VOL. XLI AUGUST 1962 No.8

The NOVA SCOTIA MEDICAL BULLETIN

GUEST EDITORIAL

The Hidden Costs.

Elsewhere in this issue of the Bulletin there is reprinted the address of Mr. B. E. Freamo, Secretary Economics, Canadian Medical Association. He examined "What Cost - Free Medical Care", in depth, and presents his reasoning and findings with logical care and precision.

It is very worthwhile to be reminded that the idea and implementation of Health Insurance is not new, that it was instituted in Europe two hundred years ago. Within this period of time many schemes in many Countries have been tried. They have the common factor of the change from Governmental provision of preventative and general services to those that are curative and individual in nature. They have exemplified the eventual control and limitation of necessary services for budgetary reasons, with a reduction in the quantity and quality of the service available. They have illustrated in varying degrees a fiscal rigidity, that has restricted systems from absorbing new expenditures. Some attempt has been made in recent years to overcome this by allowing a voluntary health insurance program to operate alongside state system, and by a shift to a reimbursement method of payment for physician services.

One of the great fallacies, Mr. Freamo avers, is the idea that the amount of sickness in Society can be reduced by providing an appropriate amount of money and by the organization of medical services. This idea ignores the fact that it is the quality of the personnel, the adequacy of their training and numbers, and the adequacy of the facilities available for their use, that determine the quality of the service they can render. An unsatisfactory coverage for all, without the alleviation of areas of real need, is an absurdity.

A succinct confirmation of this is to be found in the findings of our N. S. Medical Society reported in the Brief to the Royal Commission on Health Services. A correction of the more obvious unmet medical needs in this Province would cost approximately $53,000,000 of which only $2,500,000 would be entailed by medical insurance coverage of those unable to contribute financially to their own medical care. For government to provide the money for the latter, without a serious and major expenditure to correct the inadequacy of the facilities, and to aid in the recruitment and training of necessary skilled personnel, would not improve the health care of the individual one iota.

And finally while we officially recognize that the method of remuneration for physicians services is amenable to negotiation, we unalterably oppose civil conscription of the profession.

A.A.G.

THE MEDICAL SOCIETY OF NOVA SCOTIA

NOVA SCOTIA DIVISION
OF
THE CANADIAN MEDICAL ASSOCIATION

MEMBERS OF EXECUTIVE COMMITTEE

OFFICERS

President	D. F. Macdonald
President-Elect	C. L. Gosse
Immediate Past-President	R. F. Ross
Chairman Executive Committee	L. C. Steeves
Vice-Chairman Executive	J. E. H. Miller
Honorary Treasurer	J. F. Boudreau
Executive Secretary	C. J. W. Beckwith

BRANCH SOCIETY REPRESENTATIVES

Antigonish-Guysborough	T. W. Gorman
Cape Breton	D. H. MacKenzie, J. R. Macneil
Colchester-East Hants	H. R. McKean
Cumberland	J. C. Murray
Halifax	F. J. Barton, J. McD. Corston, K. M. Grant
Lunenburg-Queens	A. J. M. Griffiths
Pictou County	C. B. Smith
Valley	J. A. Smith
Western Counties	C. K. Fuller

OBSERVERS

Representative to C.M.A. Executive Committee	D. I. Rice
Chairman Public Relations Committee	S. C. Robinson
Chairman Medical Economics Committee	H. E. Christie

CHAIRMEN OF STANDING COMMITTEES

COMMITTEE	CHAIRMAN
Archives	C. M. Bethune
By-laws	J. E. Hiltz
Cancer	J. E. Stapleton
Child Health	R. S. Grant
Civil Disaster	S. B. Bird
Discipline	R. F. Ross
Editorial Board (Editor)	J. F. Filbee
Fees	C. H. Young
Finance (Hon. Treas.)	J. F. Boudreau
Health Insurance	D. McD. Archibald
Insurance	A. J. Brady
Legislation & Ethics	
Medical Economics	H. E. Christie
Medical Education	D. C. Cantelope
Maternal & Perinatal Health	M. G. Tompkins
Membership	J. A. Myrden
Nutrition	W. A. Cochrane
Pharmacy	J. E. MacDonnell
Physical Education & Recreation	J. M. Williston
Public Health	S. D. Dunn
Public Relations	S. C. Robinson
Rehabilitation	G. J. H. Colwell
Resolutions	L. C. Steeves
Special Research	A. A. Giffin
Traffic Accidents	A. L. Murphy
W. C. B. Liaison	A. W. Titus

BRANCH SOCIETIES	President	Secretary
Antigonish-Guysborough	G. L. Silver	R. Sers
Cape Breton	N. K. MacLennan	L. W. Christ
Colchester-East Hants	H. R. MacKean	K. B. Shephard
Cumberland	R. E. Price	R. A. Burden
Halifax	K. M. Grant	G. J. H. Colwell
Lunenburg-Queens	F. G. Bell	G. D. Donaldson
Pictou County	L. M. Sproull	W. D. MacLean
Valley Medical	G. K. Smith	E. G. Vaughan
Western Counties	R. P. Belliveau	G. D. Belliveau

AFFILIATE SOCIETIES	PRESIDENTS
Nova Scotia Association of Radiologists	A. J. M. Griffiths
Nova Scotia Society of Ophthalmology & Otolaryngology	R. H. Fraser
Nova Scotia Society of General Practitioners	A. G. MacLeod
Nova Scotia Chapter of College of General Practitioners	
Nova Scotia Division of Canadian Anaesthetists' Society	C. H. L. Baker
Nova Scotia Association of Pathologists	J. N. Park

STATEMENT

by

THE MEDICAL SOCIETY OF NOVA SCOTIA

The medical profession in Nova Scotia, as represented by the Medical Society of Nova Scotia, at its Annual Meeting, 1962 unanimously affirmed its support to the College of Physicians and Surgeons of Saskatchewan in its opposition to "The Saskatchewan Medical Care Insurance Act."

It is the sincere belief of the medical profession in Nova Scotia that plans for comprehensive medical services insurance are not only necessary, but are feasible, and that physicians' services should be available to all through cooperation between voluntary non-profit plans and the government. The profession believes that such plans must be acceptable to those providing and to those receiving the services.

The Saskatchewan Act imposes such rigid controls on the doctors and the public that certain principles are ignored. Because of this, we believe the present Act is a threat to the high standard of medical care which has been developed in this country.

Under the unfortunate conditions existing in Saskatchewan, the decision of the Saskatchewan medical profession to interrupt normal medical services and substitute free emergency services in designated hospitals was the most effective protest.

(Signed) C. J. W. BECKWITH, M.D., D.P.H.,
Executive-Secretary.

July 14, 1962.

Printed in the Chronicle-Herald July 17th, 1962.

INDEX

TRANSACTIONS — 109th ANNUAL MEETING

109th Annual Meeting
THE MEDICAL SOCIETY OF NOVA SCOTIA
May 21-23, 1962
Nova Scotian Hotel, Halifax, N. S.

First Business Session

AM 1—The First Business Session was convened by the President, Dr. R. F. Ross, at 9:50 a.m., May 21st, in the Atlantic Room, Nova Scotian Hotel. A hearty welcome was extended. Dr. Ross expressed the pleasure of the members in having Dr. G. W. Halpenny, President of C.M.A.; Dr. A. F. W. Peart, Deputy General Secretary, C.M.A.; Dr. Kenneth MacFarlane, Associate Professor of Obstetrics and Gynaecology, McGill University, and Dr. David A. Howell, Neurologist, Montreal General Hospital as our distinguished guests.
AM 2—The Executive Secretary reported the deaths of the following members in the interval since June 12, 1961:

Covert, George Leslie, M.D.
Curtis, Edgar Marshall, M.D.
Fraser, Hugh Artworth, M.D.
Granville, Frederick Joseph, M.D.
Leslie, Walter, M.D.
Withrow, Ralph Roscoe, M.D.
Wulff, Joern Marro, M.D.

One minute's silence was observed in tribute to these members deceased.
AM 3—The names of 41 applicants for membership were presented for approval. These were recommended to the Annual Meeting by the Executive Committee. On motion these were accepted as members.
AM 4—**Election of Nominating Committee.** The Executive-Secretary referred to the By-Laws and read the list of nominees from the nine Branch Societies. Owing to the absence of some, the Chairman requested nominations from the floor. The completed list was read by the President. A motion that nominations cease was carried. The President declared the members of the Nominating Committee elected. The Chairman, Dr. R. F. Ross, announced that the Nominating Committee would meet at 11 a.m., Monday, May 21st in Room 900, Nova Scotian Hotel.
AM 5—**Transactions, 108th Annual Meeting, 1961.**
On motion, the transactions of the 108th Annual Meeting were approved as circulated and published in the April, 1962 issue of the Nova Scotia Medical Bulletin.

Annual Reports of Committees and Representatives

AM 6—**Report of the Executive Committee** Chairman, Dr. L. C. Steeves (Ann. Rep. 1962 - Page 1.)
The report reviewed the activities of the Executive Committee during the year. Four regular meetings, two special meetings and an annual had been held. The two special meetings have been for the purpose of reviewing the Brief to The Royal Commission on Health Services.
AM 7—The Special Research Committee had made a monumental contribution in their preparation of the Brief to the Royal Commission on Health Services, the first presented by any Medical Society at the hearings of the Commission across Canada.
AM 8—The Committee on Fees and the Health Insurance Committee have had a very heavy year's work. Responsibilities of the Committee on Post-Graduate Education have been broadened to include undergraduate medical education and has been renamed the Committee on Medical Education.
AM 9—The Saskatchewan situation has been given close attention by the Committees on Economics, Public Relations, and the Executive. The Committee on By-Laws completed its task of the past several years by proposing adoption of the amended By-Laws (as published in the January, 1962 issue of the Nova Scotia Medical Bulletin) at this Annual Meet-

ing. Several Ad Hoc Committees had started work during the year: Building Committee, Committee on the Secretariat, Committee on Procedure at Meetings, and another to prepare a submission to the Rowe Commission. The Committee on Presidential Insignia has completed its terms of reference.

AM 10—Eight of the nine Branch Societies have held scheduled meetings prior to each Executive Committee meeting. One Branch Society had missed one such meeting. These meetings had each been attended by an officer of the Society or the Executive-Secretary. Such liaison has proven to be mutually advantageous.

AM 11—The Chairman expressed appreciation to those whose work on our many committees benefitted all members of the Society.

AM 12—Following discussion a motion for adoption of the report was put and carried.

AM 13—Special Committee on Procedure at Meetings Chairman, Dr. L. C. Steeves - (Ann. Rep. 1962 - Page 2.)

The report of the Committee is as follows:

"The 2nd Regular Meeting of the Executive Committee 1961-1962 (December 2/61) appointed an Ad Hoc Committee to develop plans for procedure during meetings. The Committee reports as follows:

AM 14— It is recommended

I. That "The Conduct of a Meeting', by W. G' Frisby, Ryerson Press, Toronto, be used by officials of the Society as a working guide for the conduct of meetings of the Society.

II. That Bourinot's "Rules of Order" be used as a reference.

AM 15—"The above recommendations are made in conformity with the Constitution and By-Laws of the Society which state (Chapter VIII, Section 4) that the rules which govern the proceedings of the House of Commons of Canada shall be the guide for conducting all meetings of the Division.

AM 16—"Following, for general guidance, is a "Typical Agenda" with notes regarding the most common situations to be dealt with. (See Frisby "The Conduct of a Meeting".)

