Some Economic Aspects of Our National Health

By Robert Kohn

IS there reason for concern over the state of our nation's health? "Indeed, considering the few diseases which here afflict humanity relatively to elsewhere, we have great reason to be thankful to the All-powerful Controller of the seasons as of our fate, that in separating us from the great branch of the European family; and in placing us where there are indeed no majestic ruins scattered around to prove past greatness or add to present interest, He has prepared for us a land where we may not only live in peace with all men, but in the assurance that . . . He keeps us in health, comfort and safety." Thus Sir William H. Hingston in 1884. And yet even then 62 per cent of all children born in Canada died under five years of age.

To-day that last figure has been reduced by about nine-tenths, and the public is complacent about the state of the nation's health. Yet not so long ago, during the war, we were alarmed over the great amount of absenteeism in our industries, largely due to sickness, and over the high percentage of rejections on medical grounds among recruits for the Armed Services.

During the war it was imperative to eliminate any waste in our manpower, whether in the Armed Services or on the industrial front. The effects of such waste could be precisely calculated in loss of life at the frontline. With the end of the war, that gauge has disappeared. But does the removal of the thermometer imply that the patient has no temperature? Certainly what affected our economy and efficiency in war-time, what hampered our production then, does the same thing now in peace. The only difference is that now the consequences are not seen so clearly.

"While much of the cost of illness is thus hidden, it can only come out of the total productive capacity of the country." So we read in the Government's proposals for the Dominion-Provincial Conference on Reconstruction. The economic implications of health and ill-health are complex and far reaching. What can be offered here in these few pages is only a broad indication of some of the aspects. Moreover there are limitations to any such study arising out of the quantity and quality of the material available. We have no exact information on the total amount of sickness in Canada and we are forced to depend largely on estimates based on piecemeal statistics. What we do know, however, suffices to show the importance and magnitude of the problems involved, and to indicate at least the direction along which we may hope to find a solution.

Expenditures on Health

It is estimated that Canada spends annually some $300,000,000 on health. Under the present set-up of Dominion-Provincial relations about 15 per cent of that amount is appropriated from public funds at the various levels of administration. This sum, large as it is, covers only direct costs, treatment, hospitalization, etc. And it is a trifle in the sum total of national expenditure; it is less than 7 per cent of war expenditures during the years 1944 or 1945; it is about 3 per cent of the total net national income in 1944 or, if you like, about 8 per cent of the national income in 1938; it is less than the annual expenditure for the interest on public debt in Canada. To cap it all, even this relatively small amount is not being spent in the most efficient and economical manner. This is not the

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place to discuss the question of how the costs of sickness should be provided, whether by "free market" health services or some system or other of collective insurance. But we can indicate certain principles which apply to any system of health services. To do this we must investigate more closely than is generally done the dynamics, so to speak, of our health situation, both the changes which actually occur and those which could be brought about. There are signs that such a new attitude is steadily gaining ground. While the need for treating illness has long been recognized, the general attitude has been, and in many cases still is, to deal with sickness whenever the occasion demands it without any thought to the possibility of avoiding it.

Two examples will serve to illustrate this point. It has been recognized that indigent blind persons above a certain age must get some financial aid. The Old Age Pensions Act provides pensions for them, subject to a means test. Those eligible received their meagre pension without any consideration as to the possibility of relief for their blindness. A recent survey, however, brought out the fact that 30 per cent of those awarded pensions were, at the time of the award, considered curable, to the extent at least that useful vision could have been restored by treatment. Moreover, 70 per cent of the group not yet eligible could have their blindness arrested or prevented by proper care; all this according to "Health, Welfare and Labour," a Reference Book for the Dominion-Provincial Conference on Reconstruction. In June, 1946, the Minister of National Health and Welfare announced the proposal to provide half the cost of treating those whose blindness might be prevented or cured by treatment. This is one instance where spending a little money at the right place could prevent suffering and would, in the long run, cost less.

Again, a considerable proportion of all sanatorium admissions is made up of patients who enter the institution for the second or third time. In many cases this could be avoided by adequate follow-up care. It is recognized that patients must be admitted as soon as symptoms occur. But with the proper preventive care the necessity for their return and thus for the considerable expense of their treatment could be avoided. Numerous similar cases could be cited where more attention to possible changes, instead of accepting conditions as they occur, would mean healthier people and lower expenses.

It is impossible to estimate the indirect cost of sickness in Canada, a figure which would include the cost of maintenance of the disabled persons and their dependents. The Mothers' Allowance Commission of Ontario recently estimated that the average cost per case to the taxpayer for assistance to a family because of tuberculosis is about $2,800. Much of our tuberculosis and venereal disease could be avoided or prevented by timely and proper care. The Provincial Secretary's Department (British Columbia) has said: "If deaths and disabilities from tuberculosis and the venereal diseases were cut in half over a period of five or ten years, it is quite possible that there would be an annual saving in mother's pensions alon of about $50,000—as much as the whole cost of the provincial venereal disease programme during the fiscal year 1936-1937. In addition, there would be other savings, probably much larger in total, incidental to reduction of care for patients in mental hospitals, general hospitals and other institutions and to lessened demands for poor relief, care of dependent children, old age pensions, etc."

