be expected since the technique of the shore fishery has altered little in this century. That the world demand for dried fish has expanded in this century is no reason for hoping that an industry with present North American costs but outdated methods can satisfy this demand at a profit. It may be possible to operate a salt fish industry at a profit by the use of capitalistic or large scale methods (vide French, Italian and Spanish trawler fleets). But these are absent in Canada's shore fishery as they are in Newfoundland's.

The decay however has been speeded by the nationalist movements among competitors and also buyers, so that the Canadian salt fish industry, with less than modern methods of catching, has for the past few years, faced a world market where its competitors were mainly national sellers, with funds available to sell at prices which would hold required markets (even Newfoundland after 1935). But the selling methods of the Canadian industry, even in face of these organized sellers has remained in the hands of individual sellers, competing among themselves for Canadian fish that were relatively expensive per quintal, and trying to compete with each other and with organized competitors in selling these in Caribbean and some other markets.

The Canadian salt fish industry lacks the modern methods of fishing, grading and selling of competitors like Norway. On the other side Canada may be as efficient as Newfoundland but the low subsistence costs there and the urgency of sales creates a type of price competition which also limits Canada's markets. Canada has found it difficult to compete with the costs and qualities of more efficient producers, and also with the lower subsistence costs of an almost equally efficient producer (Newfoundland).

Hospital Care Insurance Plans

By G. Harvey Agnew

VOLUNTARY hospital care insurance, also known as "group hospitalization", or as the "periodic payment plan for the purchase of hospital care", has met with a remarkable degree of public approval during the past few years. Several American cities now have plans enrolling hundreds of thousands of members, one on its second million. Few movements, indeed, have been accepted so quickly by the general public. Why has this been so?

Without question the public mind was ripe for this movement. Prior to and during the years of the depression the reading public was deluged with articles on the cost of sickness. When exhausted of other subjects feature writers could always hold their readers by reminding them how poor they were being kept by medical, hospital and nursing bills. That much of the data published was incomplete and inaccurate, and that many of the interpretations made and conclusions drawn were wholly erroneous did not matter. Sir Arthur Newsholm's exceedingly valuable International Studies broadened our horizon and the equally valuable report of the Committee on the Costs of Medical Care focussed attention on the problem in the United States. Here in Canada the most helpful study was that of the Committee on Economics of the Canadian Medical Association (1934).

The general conclusion of the people on this continent (if one dares to formulate a general conclusion) has been that we are not satisfied with the existing

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more or less haphazard system, excellent though it has been, but, at the same time, we are dubious about adopting state medicine as developed elsewhere. Some form of health insurance for the lower income groups is generally desired, but there is a general feeling that this should be of a voluntary co-operative nature rather than be a bureaucratic and impersonal state system.

Hospital care insurance conforms to this principle. Bread-winners and their dependents, either as individuals or as groups, unite to form a voluntary hospital insurance plan. In return for a modest monthly contribution, varying from forty to seventy-five cents a month, members receive hospitalization for a specified total period in any one year, usually twenty-one to thirty days. Most plans now accept dependents on a premium usually at a much lower rate than for the first subscriber. Some plans provide public ward accommodation; others provide a semi-private room. Some cover practically all "extras" such as operating room charges, X-ray, laboratory, etc. Others limit the extras. Naturally these variations affect the premium charged. In industrial areas, the fortnightly or monthly premium may be deducted from the pay cheque.

In the past few years the tendency has been to develop low cost plans—for instance, for a semi-public plan the cost for the breadwinner may be as low as fifty cents per month and for the family, $1.50 in all, the plan providing a wide range of extras. Semi-private service is being offered at seventy-five cents and $1.50. Apparently the lower priced plans are having the least financial difficulty, due largely to the added enrolments.

Most of the better plans are directed by a Board representing the hospitals, the public and the medical profession. Plans may be strictly local, may be limited to one company or to one hospital, may be open to all local citizens, or may be on a province—or a state-wide basis. Medical care is seldom included, but often may be purchased through a parallel plan.

Plans Widespread

How extensive are these plans? Here in Canada we have seventy or more of these plans in operation; in the United States there are several hundreds. The largest plan in Canada is that of the Manitoba Hospital Service Association, which has some 33,000 members and dependents (July, 1940). The Edmonton plan has 8,700 people covered and the one at Kamloops covers over 5,000 people. These figures are dwarfed, however, by the tremendous growth of plans in the United States, where over five million people are now enrolled. The famous "three cents a day" plan in New York City covers approximately one and one half million members. The enrollments of a few of the leading American plans are as follows (Jan. 1st, 1940):

New York	1,358,409	
Minnesota	309,216	
Cleveland	284,784	
Michigan	229,465	(July 1, 1940)
Massachusetts	221,491	
Philadelphia	185,252	
Newark	180,057	
Pittsburgh	173,171	
Chicago	147,412	

Most of these plans have been developed within the past seven or eight years; the Michigan plan started but sixteen months ago (1938). In this connection it should be pointed out that a plan of this type has been in existence in Glace Bay for over 35 years but had not been taken up in large centres for the population at large. For this initial work done in our mining and certain other industrial areas and for the stimulus to the whole cooperative movement given by the St. Francis Xavier group, we are all deeply indebted. In the United States the inspiration for much of the present movement was probably Baylor University Hospital, where a plan was instituted in 1929.

Approval of Plans

The development of these plans has been hastened, too, by the imprimatur of approval given to the principle by various recognized bodies. The American Hospital Association back in 1933 approved the principle of hospital insurance.