1. Call to Order.
2. Minutes.
3. Business arising out of the minutes.

Note: Should anyone from the floor wish to discuss anything arising out of the minutes which the Secretary did not bring up, the Chair will request that he put this wish in the form of a motion, duly seconded, e.g. "I move, Mr. Chairman, that item 'so-and-so' be now discussed by this meeting." This motion must be passed before the item can be discussed.

4. Committee Reports.

Note: The Chairman of a Committee will read his report, at the conclusion of which he will move "that this report be received for discussion". When duly seconded, *(without debate) this motion will be voted upon. Once passed, the report is open for discussion. Under the direction of the Chairman, the report is then dealt with point by point as to (1) phraseology, (2) amplifications, (3) deletions, (4) recommendation.

"Any change must be by a separate motion for each point raised. When the whole report has been thus dealt with, a motion is then in order to adopt this report either as submitted or amended. At this point no further discussion on the report is permitted, but discussion on the "motion to adopt" is in order.

"Any resolutions arising out of the discussion on the report are then presented in the form of individual motions; duly seconded, discussed, and voted upon.

Note: Should it be desired to defer the motion for adoption, for any reason, a motion to this effect must be introduced before the motion to adopt is put before the meeting.

AM 17—"It is desirable that a copy of Frisby and of Bourinot be in the hands of the Secretary at the meeting as the final court of appeal should questions arise concerning procedure."

AM 18—*A resolution was presented from the Annual Meeting of the Executive Committee that the words "without debate" be deleted. This was discussed and carried. The report, as amended, was moved for adoption and carried.

(N.B.) At the Annual Meeting each report was presented, followed by a motion that it be received for discussion. Following discussion an appropriate motion was presented and put to a vote.)

AM 19—Special Committee on the Secretariat Chairman, Dr. D. I. Rice (Ann. Rep. 1962 - Page 64).

This special Committee had reported to the Executive Committee on two occasions during the year. A major recommendation that the Executive-Secretary have the assistance of a secretary and that a full-time stenographer be employed had been accepted, acted on by the Executive Committee and included in the budget for 1962. A recommendation for an increase in the salary for the Executive-Secretary had also been acted on. The report referred to the duties of the Executive-Secretary as in Chapter X, Section 8 of the By-Laws and made recommendations to supplement these under existing conditions under the headings: Responsibility to the Office, to Executive Committee, to Branch Societies, to Standing and Special Committees, to the Bulletin, to the Canadian Medical Association, and to the Public.

AM 20—The Committee recommended that the Executive-Secretary be relieved of the responsibility of Managing Editor of the Bulletin, such duties to be assumed by 'a person selected by the Editorial Board of the Bulletin'. The report concludes: "This Committee would assure the members of the Society that we are being well served by our present secretariat."

After discussion, a motion for adoption was carried.

AM 21—Committee on By-Laws Chairman, Dr. H. J. Devereux, (Ann. Rep. 1962 - Page 39).

A motion for adoption of the Amended By-Laws as published in the January, 1962 issue of the Nova Scotia Medical Bulletin was regularly seconded and carried.

AM 22—A resolution from the Valley Medical Society, namely:

> "That this Branch Society recommend to the Executive Committee that a change in voting procedure be made to allow the vote of the delegate from each Branch Society to be equal and counted as ten votes, and that the vote of each individual member present be counted as one vote."

was referred to the in-coming Committee on By-Laws and the Executive Committee. It is possible that the resolution may envisage a Council for The Medical Society of Nova Scotia and it requires study and clarification.

AM 23—The Committee recommended study of the Terms of Reference for each Committee of the Society and that these, when completed, be available in a separate brochure.

AM 24—After discussion a motion for adoption of this report was carried.

AM 25—Representative to C.M.A. Executive Committee Dr. R. O. Jones (Ann. Rep. 1962 - Page 57).

Dr. Jones summarized the significant actions of the C.M.A. Executive during the past year. There has been increased activity because of the many important developments in Canadian medicine. Two major preoccupations were the Saskatchewan situation and the Royal Commission on Health Services.

AM 26—As is generally known there has been a progressive deterioration in the relationship between the Saskatchewan Government and the College of Physicians and Surgeons which at the moment has culminated in a deadlock, with the Government insisting they will implement their Medical Act on July 1st, 1962. The profession is protesting the implementation of the Act.

Am 27—The Brief to the Royal Commission on Health Services was prepared by the Executive Sub-Committee on Health Services, Chairman, Dr. G. E. Wodehouse of Toronto.

AM 28—There had been a marked increase in expenditures of The Canadian Medical Association, coupled with a decrease in advertising revenue from the Journal. This resulted in a deficit. Consequently it will be recommended to General Council that as of January 1, 1963 the Annual Fee will be raised $10, i.e. C.M.A. membership dues are recommended to be $30 starting in 1963.

AM 29—On nomination by this Division, Dr. W. A. Curry of Halifax has been elected to Senior Membership in the C.M.A.

AM 30—Dr. Jones concluded by expressing his appreciation to the general membership for the opportunity of being associated with the activities of the C.M.A.

AM 31—Adoption of the report was moved, seconded and carried.

AM 32—The First Business Session adjourned at 11:15 a.m.

Second Business Session

Monday, May 21, 1962

AM 33—The President, Dr. R. F. Ross, called the Second Business Session to order at 3.20 p.m. The President announced that the Saskatchewan situation would be completely presented and discussed on Tuesday, May 22nd at 10.00 a.m.

AM 34—The presentation of Annual Reports was continued.

Editorial Board, Nova Scotia Medical Bulletin Chairman, Dr. E. H. Evans (An . Rep. 1962 - Page 36).

AM 35—The report noted the continuing interest shown by members of the Society and stated that a satisfactory balance had been maintained of business dealing with the affairs of Medicine, scientific and social material, resulting in a monthly publication of general interest.

AM 36—On motion the report was adopted.

Managing Editor Dr. C. J. W. Beckwith (Ann. Rep. - 1962 - Page 16).

AM 37—It was noted that this is the fortieth year of publication of the Bulletin. An increase in advertising rates became effective in January, 1962 but the number of advertising pages had decreased. This experience has been shared with medical publications across Canada.

AM 38—On motion the report was adopted.

Membership Committee Chairman, Dr. D. M. MacRae (Ann. Rep. 1962 - Page 14).

AM 39—A further increase in membership from 578 in 1960 to 627 in 1961 was reported. 41 of this number are new members.

AM 40—Recommendations of the Committee were:

"(1) that secretaries of Branch Societies be requested to canvass non-members in their areas, and report any potential candidates to the Membership Committee; (2) that all Specialty groups be invited to form Sections within the Society as outlined in the new By-Laws."

AM 41—On motion the report was adopted.

Report of Trusteeship Committee, C.M.R.S.P., Dr. C. H. Young (Ann. Rep. 1962 - Page 11).

AM 42—This report dealt with the contributions of the 2,863 participating physicians, the current standing of the Common Stock Fund and the Insured Fund. It also reviewed the standing of the Canadian Medical Equity Fund.

AM 43—On motion the report was adopted.

Special Research Committee Chairman, Dr. A. A. Giffin (Ann. Rep. 1962 - Page 31).

AM 44—Since its inception this Committee has held 19 meetings.Very early in its studies the Royal Commission on Health Services was established. Although at first this appeared to require a diversion of effort to prepare the Brief of the Nova Scotia Medical Society to the Royal Commission, the similarity in the terms of reference was such that with the completion of the Supplementary Brief, on which the Committee is currently engaged, much of the preliminary work of the S.R.C. will be completed.

AM 45—In summary, the Committee found the amount spent on Health Services for the citizens of Nova Scotia was of the order of $63,000,000 yearly, which provided a reasonably good quality of health care. Recommendations of the Committee dealt largely with unmet needs, notably in professional education, in the provision of physical facilities, and in the

areas of mental health and rehabilitation. The enlargement of voluntary, prepaid, comprehensive medical insurance, with governmental aid for those unable to pay a premium in whole or in part is, in the opinion of the Committee, a desirable objective.

AM 46—The Committee was aided in the preparation of the Brief by the individual doctors and the Branch Societies, with the final editing being approved by the Executive Committee. This Committee still has the task of finding practical ways and means of implementing the enlargement of voluntary prepaid comprehensive medical services insurance.

AM 47—Adoption of the report was moved. Dr. J. W. Reid expressed a vote of appreciation to Dr. Giffin for the time and effort expended by him and his Committee. The motion for adoption was seconded and carried.

AM 48—Maritime Medical Care, Inc., Dr. A. A. Giffin, President of M.M.C. Inc., (Ann. Rep. 1962 - Page 49).

Dr. Giffin's report noted a significant increase in membership for the year ended December 31, 1961 with a slight decrease in the percentage of administrative costs and substantial evidence of better money management. Two important policy changes affecting plans were made: the Board of Directors have instructed management to bring forward for their approval a plan for the provision of Extended Health Benefits; the Health Security Plan was offered for the first time on an individual plan basis.

AM 49—Dr. Giffin reported accurate totals of participants in the plans as follows:

		Contracts	Persons
(1)	Comprehensive	42,197	121,405
(2)	Health Security	700	2,261
(3)	Individual Contract	1,058	3,009
(4)	Seniors' Health	6,939	9,382

AM 50—He also reported an increase from three to five lay representatives to the Board of Directors; that the offices have been changed from the Champlain Building to the extension of the Lord Nelson Hotel. Reference was made to studies undertaken which were included in the Brief to the Royal Commission on Health Services, and that M.M.C. now covers approximately 20 per cent of the population of Nova Scotia, whereas similar plans in Alberta and British Columbia cover approximately 45 per cent and 53 per cent. Sales campaigns are planned in Nova Scotia.

AM 51—Dr. Giffin concluded his report by expressing his thanks to the Finance and Executive Committees, and to the Board of Directors of M.M.C. Inc.

AM 52—Discussion. There was considerable discussion about the principles of Extended Health Benefits.

AM 53—A motion for adoption of the report was carried.

AM 54—A Prepaid Medical Plan for the Atlantic Provinces Chairman, Dr. A. A. Giffin (Ann. Rep. 1962 - Page 32).

It was reported that no meeting of this Special Committee had been held during the year. However, on June 4th, 1961 a Committee of the Board of Trustees of Maritime Hospital Services Association and a Committee of the Board of Directors of Maritime Medical Care had met, as a result of which the following resolution had been unanimously carried:

> "That the financial advantages or disadvantages of a common plan for the provision of medical services insurance in the Atlantic Provinces be explored by the administrators of M.H.S.A. and M.M.C."

AM 55—This meeting had been held. The report indicated that there would be resultant financial advantage but other factors needed study and solution before further progress could be decided on.

AM 56—Considerable discussion ensued and questions were answered.

A motion for adoption of the report was carried.

AM 57—It was regularly moved and seconded:

> "That the Medical Society of Nova Scotia make every effort to bring together Maritime Medical Care and Maritime Hospital Services Association in agreement whereby the Physicians' Services coverage would be provided by M.M.C. and the Extended Health Benefits by M.H.S.A."
>
> (N.B. Also see 5th Business Session - "New Business")

AM 58—Report of the Honorary Treasurer Dr. J. F. Boudreau (Ann. Rep. 1962 - Page 5).

The report for the fiscal year 1961 included the Auditor's Statement, a Balance Sheet, Capital Account, Statement of Income and Expenses including the Budget Accounts for comparison. The predicted deficit for 1961 in the amount of $7,500 had actually been $5,800 and had been managed through a bank overdraft of a temporary nature. An increase in the Capital Account is anticipated in 1962 and a budget surplus of approximately $2,000 has been forecast.

