voluntary prepayment arrangements to cover the cost of physicians' services had developed in both public and private sectors. By the end of 1968, basic medical or surgical coverage, or both, were being provided to about 17.2 million Canadians, 82% of the population. Voluntary plans operating in the private sector covered about 10.9 million, or 52%, and public plans of various kinds covered 6.3 million, or 30%. By early 1972 all 10 provinces and the two territories had met the criteria stipulated under the Medical Care Act as conditions for federal cost-sharing, and virtually the entire eligible population was insured for all required medical services plus a limited range of oral surgery. Members of the Canadian Armed Forces, the Royal Canadian Mounted Police, and inmates of federal penitentiaries whose medical care requirements are met under alternative provisions are excluded. Services by physicians that are not medically required (e.g. examinations for life insurance), services covered under other legislation (e.g. immunizations where available through organized public health services), and services to treat work-related conditions already covered by workmen's compensation legislation are not covered.

The federal government contributes, over-all, half of the cost of insured services. The proportion varies somewhat from province to province, depending upon actual provincial cost levels. In 1973-74 the proportions ranged from 44.3% in British Columbia and 44.6% in Ontario to 74.3% in Prince Edward Island and 81.5% in Newfoundland.

Seven of the 12 provincial (or territorial) medical plans finance their share of the cost from general revenues only and in those plans there is virtually no direct cost to families, apart from additional billing that doctors may impose. Three provinces and the Yukon Territory levy premiums to help finance their share, and one employs a payroll tax. In their plans, premiums are paid by the government for welfare recipients and, in some cases, for residents 65 years and over, and various devices are used to keep the financial burden low for families who are poor but are just above the poverty line and so are not entitled to welfare assistance.

Each plan is described briefly in the paragraphs that follow, in order of its entry into the national program. 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. It should be noted that all provinces permit specialists to extra-bill for non-referred care if the specialist rate is higher than the rate the plan will pay for such service.

**Saskatchewan.** The Saskatchewan program, introduced in July 1962, requires enrolment of the entire eligible population. Since January 1, 1974, when premiums were discontinued, the provincial share of the cost has been financed entirely from general revenues. The Medical Care Insurance Commission (MCIC), the principal administering agency, pays doctors for most of the services provided under the plan. About 5% of the population obtain their insured service under terms and conditions identical to those of the MCIC but by way of a separate