The following year the American College of Surgeons gave its approval. In 1935 the Canadian Medical Association, in a lengthy study of the movement, concluded that "the principle of group hospitalization is fundamentally sound". The Catholic Hospital Association in 1937 encouraged its members to participate in these plans, provided they conform to acceptable standards. The American Medical Association was somewhat dubious about supporting this movement but, after watching the course of development for a few years, gave approval in 1938 and formally stated that "we particularly recommend it as a community measure".

These organizations have outlined the basic principles upon which plans should be developed. For instance, all are agreed that the plans should be of a *non-profit* nature. This one recommendation alone has saved the public from a host of promoters who early saw an opportunity to make a good living by capitalizing on this widespread movement with thinly disguised profit promotions. The most steadying influence was the decision of the American Hospital Association (to which many Canadian hospitals belong) to give "approval" to insurance plans which meet certain standards.

Briefly these standards may be synopsized as follows:

1. The plan to be controlled by the public, the hospitals and the doctors.
2. No private investors should advance money in the capacity of stockholders or owners.
3. Plans to be established only where community not served by existing non-profit plan.
4. Hospital service benefits to be guaranteed by the member hospitals.
5. Majority of hospitals of standing in the area should participate in the one plan.
6. The plan should be actuarially sound, adequate amounts should be set aside for reserve and income should be apportioned as set forth in the basis of approval.

The net result of the approval of principles and the establishment of standards has been a decided impetus to the formation of sound plans and a proportionate setback to the promiscuous launching of unsound plans by fly-by-night or incapable promoters. Widespread publicity for the movement gave would-be promoters all over the continent the idea of capitalizing on this public interest to make a neat little income for themselves. Indeed many such plans were started, but the emphasis placed upon the non-profit feature and the necessity for stressing service to the public rather than gain for the promoter, have caused most of these plans to fold up. Year by year the larger plans are tending to conform to a common pattern, the differences being of detail rather than of principle.

What of the Future?

What will be the future of these plans? Undoubtedly they have come to stay, in some form or other. True, they do not constitute a panacea for the great financial burden of illness, but they do solve the problem of the cost for one of the biggest items that go to make up that economic nightmare. Experience in the mining areas of Nova Scotia where, even in the depths of depressions or strikes, the miners insisted upon keeping up their hospital insurance, come what may, indicates the extent to which these plans have been accepted by the people.

Undoubtedly these plans will be broadened in nature. Individual hospital plans will be absorbed in plans covering an entire province. A number of plans, such as that in Michigan or in North Carolina, are now state-wide. The Manitoba plan, although operating only in the Winnipeg area, has a province-wide charter, and a provincial plan is now being organized in Ontario. The recent decision of the hospital association in Nova Scotia to seriously consider the setting up of a provincial plan to cover rural as well as industrial workers and to cover all parts of the province indicates the trend in this direction.

It is anticipated, too, that the benefits

will be increased. This is now being done in the New York City and several other plans. There is also a steady demand that medical care be included. In California, Michigan, Massachusetts and other areas, parallel medical plans are now being conducted in the closest harmony and frequently with common offices. The Associated Medical Services in Ontario covers general practitioner, specialist, hospital and special nurse benefits.

Organization

As these plans grow in size there will be a tendency for them to unite, at least in a loosely knit association. This is desirable; the many conferences of plan executives held at frequent intervals in the United States have done much to unify methods and to avoid the repetition of mistakes.

Therein, however, lies a potential danger. With millions of people enrolled in what may ultimately be a few widespread plans (like bus lines or air lines), there may be a tendency for the executives of these groups to dictate to those rendering the service. We see this attitude very frequently now in the case of workmen's compensation boards, and similar bodies. Started by the hospitals as a service to the lower income groups and as a steadying influence on their own revenue, there is the possibility of this very creation of the hospitals so dictating to them as to make it exceedingly difficulty to carry on. Were medical care included, the same club might be held to the head of the medical profession.

The solution would seem to lie in a retention of the control directly in the hands of those concerned—the subscribers, the hospitals and the medical profession. The participation of the latter is stressed, irrespective of the inclusion of medical benefits, simply because the sympathetic and responsible interest of the medical staffs of the hospitals in the plans is essential to the efficient and economical operation of any plan of this type.

The Ultimate Destiny

What of the ultimate destiny of these voluntary forms of insurance? Broadly speaking, there are two schools of thought. One believes that these plans constitute but a *precursor* to out-and-out state control. It is contended that the resultant education of the public in the value of this method of spreading costs will bring about a demand for state participation; the state steps in when voluntary effort has paved the way. The setting up of unemployment insurance next year should hasten the inauguration of compulsory health insurance.

The other viewpoint is that voluntary insurance is a real *preventative* of state medicine. If voluntary effort can achieve the desired results, the people will not insist upon state intervention with all its potential weaknesses and dangers. The success to date of the hospital plans now operating and the marvellous inspiration of the voluntary cooperative movement, given such an impetus by the Maritime experiments, may lead to an ultimate solution for the wage earner in this direction. State participation may be limited to coverage for those who are without means.

Whichever be the ultimate pathway, the development of these plans must be considered as a definite milestone of progress. The financial relief for the individual member, the accumulation of sound actuarial data and the education of the public in cooperative effort have been more than worthwhile. Even if compulsory health insurance does come for the low income groups, there will still be a place for these voluntary plans for those above the stipulated income level.