AM 59—It was noted that the expenses associated with the Special Research Committee in preparing the Brief of the Society to the Royal Commission on Health Services accounted for the greatest portion of the deficit.

AM 60—After discussion the motion for adoption was carried. (The Financial Statement will be included in the next Newsletter to the members.)

AM 61—Report of the Finance Committee Chairman, Dr. J. A. Charman (Ann. Rep. 1962 - Page 68).

This report was moved and seconded for adoption. Carried.

AM 62—Report of the Representatives to Board of Trustees, Maritime Hospital Services Association. Drs. H. E. Christie and C. J. W. Beckwith (Ann. Rep. 1962 - Page 60).

This report was moved and seconded for adoption. Carried.

AM 63—The Second Business Session adjourned at 5.10 p.m.

Third Business Session

Tuesday, May 22, 1962

The Third Business Session was convened by the President, Dr. R. F. Ross, at 9.20 a.m. Presentation of reports was continued.

AM 64—Report of the Committee on Medical Economics Chairman, Dr. H. E. Christie (Ann. Rep. 1962 - Page 44).

The report covered three main centers of activity: Indian Affairs, Welfare Group and the Economics Committee of the C.M.A. The latter included details concerning the Royal Commission on Health Services, the Saskatchewan Situation, Medical Services Insurance, Relative Value Studies, Insurance Coverage for Doctors on Emergency Missions, T.C.M.P., Insurance Forms, Medical Education and Prepaid Medical Care.

AM 65—During discussion of the report, questions were asked concerning the coverage of the Welfare Group by Maritime Medical Care, Incorporated. The following resolution was regularly moved and seconded:

> "That the Committee on Medical Economics be empowered to approach the Nova Scotia Department of Welfare to extend coverage under the Welfare Plan to other recipients of the Social Assistance Act." Carried.

AM 66—A motion for adoption of the report was carried.

AM 67—Committee on Health Insurance Chairman, Dr. N. K. MacLennan (Ann. Rep. 1962 - Pages 27 & 61).

The report presented chronologically and in detail the action of the Committee in dealing with the principles involved in methods of remuneration for radiologists and pathologists rendering insured services under the Hospital Insurance Plan. Meetings had been held with the Pathologists, the Radiologists, the Nova Scotia Hospital Association, and the Nova Scotia Hospital Insurance Commission.

AM 68—Following a report to the Third Regular Meeting of the Executive this Committee had held separate meetings with the pathologists and radiologists.

AM 69—The supplementary report reviewed the Committee action in reference to a dispute between a radiologist and a group of three hospitals about work load and method of remuneration. At the request of the Committee Chairman a joint meeting had been held of representatives of the three hospital Boards and the Committee, accompanied by two radiologists as observers. The result of this meeting was a mutually agreed course of action

which the hospitals' Boards would endeavour to implement. The final result was not known at the time of the meeting.

AM 70—A motion was approved to receive the report for discussion. During discussion Dr. G. G. Simms presented the viewpoint of the Hospital Insurance Commission relative to methods of remuneration. Dr. C. M. Jones remarked that the amount of remuneration was not in question, but the methods were the basis for complaint.

AM 71—On motion, the report — including one amendment in wording — was adopted.

AM 72—Committee on Maternal and Perinatal Health Chairman, Dr. M. G. Tompkins, Jr., (Ann. Rep. 1962 - Page 37).

The report indicated that the studies on perinatal and maternal mortality are continuing and that the Obstetrical Emergency Team continues to provide a needed service. Services of the Committee were offered to Branch Societies to start local studies.

AM 73—On motion the report was adopted.

AM 74—Committee on Child Health Chairman, Dr. R. S. Grant (Ann. Rep. 1962 - Page 15).

This is the first report from this Committee. The Committee recommends a study of Erythroblastosis in Nova Scotia and improved management of such patients.

AM 75—On motion the report was adopted.

AM 76—Committee on Cancer Chairman, Dr. J. E. Stapleton (Ann. Rep. 1962 - Pages 38 and 67A).

The Committee reported progress toward the establishment of a Tumor Registry for Nova Scotia and referred to Chapter VII of the Public Health Act, 1962 which deals with reporting cases of Cancer.

AM 77—On motion the report was adopted.

AM 78—Committee on Presidential Insignia Chairman, Dr. A. W. Titus (Ann. Rep. 1962 - Page 48).

The report gave the background of the work of this Committee culminating in the Presidential insignia, Past-Presidents' pins, scrolls for senior members, and certificates for Branch Societies, all of which were available for members to view.

Motion for adoption included a vote of thanks to the Committee, and was carried.

Saskatchewan. The President had previously announced that the Saskatchewan situation would be presented at 10.00 a.m., Tuesday, May 22nd.

AM 79—The Saskatchewan Medical Care Act received assent on November 17, 1961. It was to have been implemented on April 1, 1962 but the Saskatchewan Government postponed this to July 1, 1962. The College of Physicians and Surgeons of Saskatchewan are opposed to the Act and have sought postponement of the implementation pending discussion with Government to alter the objectable features.

AM 80—The President welcomed Dr. G. W. Halpenny, President of the Canadian Medical Association; Dr. A. F. W. Peart, Deputy General Secretary, C.M.A.; and Dr. J. O. Godden, Associate Editor of C.M.A. Publications. Dr. Peart, Dr. Halpenny and Dr. Godden each spoke. Each speaker gave a comprehensive outline of the developments in Saskatchewan since 1960, culminating in the presentation of the Bill to the Legislature in the Fall of 1961. The Bill had been made legislation and had received assent in November 1961. Despite earlier declaration by the Government that such legislation would be acceptable to those providing and those receiving the medical services, no prior consultation or discussion with representatives of the medical profession had taken place. The Act as written was unacdeptable to Medicine because it gave authority to Government for direction and control of medical services as well as Government creating itself the sole agent for the provision of medical services to the public.

AM 81—A meeting of the physicians of Saskatchewan gave unanimous support to the policy of the College in its opposition to implementation of the Act.

AM 82—Such discussion as had taken place to May 22nd, 1962 between the College and Government was outlined, including the termination of these and the immediate introduction of the Amendments to the Act which resulted in making it virtually impossible legally to practice medicine outside the Act.

AM 83—In consequence, the College with full approval of its membership, had informed the Government of its opposition to the Act, and as evidence of this opposition decided to withdraw usual or normal medical services and to substitute free emergency services in selected hospitals.

AM 84—Discussion: Some members expressed concern about the results of interrupting normal medical services. Suggestions were advanced to create a test case for legal procedure. It was noted that the interval between this date (May 22nd) and July 1st might indicate modification of the attitude of the Government; that if this did not occur the best judgment would have to prevail as to the appropriate action to be taken.

AM 85—Dr. L. C. Steeves, Chairman of the Executive, informed the meting that following a review at the Executive Committee meeting, February 24th, a communication had been forwarded to the Saskatchewan Division expressing support by the Executive Committee; that at the Fourth Regular (May 19th, 1962) and the Annual Executive (May 20th, 1962) the Executive had again reviewed the situation. It was moved by Dr. Steeves, seconded by Dr. D. I. Rice:

> "That we are in sympathy with and support the Saskatchewan Division in their efforts to provide medical services to the people of Saskatchewan in the face of civil conscription of the medical profession."

AM 86—The motion was carried unanimously.

AM 87—The president thanked the speakers and adjourned the Third Business Session at 11.15 a.m.

Fourth Business Session

Wednesday, May 23, 1962

The Fourth Business Session was convened by the President, Dr. R. F. Ross at 9.03 a.m. Wednesday, May 23rd, 1962.

The presentation of Annual Reports continued.

AM 88—Special Committee on Building Chairman, Dr. C. L. Gosse (Ann. Rep. 1962 - Page 66).

The special committee on Building had been established to study the feasibility of erecting an office building to accommodate the Medical Society of Nova Scotia, Maritime Medical Care, Inc., and paramedical associations that might be interested. A questionnaire had been sent to these. Some replies have been received. The Committee will continue its study.

AM 89—It was moved and seconded this report be adopted. Carried.

AM 90—Committee on Medical Education Chairman, Dr. D. C. Cantelope (Ann. Rep. 1962 - Pages 67 & 68).

The Executive Committee (February 24, 1962) changed the name of the Committee on Post-Graduate Education to the Committee on Medical Education so as to include undergraduate medical education in its studies. This also gives the Nova Scotia Division representation on the C.M.A. Committee on Medical Education. The Committee had no recommendations but stated considerable information had been accumulated.

AM 91—A motion for adoption was carried.

AM 92—Special Committee on Specialist Register Chairman, Dr. H. J. Martin - (Ann. Rep. 1962 - Page 60).

The Committee reported that the principle of establishing a Specialist Register had been accepted by the Branch Societies. A letter had been directed to the Provincial Medical Board asking if the principle of a Specialist Register would be accepted and, if so, whether the Board will accept the administration of such a Register after the details have been developed. The reply was favorable.

AM 93—Discussion. Arising from the discussion the following motion was regularly moved and seconded:

> "That the degree of general practice permitted a specialist be determined by the Committee on Specialist Register rather than by the specialists themselves." Carried.

AM 94—On motion the report was adopted.

AM 95—Special Committee on Rowe Commission (Victoria General Hospital.) (Chairman, Dr. D. I. Rice)

Dr. Rice outlined the background leading to the formation of this Committee and the naming of its members by the Executive Committee. The Committee had submitted a report to Mr. Rowe, and Dr. Rice asked the members if it seemed advisable to discuss the report at this time. It was regularly moved and seconded:

"That any discussion on this matter at the Annual Meeting be deferred until the report is further advanced." Carried.

AM 96—Special Committee on Annual Meetings Chairman, Dr. D. I. Rice (Ann. Rep. 1962 - Page 62).

The report referred to previous efforts of the Committee on matters of the best time and sites for the Annual Meetings in order to encourage greater attendance. The report also referred to factors which have made the Society a better instrument for organized medicine in Nova Scotia and included six recommendations.

AM 97—Discussion. There was lengthy discussion on the report, and resolutions from the Annual Meeting of the Executive Committee were introduced. The following motions resulted from the discussion:

1. It was regularly moved and seconded:
"That: Branch Societies be requested to discuss the report of the Special Committee on Annual Meetings at the first regular meeting of the Branch and to report their opinions to the Executive-Secretary's office by the 15th of November, 1962." Carried.
2. It was regularly moved and seconded:
"That: considering the objection of a number of the members to holding the next (1963) Annual Meeting in Halifax, the matter of date and place for the 1963 Meeting be left to the incoming Executive." Carried.
3. On motion Recommendation 6 of the Annual Report was not accepted.

AM 98—On motion the report as amended was accepted.

AM 99—Special Committee on Post-Graduate Education Chairman, Dr. L. C. Steeves (Ann. Rep. 1962 - Page 22).

This report was presented by the Director of Post-Graduate Education, Dr. Steeves, and provided information about this division of the Faculty of Medicine, Dalhousie University. During the past year the program included the Dalhousie Refresher Course, and Short Courses in Anaesthesia, Psychiatry, Surgery, and Obstetrics-Paediatrics; regional courses in addition to those scheduled can be arranged for other areas in the Province.

On motion the report was adopted.

The Fourth Business Session adjourned at 11.00 a.m.

Fifth Business Session

Wednesday, May 23, 1962

The Fifth Business Session was convened by the President, Dr. R. F. Ross at 2.30 p.m., May 23rd, 1962. The presentation of Annual Reports continued.

AM 100—Committee on Nutrition Chairman, Dr. W. A. Cochrane (Ann. Rep. 1962 - Page 16).