Reduced Productive Capacity

We can only estimate the total amount of disabling sickness in Canada. The facts upon which such an estimate can be based are to be found in a number of surveys which are themselves restricted either as to locality or as to the make-up of the group under survey. In appraising the results of such surveys among industrial groups, the possibility must always

be borne in mind that the survey will in many cases register only the comparatively short absences due to acute sickness and will ignore the permanently disabled and many of the chronically ill. These latter will in most cases have quit their jobs altogether and thus will no longer figure as "absent." The effect can be seen from the example of a morbidity survey in certain predominantly rural areas of Manitoba which shows two days as the average disability per resident per year; the permanent disability cases, however, not included in that average would account for an additional 2.7 days if distributed over the entire population of the area.

As may be expected, the results of such local surveys in various parts of Canada vary as widely as from two days of disability per year for the population of certain rural districts in the Prairies to twelve days for miners in Glace Bay. The average of those two figures, that is to say seven days of disabling sickness per person per year, is about the same as has been found for the Civil Service of Canada. It conforms closely with the results of certain comprehensive surveys in the United States and also with the figure arrived at by the Advisory Committee on Health Insurance for the general population of Canada. Even so it is not clear how far chronic and permanent incapacitation has been considered in all these calculations, and they must be regarded as tentative.

Disabling sickness unfavourably influences the efficiency of our economy, both directly in the cost of medical care and indirectly in a number of ways: absence among school children retards the process of education, sickness among old people ties down the persons who have to care for them. These indirect effects are impossible to measure with precision, but we can at least measure to a certain extent the effect of disabling sickness among wage-earners. The Report of the Advisory Committee on Health Insurance estimates that sickness among wage-earners in Canada involves a loss of income approximating $70,000,000 a year (based on income figures for 1931, i.e. average weekly earnings of $22.56 and $12.01 for male and female wage-earners respectively).

According to the same source the total number of days of disablement among the wage-earning group is over 18,000,000 per year. Compare this with the number of working days lost in 1945 in Canada due to strikes and lockouts, slightly under 1,500,000.

A study on "The State of the Nation's Health" by the United States Bureau of Research and Statistics estimates that in the United States on an average day of the year more than 7,000,000 persons are disabled by sickness. Of these about half have been disabled for less than six months, the remainder for longer periods. Almost half of that number disabled on any day are in the labour force and much less than a tenth (perhaps as little as a twentieth) of disablement among this group is due to work-connected accident and disease; nearly all the rest represent various types of non-industrial sickness and accidents.

Increased Life Expectancy

Improved public health measures and the general progress in medical science have contributed enormously to the betterment of health conditions. A few hundred years ago plagues wiped out half or more of the population of Europe and the British Isles. Now typhoid and diphtheria have been reduced almost to insignificance, and the death rates from tuberculosis, maternity and the diseases of infancy are steadily decreasing. All this is reflected in the tables of life expectancy compiled by insurance companies. At the turn of the century the average length of life was about 50 years; it has now become almost 65. This has meant, according to a study made by the Metropolitan Life Insurance Company in 1942, a saving of one million lives of white persons.

There is much still to be done. Great inequalities exist between different parts

of the country in the rates of morbidity and of deaths from certain causes. Accidental death, largely preventible, is the principal cause of death for the age-groups 1 to 14 years, and the second cause for the age-groups from 15 to 39 years. Tuberculosis, completely preventible, is the chief cause of death between the ages of 15 and 39 years and exacts a considerable toll among almost all other age-groups.

Conclusions

This is not an attempt to assess in dollars and cents the value of life or health. To regard these as commodities is to confuse economic ends and economic means. "There is no wealth but life," said Ruskin. The so-called money value of a man, computed by several authors from William Farr to L. I. Dublin, is only the assumed present worth of his net future earnings. Those figures are useful and interesting but they reflect only the price paid for certain services and not their value, even in a strictly economic sense. And man makes a far greater contribution to society than is expressed by his activities as a breadwinner.

But this is not to deny the importance of these activities. And if our level of production is to be maintained and increased, one of our principal considerations must be avoidance of incapacitation from illness. Money spent efficiently on the prevention of disease is not money wasted; it pays a tenfold dividend in the increase of the national wealth.

Voluntary Insurance For Comprehensive Medical Service

By Dean A. Clark

VOLUNTARY insurance for various types of medical and hospital care has been making rapid progress in the United States in recent years. Insurance for hospitalization, for instance, now includes more than 20,000,000 persons under the Blue Cross plans alone. But most voluntary programs in this country cover only a portion of the medical services people need. Typically, they are limited to hospitalization or to surgery and obstetrics or some other specific service. Because of these restricted benefits such programs are very incomplete, offer no preventive services, and at best have proven to be only partially satisfactory. On the other hand, the few programs that do furnish a broad scope of medical services on an insurance basis are usually limited to the employees of one industry or to the patients of a single group of doctors and thus are not available to the whole community. The Health Insurance Plan of Greater New York, however, will provide a comprehensive medical insurance plan, open to all groups of employees (and their dependents) who wish to join, and open to all groups of physicians who meet minimum professional standards and who desire to participate.

The provision of comprehensive medical service under voluntary insurance plans in this country has been attempted principally by two methods. One is through the payment of fees for each service rendered to insured persons, utilizing any physician whom the subscriber may happen to select. This is often called the "open panel" method. The other is through the use of specified physicians or groups of physicians—a "closed panel"—who are paid on a yearly basis in accordance with their training and competence and in accordance with

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