The Committee reported a reduction over the past year in the incidence of scurvy and recommended study of the extent of use of a fluoride containing vitamin preparation.

AM 101—A motion for adoption of the report was carried.

AM 102—Committee on Legislation and Ethics Chairman, Dr. D. F. Smith (Ann. Rep. 1962 - Pages 23 & 53).

The summary of this comprehensive report follows:

"No. 1. The 'Permission to Examine' form has been carefully perused by the solicitors of the Medical Society of Nova Scotia and they are of the opinion that such 'Permission to Examine' form when signed by the patient prior to examination by the doctor concerned would give the examining doctor complete protec-

tion against future recurrences of adverse dicta by trial judges and actions. They suggest that the form should contain a date line, and the signature of the patient should be witnessed. Also if the patient is a minor the consent should be signed by his or her guardian and also be witnessed.

An example of such "Permission to Examine" form follows:

"I, name of patient , hereby authorize any physician or any hospital or institution that has any records of my health or X-ray films of my body to give all such records and X-ray films to Dr.———————————— for examination with a right to use the information derived from such records and X-ray films for any purpose whatsoever."

"No. 2. Questions from a member of the Medical Society of Nova Scotia concerning his association with a chiropractor have been answered.

"No. 3. Questions from a member of the Medical Society of Nova Scotia regarding the dual insurance coverage have been answered.

"No. 4. The 1961 Code of Ethics of the Canadian Medical Association has been reviewed by your Committee and certain suggestions have been agreed upon.

"No. 5. The Provincial Attorney General has been approached to have provincial legislation passed making information obtained from maternal and perinatal health studies privileged information and inadmissible as evidence in court.

"No. 6. A meeting was held with the medical members of the N. S. Legislature.

"No. 7. An Arbitration Committee (Ad Hoc) of the Provincial Medical Board is now available to arbitrate disputes between doctors in Nova Scotia."

AM 103—The Supplementary Report quotes the legislation requested (in Summary No. 5) as it appears in Section 128 of the Public Health Act, 1962:

" '128 (1) The information, records of interviews, reports, statements, notes, memoranda or other data or material prepared by or supplied to or received by the officers of the Department of Public Health in connection with research or studies relating to morbidity, mortality or the cause, prevention, treatment or incidence of disease, or prepared by, supplied to or received by any person engaged in such research or study with the approval of the Minister, shall be privileged and shall not be admissible in evidence in any court or before any other tribunal, board or agency except as to the extent that the Minister directs.

AM 104—" '128 (2) Nothing in this Section prevents the publication of reports or statistical compilations relating to such research or studies which do not identify individual cases or sources of information or religious affiliations.' "

AM 105—After discussion, a motion for adoption of this report was carried.

AM 106—**Committee on Fees** Chairman, Dr. C. H. Young (Ann. Rep. 1962 -Page 35).

The Committee reported having held 20 meetings to March, 1962 and that a review of the 1958 Schedule of Fees is continuing.

AM 107—On motion, the report was adopted.

AM 108—**Committee on Traffic Accidents** Chairman, Dr. A. L. Murphy (Ann. Rep. 1962 - Page 47).

The report included reference to our Medical Advisory Board, now functioning, to the Motor Vehicle Branch of the Department of Highways and appointed by the Provincial Government. This Committee is now functioning. A small research project has been instituted to study and correlate hospital records of traffic accident victims with the Motor Vehicle Department records of the same accidents. Negotiations are proceeding with the Department of Highways to bring provincial ambulances under their direct control.

AM 109—The automobile seat belt campaign of the Canadian Highway Safety Council has been very successful and an increasing number of vehicles is being equipped with these.

AM 110—The Canadian Medical Association is interested in traffic accidents, and the Canadian Automobile Association suggested having a group in Canada form a Research Committee on traffic accidents on a national basis. Certain research projects will be assigned to the Medical Associations as members of the C.M.A. together with a Committee from Ontario and Cornell University.

AM 111—A motion for adoption of this report was seconded and carried.

AM 112—Committee on Public Relations Chairman, Dr. S. C. Robinson (Ann. Rep. 1962 - Page 34).

The report reviewed the activities of his Committee and various members of the Society in the field of public relations—much has been accomplished. It is hoped that a proper picture may be presented to the public on the value of prepaid medical insurance. As a Medical Society one of our primary obligations is the responsibility to tell the people what type of medical care plan we favour and why. Much of the difficulty in Saskatchewan has arisen as the result of people knowing what doctors are 'against', but not knowing what they are 'for'.

AM 113—A motion for adoption of the report was seconded and carried.

AM 114—Committee on Public Health Chairman, Dr. S. D. Dunn (Ann. Rep. 1962 - Pages 5 & 55).

The supplementary report included up-to-date information on the Sabin Oral Polio vaccine and the action of the Nova Scotia Department of Public Health in making the supply available to the residents of Halifax, Dartmouth and Halifax County. As the supply is limited it has not been possible to make it available to physicians. The Committee recommended endorsing the use of the vaccine and requested the cooperation of the members of the Society in making it available to the Public.

AM 115—A motion for adoption of the report was carried.

AM 116—It was regularly moved and seconded:

"That: the Medical Society of Nova Scotia endorses the use of Sabin Oral Polio vaccine." Carried.

AM 117—Liaison Committee, Workmen's Compensation Board Chairman, Dr. A. W. Titus (Ann. Rep. 1962 - Page 42).

The report indicated that meetings between representatives of the Society and the Workmen's Compensation Board were held on several occasions; that following the directive from the Annual Meeting, 1961 the W.C.B. had agreed to observe the 1958 Schedule of Fees at 85%, and that discussions on the basis of the revised Schedule (not yet available) would be undertaken. It is mutually agreed that 85% is temporary and subject to further discussion. The Newsletter of January 1962 had provided this information to the members.

AM 118—The W.C.B. desires to include a mutually satisfactory "General Instructions on Medical Aid in Respect to W.C.B. Cases" to circulate to the profession. A resolution from the Annual Meeting of the Executive was presented:

"That — The Society members of the Workmen's Compensation Board Liaison Committee be empowered to approve (or propose amendments to) the 'General Instructions on Medical Aid in Respect to W.C.B. Cases' to accompany the 1958 Schedule of Fees of The Medical Society of Nova Scotia. This procedure to facilitate the printing and distribution of the W.C.B. Physicians' Handbook." Carried.

Am This resolution was approved.

AM 119—A motion for adoption of the report was carried.

AM 120—Special Committee on Group Disability Insurance Chairman, Dr. A. J. Brady (Ann. Rep. 1962 - Page 13).

The Committee reported that 339 members were now participating, that 39 claims had been processed and that 7 were pending. The Committee is inquiring into the possibility of a "Group Office Overhead Expense" policy. Blanket insurance coverage for physicians on duties of a mercy nature is under continuing investigation.

AM 121—On motion the report was adopted.

AM 122—The members were notified that because of the widening interests in the field of insurance, the Annual Meeting of the Executive created a Standing Committee on Insuance to replace the Special Committee on Group Disability Insurance.

AM 123—Special Committee on Salaried Physicians Dr. J. S. Robertson (Ann. Rep. 1962 - Page 17).

The report analyzed a questionnaire forwarded to 110 salaried physicians in 1961. 54, or 49%, had replied. Of these, 38, or 76%, were members of a Branch Society; 34, or 68% were members of the Medical Society.

AM 124—Discussion. There was discussion about the number of salaried physicians who have been officers of the Society and Chairmen of Committees. It was announced that the Chairman of this Committee had been invited to attend the First Meeting of the new Executive for a discussion of this report.

AM 125—Motion for adoption of this report was carried.

AM 126—Committee on Rehabilitation Chairman, Dr. G. J. H. Colwell (Ann. Rep. 1962 - Page 3).

Dr. Shears, as a member of this Committee, read the report and made the following comments. The Committee on Rehabilitation had two meetings during the year and between times the members had been engaged on work and discussion on rehabilitation problems in the Province. An announcement was made that the Nova Scotia Brace and Appliance Centre is available to the medical profession in the Province and that any doctor can obtain prosthetic appliances for his patient at this centre. All that is needed is that the physician arrange an appointment and provide the Centre with a suitable prescription.

AM 127—The number of hospitals with physiotherapy departments is gradually increasing. It is recommended that the medical staff of each of these hospitals should appoint a Committee to take an interest in such a department and serve as an official channel of communication between the physiotherapist and the medical staff.

AM 128—Difficulty was reported in obtaining sufficient paramedical staff for the present Nova Scotia Rehabilitation Centre. The future is envisioned in the following paragraph (A17) from the report:

> "The Committee discussed certain key paragraphs of the statement on Rehabilitation and recommendations of the C.M.A. General Council (1961) dealing with the education of doctors in the total process of rehabilitation, and the approach to Provincial Governments regarding the relative shortage, and the future needs of medical and paramedical personnel required in Rehabilitation programs. It is recognized that Dalhousie University has agreed in principle to the establishment of a school of Physiotherapy and Occupational Therapy. This school will eventually help to alleviate the shortage of paramedical personnel. The University cannot proceed with the establishment of the school until sufficient teaching space is available and is relying **in part** on the construction of the new Rehabilitation Centre to provide additional teaching space and facilities for this type of instruction. We feel that the University is aware of the problem and it is not in a position to expand its teaching in the Rehabilitation field at this time."

AM 129—An amendment was accepted that the words 'in part' be inserted in a sentence in Paragraph A17. A motion was carried for adoption of the report, as amended.

AM 130—On motion of Drs. K. M. Grant and J. A. MacDonald the following reports were referred to the Executive Committee with authority to take action: Board of Registration —Nursing Assistants Act; V.O.N. (Canada) Board of Governors; Provincial Medical Board; Federal-Provincial Health Grants; Discipline Committee; Civil Disaster; Dalhousie Medical Library.

Old Business

New Business

A130A—Re: Resolutions. A question was asked whether it is required that reolutions made by the Executive Committee during the year be presented to the Annual Meeting. The Executive-Secretary replied that he had no knowledge of such a requirement but that practice had been to present such resolutions as the Resolutions Committee decided on.

AM 131—Re: Annual Reports. A member noted that only two of the forty-four Annual Reports had a summary at the end of the Report. The Executive-Secretary stated that Committee chairmen had been requested to make summaries.

AM 132—Re: Prepaid Medical Plan for Atlantic Provinces. The following motion was presented by Dr. C. H. Young, seconded by Dr. H. J. Devereux:

> "That: WHEREAS this Society expressed its interest in one Prepaid Medical Services Insurance Carrier to serve the four Atlantic Provinces sponsored by each and all Atlantic Provinces by resolution at the Annual Meeting, October, 1958.

"And WHEREAS this resolution directed initial studies to be made by representatives of the medical profession and requested the prepaid plans concerned to advise on the possibility of such a scheme,

"And WHEREAS a Committee formed for this purpose at the Annual Meeting in 1960 submitted a report of their deliberations at the professional level, and at this general meeting a further report was received regarding studies by the medically sponsored prepaid plans concerned:

"THEREFORE be it resolved that this Committee proceed with the original terms of reference and with the aid of the medically sponsored insurance carriers produce specific considerations necessary to a plan.

"BE IT FURTHER RESOLVED that this Committee be composed of members who are not currently involved with the administration of either insurance carrier."

AM 133—During discussion Dr. Young remarked he believed many of our own members had the opinion that a Prepaid plan for the Atlantic Provinces could be advantageous. He also believed members in the other Atlantic Divisions felt the same way. The purpose of the motion is to give direction.

AM 134—The motion was carried.

AM 135—**Re: Special Research Committee.** A member made an enquiry about the Special Research Committee. Information was given to the effect that such a Committee had been authorized at the Annual Meeting, 1960, a special meeting of the Executive Committee had been called in September, 1960 to select the members. The five members selected had accepted and met to elect their own Chairman. Terms of reference had been submitted to, and approved by, a regular meeting of the Executive in October, 1960.

AM 136—Of the terms of reference approved, two are of primary importance, viz.,

1. "That the Committee (S.R.C.) formulate a plan or plans which will make available to all people of Nova Scotia an adequate medical care service of high quality.
2. "That the Committee carry out such studies and investigations as may be necessary in the formulation of such a plan."

AM 137—In December, 1961 the Prime Minister announced that a Royal Commission on Health Services would be created. On February 4th, 1962 our Executive Committee had directed the Special Research Committee to prepare a Brief for the Medical Society of Nova Scotia, to be presented to the Royal Commission. The terms of reference for the Royal Commission had become available in June, 1961. Consequently, the activities of the Committee had been directed to the development of, and approval by the Society of the Brief and its presentation to the Royal Commission during October, 1961. There remains the finalization of a supplementary Brief to the Royal Commission in the Fall of 1962.

AM 138—Pertinent knowledge had been increased as a result of preparation of the Brief. The Special Research Committee plans to return to its original terms of reference as soon as its obligations to the Royal Commission are completed.

AM 139—**Re: Study on Habitual Abortion.** Dr. W. R. C. Tupper informed the meeting of this study, now in process. He wished the Society to consider the following motion, seconded by Dr. D. F. Smith:

"That: The Medical Society of Nova Scotia give approval to the Research Group of Dalhousie University working on the Etiology of habitual abortion to proceed as follows:

1. That Doctors be asked to submit to this group, with their patients' permission, the names of patients suffering from this entity.
2. That permission be granted to the group to write an article to be carried in the lay press, asking any persons suffering from the above entity to submit their names so that the questionnaire may be sent to them."

AM 140—The two clauses of the above motion were put before the meeting separately and both approved.

AM 141—**Report of Nominating Committee.** The Chairman, Dr. R. F. Ross requested the President-Elect, Dr. D. F. Macdonald to take the Chair while he presented the report of the Nominating Committee.

AM 142—The Nominating Committee reported as follows:

For President	—	Dr. D. F. Macdonald, Yarmouth
President-Elect	—	Dr. C. L. Gosse, Halifax
Past President	—	Dr. R. F. Ross, Truro
Chairman of Executive	—	Dr. L. C. Steeves, Halifax
Vice-Chairman of Executive	—	Dr. J. E. H. Miller, Halifax
Honorary-Treasurer	—	Dr. J. F. Boudreau, Halifax

AM 143—The Chairman asked for other nominations. A motion that nominations cease was carried. The Chairman declared the officers elected.

AM 143—**First Meeting of New Executive.** The Chairman of the Executive Committee announced that this meeting would be held in the Board Room of M.M.C. Inc. in the new wing of the Lord Nelson Hotel on Thursday, May 24th at 9.30 a.m. He also announced that the Committee on Committees would convene at a breakfast meeting in the Lord Nelson at 7.30 a.m., May 24th.

AM 144—Dr. Hewat tendered a vote of thanks to the officers and officials of the Medical Society of Nova Scotia for their work during the past year. This was seconded and approved.

AM 145—The 109th Annual Meeting of the Medical Society of Nova Scotia (1962) was adjourned at 5.10 p.m.

C.J.W.B.

"WHAT COST - FREE MEDICINE"

MR. B. E. FREAMO*
Toronto, Ont.

Mr. Chairman, Ladies and Gentlemen:

The theme for this Conference is "What Cost - Free Medicine". In choosing the title of my contribution I have deliberately restricted the scope of the suggested enquiry, to the subject—Medical Services—with which I am most familiar. I propose to discuss with you—What Cost - Free Medical Care.

It is, of course, impossible to segregate completely Medical Services from other Health Services provided in our communities. Of necessity, my remarks, in some instances must be related to the broad spectrum of Health Services. However, it is possible, in some important areas, to segregate Medical Services as a separate entity and, in my opinion, it is important that we do so.

To-day, in Canada, almost all citizens in all ten Provinces are covered for basic ward hospital care by a comprehensive Plan of Hospital Insurance, substantially financed by the Federal Government, but administered by the respective Provincial Governments. The extent of coverage varies slightly from province to province, but basically approximates that which was previously provided by Blue Cross, with these important differences—there are no waiting periods, and few restrictions on cost of drugs or length of stay other than medical necessity.

At the Federal level this hospitalization program was initiated by a Liberal Government, and implemented by a Conservative Government. It has won wide-scale public approval. The legislation was the subject of an extended debate in Parliament, and it is worthy of note that the majority of adverse comments related to the inadequacy of the benefits proposed, and that the Bill was finally adopted without a dissenting vote.

The legislation as enacted goes beyond the provision of ward care coverage. Diagnostic services are included as insured benefits. The medical profession in Canada does not agree that laboratory and radiological services are hospital services, but rather has repeatedly asserted that these services are in fact medical services.

Nonetheless, they are insured services. As expected, utilization has increased sharply and the profession is concerned that the revenues of these departments of pathology and radiology remain adequate to allow the provision of sufficient personnel to maintain quality of service, despite the increased demands made, and to avoid control or limitation of necessary services.

The foregoing comments relate only to the provision of in-hospital services. The difficulties encountered in extending hospital insurance to out-patient diagnostic services are greater, and for this reason only a few provinces have included out-patient services as insured benefits within their present programs. You can visualize the problem presented by this innovation in any province wherein a reasonable proportion of radiological services is provided in private physicians' offices. It is grossly unfair that private physicians should be required to compete with a free service, yet the alternatives pose many difficult problems.

---

*Assistant Secretary (Economics) Canadian Medical Association.

We are perhaps fortunate that we have not as yet had to face up to any acute phase of these problems—out-patient services, increased utilization and departmental revenues—about which I have expressed concern. Certainly, the program has been implemented with a minimum of dislocation. I am, however, concerned about the long-term implications—will rising costs suggest to the administering agencies budgetary restrictions which will be reflected in reductions in the quantity and quality of the services available? Will the inability or unwillingness of governments to assign sufficient revenues for this purpose adversely affect the general implementation of scientific advances in medicine? We are aware that these things are possible and we are alert to protest their actual development.

It is with this background that Canadians must analyze and assess the future of physicians' services and, more particularly, the future of medical services insurance. Many Canadians believe that we have now made the philosophical decision that health services should be provided by the State, and that the next step—the provision of Medical Services—is a problem only of timing and finance.

I do not agree with this prediction although I am aware of the possible effect of the proposals which Mr. Douglas has recently introduced in the Saskatchewan legislature. Hospital care and medical services are different in kind, rather than degree. Hospital care is an impersonal institutional service; few relationships are more personal than that which exists between doctor and patient. Hospital care is controlled by the doctor; medical services are initiated by the patient.

Thus, to me, implementation of a medical services program, compulsory for all, and controlled by Government, would require a new and quite different philosophical decision. I therefore believe that it is of the utmost importance. that the public and the politicians, who will one day be asked to make such a decision, possess and be influenced by a substantial knowledge and understanding of health insurance and its problems. In the absence of such knowledge, decisions will be based on incorrect assumptions and an acknowledged superficial appeal. Few of us can resist a bargain—and health insurance underwritten by government is almost irresistible to the uninformed.

If you deduce from this statement that I am opposed to a compulsory system of medical services insurance, you are correct. This does not mean, however, that I am opposed to Government interest, or present degree of participation, in medical affairs. In Canada, our Provincial Governments, in particular, have assumed many responsibilities for providing medical services in certain well-defined traditional areas. The opportunity does not often arise to compliment our Governments for the efforts they expend, and I would like to take this opportunity so to do.

When I speak about medical services and medical services insurance, I am referring to those services performed by physicians or performed under their immediate supervision, which constitute what we now understand as the private practice of medicine. I am not speaking about those areas of medical practice which have traditionally been provided at Government expense.

When I speak about the cost of medical services I am referring to cost and not expenditure. Expenditure refers to the sum of the moneys paid for the changing quantity of medical services which is used. Cost relates the price paid to the value obtained. It refers to both quantity and quality. In the particular context with which we are today concerned, cost has more than a pricing connotation. The cost of free medical care can not be analyzed except

in terms of its success in attaining its legitimate objectives.

Health Insurance is one manifestation of a deep-seated concern in each one of us for protection against the hazards of life. It is part of our search for security—a phenomenon of human nature which is not confined to ourselves and our contemporaries, but which was present equally in previous generations. Unfortunately, few of our forefathers could be as successful in achieving security through their own efforts as we can be today. In Europe, their relative inability to overcome the economic restrictions with which they were faced, made social security an opportunity for the politically ambitious.

Health Insurance began in Europe more than two hundred years ago. With the advent of the industrial revolution, workers began to band together to form Craft Guilds. These were the forerunners of the Friendly Societies which still exist in Europe today. An important feature of these Guilds was their attempt to meet collectively the financial hazards of illness. The emphasis was placed on cash sickness benefits, and medical services insurance was considered as a supplementary phase.

Governments' first activities in this field were of a regulatory nature. Britain introduced the British Friendly Societies' Act in 1793, and Germany followed with a similar law in 1794.

Piece-meal compulsory participation was introduced in Germany in 1845, The number involved was small, and the attitude of Government did not interfere with the growth of the voluntary movement. Trade unions gave an additional impetus to voluntary participation and all European countries had a substantial enrolment in these voluntary organizations long before the introduction of compulsion by Government.

Widespread compulsion was first introduced in Germany in 1884. Compulsion was applied on a selective basis to wage-earners below a stated income. It was initially opposed by the trade union movement. However, subsequent developments saw political pressures being used to widen both the occupational groups and the income classes to be included in the scheme.

Bismarck's reasons for introducing a compulsory form of health insurance were not humanitarian. They were political. One of his biographers stated "To his mind, the State, by aiding the workers, should not only fulfil the duty ordered by religion, but it should obtain, in particular, a claim on their thankfulness, a gratitude that was to be shown by loyalty to the Government and by loyal pro-Government votes in elections".

Ironically, the basis of Bismarck's original program for medical services insurance did not differ greatly from that which Mr. Douglas recently announced in Saskatchewan, excepting that the administering agencies were given more freedom in Bismarck's day. His program was financed by premiums from participants with some employer and State contributions. Doctors were paid on a fee-for-service basis on an agreed fee schedule. His program was designed to operate within reasnable financial limits on the basis of the volume and type of medical services then provided.

Bismarck's scheme provided only a minimum level of medical services because only a minimal service was available. In that era of the great sanitarians, medicine emphasized the broad environmental approach. The energies of medical doctors were primarily directed to the eradication of bacterial disease, the improvement of methods of sanitation and water supply, and, subsequently, immunization against specific diseases, such as typhoid fever.

Bismarck's pattern was adopted by a number of countries during the early years of the twentieth century. The reasons were both political and economic.

The basis of the program was that it should provide a minimal service—sufficient to ensure that a worker who was ill would receive the medical treatment necessary to return him to good health and productive employment.

The participant was given free choice of doctor with the limitation that he could only choose a physician who had entered into a contractual relationship with an approved society. Otherwise, medical practice was to be the same as in private practice, except that the fee was controlled by the contract between the doctor and the Friendly Society. However, increased demands for services increased expenditures and consequently at each period of contract renewal, a major attempt was made to squeeze down still further the doctor's schedule of fees to keep the budget stable. Coincident with this increased demand for services was a change in the emphasis in medicine from preventive to curative services. Each succeeding decade has seen a tremendous increase in the number and effectiveness of services provided by physicians for individual patients. Each of these increases has meant an increase in expenditure on medical services.

The social security schemes built on the Bismarck pattern were not geared financially to accept this change from preventive to curative medicine and the consequent increases in expenditure. The tax revenues of governments were substantially less than the levels which exist to-day. Additional moneys could not be allocated for health insurance because of other more pressing demands on limited funds. It was not politically possible to demand that employees and employers substantially increase their contributions. Consequently, substantial alterations were made in the benefits provided and in the method and amount of payment to doctors.

In most countries the provision of medical and hospital services became the main props of the social security system, and the sickness benefits were down-graded as the expenditures on health services increased. As well, in most countries, the method of paying doctors changed from a fee-for-service basis to a capitation basis in order to allow Governments to retain a more effective control over expenditure.

Each of us, and perhaps Mr. Douglas, should study very carefully the history of Bismarck's experiment and its inability to bridge the gap between a service which was primarily preventive and general, and a medical service which was to become primarily curative and individual in nature. The change in medical services was dynamic, but the health insurance organization and finances were relatively static.

A few countries did learn something from the failure of the Bismarck prototype. In 1945, France introduced a program which did not attempt to provide insurance against the full expense for medical services. It was based on a specified amount of indemnity paid to the participant, as a reimbursement, which represented 80% of the cost of the medical services if obtained from a physician who, by contract, had agreed to charge not more than a scheduled amount. The participant could, if he wished, obtain services from a private non-participating physician and recieve the same amount of reimbursement. Of course, under these circumstances, he was required to make a larger contribution from his own resources as the fees of the private physician were likely to be higher.

In some countries the plan pays the amount of the indemnity directly to the doctor and the patient pays the remainder of the account at the time he receives the service. We might, in our terminology, label the patient payment as a deterrent fee. I will refer to this method and the pure reimbursement

system interchangeably as reimbursement programs, because some countries use both arrangements. There is, however, an important difference in the practical results of the two methods due to an inherent control mechanism in the pure reimbursement system.

Norway and Sweden adopted arrangements similar to France, insuring all or almost all of their populations and providing an indemnity or a reimbursement basis. Both of these countries amended the French system to suit their own specific purposes, and both schemes have worked out reasonably well.

The French system, however, did not fare as well. A large proportion of the French physicians chose to remain as private doctors rather than enter into a contract to provde their services at a scheduled rate. As a consequence, a recent edict militates financially against a participant choosing a private physician. In effect, the participant who chooses a private physician receives an indemnity of only half the amount which is repaid to a participant seeking services from a contract physician. This regulation is of relatively recent origin and it is not possible as yet to assess its implications. However, it would appear that French physicians are being coerced into becoming contract doctors by economic sanctions imposed on their patients.

Australia, as you shall hear in greater detail later to-day, saw much to commend the reimbursement method. However, neither its profession, nor its people were willing to accept the consequences of compulsory participation. As a result, the Australian scheme functions on a voluntary basis, reimbursing its participants for some, but not all, of their medical care expenses. The program is financed by the premiums of subscribers and a substantial Government subsidy.

The Australian scheme commends itself to our careful study because it has achieved a very substantial enrolment on a voluntary basis. We must, however, assess the implications of the amount and method of the substantial Government subsidy. The subsidy is paid to voluntary plans as a specific amount for each item of service reported, rather than a pro rata sharing of the over-all plan expenditure. It represents almost one-half of the amount of reimbursements paid to participants. In my opinion, the method is questionable as it makes no allowance for inflation in the general economy. As well, the percentage may be too high, as there seems to have resulted an indirect economic control by Government.

One other country has avoided a major degree of compulsion and has used a Government subsidy of much smaller proportions. This is Switzerland. Switzerland has a large group of health insurance associations of varying size which, for the most part, provide health insurance on a voluntary basis. In addition to premiums of subscribers, these organizations receive a subsidy from the Federal and Cantonal Governments of approximately 15% of their total expenses. Under Swiss law, participants in these Funds are obliged to meet directly a proportion of their own medical care expenses, usually about fifteen per cent.

The growth of health insurance under voluntary auspices is striking. Switzerland has achieved about the same percentage coverage as Australia (approximately 75%), and it has accomplished this objective without requiring as large a subsidy to the health insurance Funds as is provided by Government in Australia. It is noteworthy that the Swiss Government does not attempt to exercise control over the health insurance Associations or the doctors, either directly or indirectly. This may provide a lesson to us regarding the maximum degree of Government subsidy which it is possible to obtain without

the necessity of enduring a substantial measure of direct or indirect control.

The British and the Russian systems are the anomalies in Government Health Insurance Programs. While it is, perhaps, understandable that Russia, for ideological reasons, prefers a completely Government-dominated service, one wonders why Britain did not profit from the experience of the other European countries. In our review, we have noted a tendency over the years to increase the number of persons covered by compulsory means, but we have, as well, noted the tendency to move from a direct relationship between the Insurance Fund and the physician to a reimbursement arrangement.

Jewkes has commented that the revolutionary change brought about by the introduction of the National Health Service in Great Britain was effected because three hypotheses were considered valid:

(1) That the British Medical system before the Second World War was seriously defective, and that nothing short of a centrally-controlled "free" system could provide appropriate remedies.

(2) That increased expenditure on health services would be sound economic investment because it would increase production, and because, by reducing ill-health, it would decrease the cost of medical services.

(3) That social justice called for identical, and the best possible, medical services for each and every citizen.

In "Genesis of the British National Health Service" Jewkes comments on the first of these arguments. He found that since the introduction of N.H.S., the substantial increases in utilization of services have been restricted very largely to very old men, and women up to thirty-five years of age. He does not consider that the statistics now available indicate that the British system before the Second World War was seriously defective, or that the gains which have been made in the interval, would **not** have been made, in any event, with or without the introduction of N.H.S.

Dennis Lees has commented on expenditure on health services as an economic investment. He refers to the widespread belief at the inception of the National Health Service that the amount of sickness in society could be reduced by ensuring an appropriate amount and organization of medical services. He calls this original assumption of N.H.S. a major error. He notes that despite substantial increases in expenditure the number of days lost through sickness has remained relatively constant in Britain over the past decade, and seems to have been rising, not falling, over the last thirty years.

The third reason—social justice—was perhaps of greatest importance in determining the form and function of the National Health Service. Many people ascribe to the Beveridge Report the philosophy that the Government should try to provide a maximum service for all residents. This assumption is incorrect. The report envisaged the establishment of a national minimum service, which would leave room for and encourage voluntary action by each individual to provide more than that minimum for himself and his family. The idea of a maximum service was one promulgated by the Coalition Government in 1944, when it stated:—

> "The Goverument have announced that they intend to establish a comprehensive health service for everybody in this country. They want to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether

they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens."

It fell to Mr. Aneurin Bevan, the Minister of Health under the Labour Government, to introduce the National Health Service and he added to the idea of a maximum service his requirement that the medical profession be very rigidly controlled. He negated the idea of voluntary action in every way possible. From the outset of N.H.S., regulations have provided that the complete service be used on an "all or none" basis. It is not possible to use the services of a private physician and obtain pharmaceutical benefits, or hospital benefits, through N.H.S. If a participant uses a private physician's services he must himself pay privately for needed drugs and hospital services.

These regulations reflected the determination of the Labour Government that in Britain there should be one level of medical services and that it should, as far as possible, be made to apply to all citizens. As recently as 1960, the Minister of Health stated in reply to a question in the House:—

"The Government attaches importance to the preservation of private practice and the right of patients to resort thereto, and would certainly consider making drugs available to private patients on National Health Service terms, in the context of available resources and competing claims, if it were shown that the present position was endangering the existence of private practice, or preventing any substantial number of people from availing themselves of it, who would otherwise wish to do so. But they have no present plans for legislation on this subject."

This admirable bit of official double-talk indicates that even the present Conservative Government of Britain is unwilling to provide conditions which would foster the growth of private practice. Notwithstanding this, it is of more than passing interest to note that almost 1,000,000 British residents purchase coverage through voluntary insurance, which enables them to use the services of private physicians on a reimbursement basis. Thus, in the face of regulations which quite frankly deter the existence of private practice, the demand of some persons for a type of insurance which will provide an alternative, and one must consider a better, standard of service, has negated the goal of the planners to provide an identical service for every resident.

You are all familiar with analyses of the National Health Service which concern themselves with determining whether or not people are happy with the services they are providing or receiving. In the main, these subjective comments from the British people have been favourable. These questioners have, however, never enquired as to the success of N.H.S. in meeting the objectives for which it was originally created. Jewkes and Lees find little evidence of any measure of success for N.H.S. in this regard.

Thus far, I have attempted to set out the history of compulsory health insurance in Europe, where it originated. The British system is the anomaly in that it attempts to provide a maximum service for all residents originally without any obvious cost and, even now, with only slight cost to the participants.

The trend in many other countries of the world has moved away from a relationship of direct control between the Government-dominated plan and the doctor, and is now based on a refund system which returns to the participants a major proportion of the expenses incurred but which requires a personal contribution from the insured when he obtains a service. In Australia and Switzerland the trend to compulsion has been reversed, and the activities of

Government are limited to the provision of a subsidy. In Switzerland, where the Government subsidy is nominal, we find the least tendency for Government to exercise direct or indirect control.

One measure of the cost of free medical care is the total of the expenditures made, weighed against the benefits obtained. A second measure of cost is the imposition of controls and restraints, unless these are requirements of providing a satisfactory service. These elements of cost can perhaps be better analyzed if we attempt to rationalize some of the misleading generalizations which are oft-repeated by those who portray governmental programs as the only desirable method of providing personal health services.

The first of these generalizations is the doctrine of historical necessity. The public is continually being told, by supposedly well-informed persons, that we need a Government-controlled program of medical services insurance because everybody else has got one. Recently, I was surprised to read a statement addressed to a meeting of the American Medical Association by a person well-disposed to the medical profession. He asked "I wonder if it has ever occurred to the members of this audience that the United States is the only major nation in the world that does not have a national compulsory system of State payment for medical care".

I hope that the rather brief history which we have traced of the development of health insurance has convinced you that there is no evidence of historical necessity. If we can see any trend it is in the development of the reimbursement method; voluntary programs have been introduced, as well as compulsory systems.

A second generalization that has been repeated so often that it is usually accepted as fact, is that there exists a vast pent-up need for medical services which are not now being provided but which would be provided under a governmental system. Britain's experience would not support this conclusion. In the first few years of N.H.S., the pent-up demand, which was expressed, related to dentures and to spectacles. In the first five years Britain supplied nearly six million pairs of full dentures, and twenty-six million pairs of spectacles for a spectacle-wearing population of something less than twenty million. The number of prescriptions increased sharply, but the demand for doctors' services did not rise in nearly the same degree. In the first three years, the demand for general practitioners' services rose by about four per cent per year—an increase in utilization which is not dissimilar to our experience with a voluntarily insured population.

We recognize that unmet medical needs exist in Canada and that they must have existed in Britain at the outset of N.H.S. Why was this not reflected in a greater increase in demand for medical services? The major reason is that the supply of personnel and facilities was not, and still is not, sufficient to meet the demand. A change to a government service does not automatically increase the supply of physicians, and may in fact in the long term actually reduce the supply. Of itself the change in system does not supply one additional hospital bed, and it may in fact actually tend to reduce the supply which would otherwise be available because governments have found, even in Canada, that one certain way to control expenditures on hospital care is to limit the number of new beds which are built.

We believe that a much more practical method of relieving unmet medical needs is a process of selective subsidization of medical services insurance premiums for persons with low incomes. This would greatly reduce the financial commitments of government and, as a result, would allow government to con-

centrate financial assistance in depth to those areas of real need. Too often the introduction of a government system, backed by relatively limited finances, has resulted in the provision of an unsatisfactory system for all, without substantially alleviating the area of real need. This has occurred in countries where the system was underwritten by a central government with, theoretically at least, unlimited taxing powers. It would be much more difficult in one of our provinces or one of the States, because while their responsibilities are many, their sources of tax moneys are very limited.

A third generalization is that medical services have become so expensive that we can no longer finance them, except through a Governmental program, which would substantially reduce the apparent cost to the consumer. Certainly, medical services expenditures have increased. Disregarding the effects of inflation, they have increased because the public has demanded more services, and because scientific advances have made more and more expensive techniques available for general use. In all likelihood, medical services expenditure will continue to increase in the future.

There are many reasons for this prediction of increased expenditure. More widespread health education will generate an additional demand for services. Continual increases in our standard of living will present still further demands. But, basically, it is the inherent dynamic quality in medicine which will have the greater effect. We have spoken of the shift in medicine from a preventive science to an individual curative service. This shift did not eliminate the need for preventive services, but rather added the expense of curative services to that which was previously known. Over a period of years the expenditures on curative services has increased substantially, as new methods and techniques have become available.

Now the curative phase has reached its zenith and we are entering a phase where medicine is regarded as the science which treats man in his total environment. We have admitted the existence of stress and we are trying to understand the problems of change. Within the foreseeable future, the expenditures on psychiatric and related services, within the private area of medical practice, will increase substantially.

A further phase of medicine is in the offing. I refer to the long-term treatment of degenerative disease. It will not replace the phases concurrently in existence today, but it will add to the expense of medical services. The successes of medicine will, within a relatively few years, conquer many of the diseases responsible for early death, and the consequent increase in incidence of the degenerative diseases will place a special emphasis on the field of geriatrics.

These foreseeable developments will add up to substantial increases in expense during the next ten, twenty or thirty years. We have seen that in the past compulsory systems set up to provide that level of services required at a particular time and under a specific set of circumstances were not necessarily capable of assimilating additional expenses arising from the introduction of new techniques or shifts in emphasis in medicine. Will programs geared to the curative phase of medicine meet the demands of new methods of psychiatric treatment or vastly increased expenditures on geriatrics . Should government direction replace individual decisions in a complex of medical services which will place special emphasis on individual problems?

Examination of these phases of medicine should be of special interest to Governments, because every program substantially financed from Government funds has had to increase its expenditures many times in the past, and if our

predictions are accurate, the increased expenditures of the future will at least parallel those of the past. History shows us that it was increasing expenditures which suggested to Governments that they should change from a system which paid the full amount of the service provided, to one which paid only a major portion, requiring the participant to make a contribution at the time he received the service.

Governments are faced with many demands on the tax moneys which they collect. Social service programs which have traditionally been underwritten by Governments on this continent, usually require a volume of expenditure which is reasonably predictable. Should Governments assume a responsibility to provide a service which has every prospect of continually increasing and currently unpredictable expenditures?

The consistent increases in expenditures on the National Health Service are well known to all of you. In 1950, they totalled £450,000,000, and for 1961 they are estimated at almost £920,000,000. This is an increase of more than one hundred per cent in the relatively short span of eleven years. Unfortunately, the major criticism of this substantial increase in expenditure is that the increase was not big enough because it did not begin to fulfil the promise of Government to provide a maximum level of services for all residents of Great Britain.

Political realities must impose a maximum on the allocation of tax moneys to health service expenditures. This has happened in Britain. As a consequence only one new major hospital has been built in Britain since 1945. Long waiting lists for elective procedures are common, and general practitioners' surgeries are over-crowded. In fact, the Guillebaud Committee reported "We do not believe that the country will be in a position to provide a fully comprehensive health service, which is adequate for all desirable needs, in the foreseeable future".

Why has the Government of Great Britain now found itself in the position where it cannot provide the service which it promised at the outset of the National Health Service? There is one basic reason. Of itself, it should be sufficient to prevent any responsible Government from making a similar mistake. Under the National Health Service, the Government promised to provide and pay for health services rather than assist in their payment. Thus, the Government is placed in a position of providing and paying for a service without being able to control the demand for services.

Under such a program, Government must pay, without question of need, the bills which result from decisions made by the participants. This is the only service underwritten by Government in which it is placed in this invidious position. Governments themselves decide what roads shall be built, what grants shall be made to the educational system, what new buildings will be erected. In each instance, Government retains control over the amount of expenditure and can defer projects to a succeeding year if their financial circumstances would so dictate. This is not true in health insurance. The basic decision as to whether or not he should see a doctor is made by the participant. His visit to his physician sets off a chain of events which is reflected in an expenditure by Government on medical, hospital or other services. If the demands and, therefore, the expenditures are too high, there can be no deferment of payment until the next fiscal year. The only action which Government can take to retain expenditures within its financial capacity, is to place itself in the humiliating position of having to restrict the services which it has promised. When this happens, Government negates its reasons for introducing the program.

As the future of medical services unfolds, I believe that we shall need greater, not smaller, areas of individual decision. This applies both to the role of government and to the role of the voluntary insurance and prepayment plans. Government should restrict its activity to financial assistance in depth in areas of real need—the low income groups and the aged. Our voluntary insurance programs will have to broaden the base of their coverage and possibly restrict the depth of coverage. I find it difficult to assume that further increases in our real standard of living will match the increases in premiums necessary to continue to provide a 'maximum' level of benefits in the changing character of medical services which I foresee. As well, the change in demand which will be reflected as treatment and expenses alter from the disease episode phase to the chronic disease or non-specific phase, requires more individual participation in the expense factor at the time the service is provided. Government's entry into a compulsory program, anticipating the changes I have postulated, would be sheer abdication of fiscal responsibility.

If Government's entry into the field of compulsory health insurance indicates fiscal irresponsibility, why have these programs been introduced? In some instances, the reasons have been strict political opportunism. Promising something for little or nothing will win votes, and votes get Governments elected. This was the philosophy of Bismarck, who first undertook to provide such a program.

In other instances, programs were introduced to implement an ideology. The National Health Service was introduced at a time when various industries were being nationalized as a practical expression of the belief, current between the nineteen thirties and the early nineteen fifties, that administration is everything and that large-scale organizations are more efficient than small organizations. In the provision of medical services, dependence on the method of organization is more fallacious than in other circumstances. Medical services are provided by physicians who do not acquire new skills or new techniques coincident with the adoption of a new method of organizing health services. In this field, in particular, our dependency is upon the personnel available and the adequacy of their training, rather than upon the method of organization.

In some instances, programs of compulsory health insurance have been introduced as a method of control over the medical profession. I am convinced that Mr. Bevan believed that if he could exercise complete control over the profession he could, in effect, provide a more adequate health service. Excessive controls are inimical to our society. The experience to date would indicate that the widespread control exercised by Government in Britain has caused widespread dissatisfaction within the profession. It is also true that no evidence has ever been introduced to indicate the necessity for the degree of control which is exercised.

Control and compulsion are similar words and they have similar connotations. We have seen a trend for most countries, with the exception of Australia and Switzerland, to extend compulsion in their health insurance schemes to more and more of their residents. It is also true that in countries which restricted their compulsory component to certain groups, political pressures were brought to bear to extend compulsion to other groups so they might benefit from Government financial participation.

Why is compulsion in medical services insurance wrong? Compulsion for all residents means that a single type of program will be introduced. A monopoly in medical services insurance would prevent any comparison with other methods. Lees comments—"Insistence on a single standard of service

for all eliminates the internal forces making for improvement that would be generated by emulation between diverse standards. Rapid advances in medical knowledge demand adaptation to change and freedom to experiment. The concentration of decision-making power in the hands of Government is thus inimical to progress".

A compulsory program devised to produce uniformity of service is doomed to failure, or at least to a lowering of the peaks of excellence which denote progress. As individuals, humans are non-conformists. Some persons will rebel against the conformity and will seek to obtain the standard of medical service which they desire by another method. This has been shown in Britain by the decision of a proportion of the population to seek services on a private basis, even though many artificial barriers have been raised to prevent it. It will also prove true in Saskatchewan even though the proposed legislation militates against such choice by refusing to provide reimbursements to participants who choose to seek services from a non-participating Saskatchewan physician. Ironically, the legislation does provide for reimbursement if the participant obtains his medical services outside the province.

The reaction of the individual against compulsion and direction is a natural attribute of human nature. Even though, en masse, the public might agree that all doctors should become civil servants, individually few would agree that they must accept treatment by a civil servant doctor. It is interesting to note that in Britain this individual reluctance has even been applied to the architects of the scheme. Mr. Bevan and other senior officials of Government chose not to accept the system they had designed for their fellow citizens, but rather sought their medical services from private sources.

I am certain that no responsible politician in Canada, or the United States, would suggest that he is seeking the results which I have portrayed arising from a compulsory program of medical services insurance. We cannot, however, be comforted by the sponsors of the legislation which has been introduced in Saskatchewan.

How can we trust the judgment of those who will not learn lessons from history? How can we trust the motives of those who would erect a barrier to freedom of choice of physician by decreeing that the patient is not eligible for reimbursement if he seeks the services of a private doctor? How can we reconcile the control they wish to impose with the freedom which is essential for the future development of medical services?

Within the past fifty years, history has shown us the transition of medical services from a preventive service to one more specifically related to treatment of diseases in individual patients. I have suggested that we are now entering a phase in which psychiatry and its ramifications will play a more major role, and that we shall shortly encounter a substantial increase in the services required for the treatment of the degenerative diseases.

These new services will increase expenditure on medical care. They are areas in which the demands for medical services are limitless. The problem of providing and paying for these services is a different problem to that which we have faced in the past and calls for the cooperation of the profession, voluntary insurance and Government.

I believe that to meet this problem our voluntary programs must be more willing to experiment. You may find that the application of a modified reimbursement method may allow you to retain present premium levels and still provide a broader range of benefits, particularly in the field of psychiatry and geriatrics. Medicine must find and train the doctors who will provide this

increased volume of services. Government must assist the low income groups to obtain insurance, and must subsidize the older age groups, whose expenditures on an insured basis are double the average and whose premiums must continue to rise. This combination of selective assistance by Government, experimentation in coverage and method of payment by the voluntary agencies, and a well-trained force of free physicians will enable us to overcome the challenges of the future.

Our present and pressing problem is to convince our political masters and their masters, the public, that this is so, and that rather than trying to perpetuate the status quo, our primary concern is to maintain and improve a system which is sufficiently flexible to meet and adjust to the challenges of to-day and tomorrow.

BOOK REVIEW

FUNDAMENTAL NUTRITION IN HEALTH AND DISEASE. By Mary C. Hiltz, Price $3.75, 294 pages. Published by MacMillan Company of Canada Ltd., 1961.

This book is divided into three main parts, the first dealing with nutrients, the second with normal nutrition, and the last with diets in disease conditions.

It is an excellent book for student nurses, nurses, dietitians and students learning home economics.

The last section and the tables will be most helpful to medical students and physicians as well.

The style of the book is simple and easy to read. The diagrams, tables and charts should be a great help and will no doubt be extensively consulted.

Miss Hiltz's book has filled its purpose completely and should be made available in the library of most hospitals.

In summary, this is a good teaching book for all students, and also a very good reference book for all concerned in nutrition, including physicians. The last section dealing with special hospital diets will be of great help to internes and residents, as well as physicians in general.

G. NIGRIN, M.D.

A MASS COMMUNITY IMMUNIZATION PROJECT IN NOVA SCOTIA

DR. H. B. COLFORD, M.D., M.P.H.
Director of Maternal and Child Health and Communicable Disease Control.
Department of Public Health.

Sabin Oral Poliomyelitis Vaccine was first licenced for use in Canada in April 1962, and the Provincial Department of Health was notified at that time that 200,000 doses would be available from Connaught Medical Laboratories, Toronto, in May of this year.

After discussions with interested bodies including the Halifax City Department of Health, Dalhousie University Medical School, the Provincial Virus Laboratory and the Medical Society of Nova Scotia arrangements were made to carry out an immunization programme in the County of Halifax, including the Cities of Halifax and Dartmouth.

The population of this area is some 220,000 persons, and vaccinations were carried out on the 4 days from May 22 to 25. This is the first time such a project has been undertaken in Nova Scotia.

Time for preparation of the project was short, little more than 2 weeks. During this time an intensive advertising campaign was carried out, both to publicise the program and to educate the public as to its importance. All advertising media were extensively used including press, radio and T.V. Full co-operation was obtained from all media, with free space in the news, and other feature programmes right through the period. There was also some paid advertising, including full and half page newspaper advertisement giving the clinic schedules.

Vaccination records were kept on I.B.M. cards, which also served to record the parents' consent, being taken home for completion by school children before the clinics. Volunteer workers were recruited in Halifax city through the March of Dimes, and in the county, through the federation of Home and School Associations. The Pharmaceutical Association offered to send volunteers to help in dispensing the vaccine which was taken on lumps of sugar. This method of taking it proved highly acceptable to the public. Public Health Nurses were brought in from other Health Units in the Province, both to help supervise the clinics and to gain experience for the day when similar programmes are carried out in their own areas. There were sufficient personnel to keep the clinics running smoothly at all times, although there was not always time to complete the IBM cards fully.

The results of the programme are given in the following table. It was intended to vaccinate the entire population excepting those under 3 months of age; in fact 81.4% received the vaccine. Having in mind the number who, because of illness or other reasons cannot be reached, it is unlikely that a higher figure could have been achieved in this time. It is seen that of those having previously received Salk vaccine, the highest percentage are in the school age group. This may indicate that the general immunization program for pre school children needs to be stepped up. Also of interest was the number of persons who did not know whether or not they had had Salk vaccine. Apparently many persons do not receive a record of their immunization, or do not properly care for this record.

The folder accompanying the vaccine caused a new difficulty. It referred to the penicillin content, to certain contra indications and to symptoms experienced by some. Actual use of the vaccine here and elsewhere has demonstrated that for all practical purposes it is safe.

Field trials with Salk vaccine were carried out in the city of Halifax in 1954. This was a blind trial with half the children receiving a placebo. All the complaints of severe reactions at that time occurred in children receiving the placebo, and there were no reactions in those receiving the vaccine.

The success of a mass immunization program depends on Education, Organization and Team Work. There must be an intensive educational program using all available media, and besides the public, it must reach all persons participating in the program: the clergy, the school teachers and others in the community who might in any way influence the public. Organization of clinics must be planned to the last detail, well in advance so that there will be no confusion as to places and dates of clinics, or as to personnel to staff them. A great deal of team work is necessary, with Health Unit Directors maintaining very close relations with central office personnel, the medical profession, and other agencies in the field, and their own staffs in order to keep the objectives clear and to eliminate any avoidable confusion. A public with full and accurate information, can be expected to be enthusiastic.

NUMBER AND PERCENT OF PERSONS WHO RECEIVED ORAL POLIO VACCINE and NUMBER AND PERCENT WHO HAD HAD PREVIOUS SALK VACCINE

	Previous Salk Vaccine	Age 0 — 5		Age 6 — 19		Age 20/		Total	%
Halifax City	Yes	6227	81.30%	17674	88.49%	23870	56%	47771	67.96%
	No	1247	16.28%	1509	7.55%	17289	40%	20045	28.52%
	?	185	2.42%	791	3.96%	1498	4%	2474	3.52%
	Total	7659	100%	19974	100%	42657	100%	70290	100%
Dartmouth	Yes	5943	87.03%	11122	92.45%	11398	60%	28463	75.40%
	No	782	11.45%	617	5.13%	6605	35%	8004	21.20%
	?	104	1.52%	291	2.42%	887	5%	1282	3.40%
	Total	6829	100%	12030	100%	18890	100%	37749	100%
Halifax County	Yes	11404	81.35%	21965	89.97%	18888	55%	52257	71.98%
	No	2185	15.59%	1422	5.82%	13380	39%	16987	23.40%
	?	429	3.06%	1028	4.21%	1896	6%	3353	4.62%
	Total	14018	100%	24415	100%	34164	100%	72597	100%

Total Population - 1961 Census Halifax County including the two Cities — 220,640
Total Number Receiving Vaccine — 180,636
Percent Who Received the Vaccine — 81.4
The Percentage in Halifax City was — 78
The Percentage in Dartmouth was — 83
The Percentage in Halifax County was — 87

PERSONAL INTEREST NOTES

We regret to record the death of Dr. H. A. Giovannetti at the age of 83. Dr. Giovannetti was one of Nova Scotia's oldest and best known Medical Practitioners. A full obituary notice will appear in the September issue.

Coming Meetings

The Post-Graduate Division, Faculty of Medicine, Dalhousie University announces a Short Course in Anaesthesia for General Practitioners — September 24th to September 28th inclusive. This course, arranged by the Department of Anaesthesia, is designed to give the general practitioner anaesthetist, practical experience in observation and participation in actual anaesthetic techniques in the operating rooms of the affiliated University teaching hospitals in Halifax. Any registrant interested in intensive experience in a specific technique should write Dr. C. C. Stoddard, Professor of Anaesthesia, Victoria General Hospital, Halifax, N. S., in order that this may be arranged.

The afternoons will be spent in seminars and round tables dealing with complications of anaesthesia, paediatric anaesthesia, muscle relaxants, obstetrical anaesthesia, resuscitation of the new born, respiratory insufficiency, and fluothane.

Two eminent American authorities will be guest teachers: Dr. Ronald Stephen, Professor of Anaesthesia, Duke University; and Dr. John Abajian, Jr., Professor of Anaesthesia, University of Vermont.

As the numbers that can be accommodated are limited, please apply promptly to Post Graduate Division, Faculty of Medicine, Dalhousie Public Health Clinic, Halifax, N. S.

The Second Eastern Regional Meeting of The Royal College of Physicians and Surgeons of Canada will be held at the General Hospital in St. John's, Newfoundland, on Monday, Tuesday and Wednesday, October 8, 9 and 10, 1962, in conjunction with the Annual Scientific Meeting of the St. John's Clinical Society (St. John's Branch, Newfoundland Medical Association) and the Newfoundland Chapter of the College of General Practice of Canada. The Annual Meeting of the Atlantic Orthopaedic Society is being held concurrently with this Regional Meeting.

A cordial invitation is extended to Fellows and Certificated Specialists of The Royal College of Physicians and Surgeons of Canada living in the four Atlantic Provinces to attend this meeting. Specialists living in other parts of Eastern Canada will also be welcome to attend.

The program will contain sessions in Medicine, Surgery, Obstetrics and Gynaecology and Paediatrics and will include the following outstanding guest speakers:

Dr. Douglas G. Cameron
Professor of Medicine and Physician-in-Chief
Montreal General Hospital
(Royal College Lecturer in Medicine)*

Dr. Frederick G. Kergin
Professor and Head, Department of Surgery
University of Toronto, and
Surgeon-in-Chief, Toronto General Hospital
(Royal College Lecturer in Surgery)*

Dr. Douglas E. Cannell
Professor and Head
Department of Obstetrics and Gynaecology
University of Toronto
(Royal College Lecturer in Obstetrics and Gynaecology)*

Dr. Sydney S. Gellis
Professor of Paediatrics, Boston University School of Medicine, and Director of Paediatrics, Boston City Hospital
(Supported by Postgraduate Division, Faculty of Medicine, Dalhousie University)

Fellows or Certificated Specialists of the College desiring to offer papers for presentation are requested to complete and forward the attached memorandum to the Chairman of the Program Committee, Dr. Richard Kennedy, F.R.C.S.(C), 15 LeMarchant Road, St. John's, Newfoundland, not later than August 1, 1962, together with an abstract of their paper. Papers will be limited to fifteen minutes.

EMERGENCY HEALTH SERVICES COURSE

An Orientation Course in Emergency Health Services for practicing Physicians and Surgeons will be held at the Victoria General Hospital, Halifax, on September 24 - 25, 1962 under the sponsorship of Post-graduate Study of Dalhousie Medical Faculty and Emergency Health Services of Nova Scotia. The program will include items concerning local emergencies and nuclear warfare. There will be no tuition charge for this course.

Doctors wishing to attend this course should notify Post-graduate Study office, Dalhousie Medical Faculty or Emergency Health Services, P.O. Box 1502, Halifax, N. S.

EMERGENCY HEALTH SERVICES

Medical Officers' Course - Victoria General Auditorium

September 24

8.45-	Bus leaves hotel for Victoria General
9.00- 9,30	Registration
9.30- 9.35	Opening remarks
9.35- 9.40	The Co-ordinator
9.40- 9.50	The Minister or Deputy Minister
9.50-11.00	Emergency Health Services (Dr. A. C. Hardman)
11.00-11.15	Coffee Break
11.15-12.10	Nuclear Weapons - Effects (Mr. E. G. Sherring)
12.15-12.40	Emergency Measures Organization and Civil Defence
12.40- 1.45	Lunch (Victoria General Cafeteria)
1.45- 2.30	Psychiatric Problems in Disaster (Dr. R. J. Weil)
2.35- 3.15	Handling of Mass Casualties (Dr. A. C. Hardman)
3.15- 3.30	Afternoon Break
3.30- 3.45	Organization of Emergency Health Services in Nova Scotia
3.50- 4.30	Radiological Decontamination (Mr. E. G. Sherring)
4.35- 5.30	Discussion Period
5.30-	Dinner (Victoria General Cafeteria)

September 25

8.45-	Bus leaves hotel for Victoria General Hospital
9.00- 9.45	Hospital Disaster Planning (Dr. W. D. Piercey)
9.50-10.30	Community Organization
10.30-10.45	Coffee Break
10.45-11.30	Public Health and Sanitation Problems in Disaster
11.35-12.10	Biological Effects of Nuclear Explosions (Dr. F. C. Pace)
12.15- 1.30	Lunch (Victoria General Cafeteria)
1.30- 2.15	NDFRS and Role of the Armed Forces (TAHQ)
2.20- 2.50	Auxiliary Services
2.55- 3.10	Afternoon Break
3.10- 3.40	Emergency Welfare Services
3.45- 4.30	Panel Period (Guests and Province)
4.30- 4.40	Summing up
4.40-	Administrative Instructions

BOOKS - JOURNALS

The Dalhousie Medical Library can loan you any books, journals, pamphlets, or other printed material in the field of medicine that you may need. Send your requests to:

T. H. Rees, Jr.,

Librarian,

Dalhousie Medical Library,

Carleton St.,

Halifax, Nova Scotia