proportional representation is assured by means of the single transferable vote. This system, which is admin istered by electoral tribunals, involves the official recognition of political parties as legal entities. The registration of a political party having been approved by the electoral tribunal, that party may submit to the tribunal a list of candidates; and no candidate may be registered except by a political party. In federal elections each state and the federal district is a single constituency which elects a number of deputies, depending on the population of the state; and each state elects three senators. On polling day the voter does not mark a ballot but instead places in the ballot box, in an envelope given to him by the poll clerk, a printed slip of paper bearing the name of a party and one of the candidates of that party. When the votes are counted, the votes for parties are considered first. The so-called electoral quotient is established by dividing the total number of votes cast by the number of seats to be filled. Any party which receives fewer votes than the electoral quotient is ruled out, and the seats are then divided among the successr ful parties in proportion to the numbe- of votes cast for each of them. Once the number of deputies to be elected by each party has been determined, the votes for individuals are considered, and the party candidates who have polled the most votes are declared elected. Senators are elected as individuals.

If a single candidate is elected in more than one state, he must declare for one of them and his name is struck off the party list in the others, the candidate with the next largest number of votes takeing his place there. Similarly, in the event of a vacancy by death or resignation, the man next on the party list is declared elected.

In the state elections the whole state is regarded as a single constituency.

Elections for President of the Republic and for Governor of the State are between individuals, the candidate with the greatest number of votes being declared elected. Candidates must, however, be nominated by a political party, and it frequently happens that the same candidate will be nominated by several political parties.

Province-Wide Hospitalization in Saskatchewan

By Leonard S. Rosenfeld

THE increasing acceptance of the concept of health insurance in modern countries and the rapid growth of voluntary hospitalization insurance in the United States and Canada during the past fifteen years would seem to give clear indication that protection from the economic and social, as well as physical and mental, effects of illness is a basic social need. From a modest start in 1932, when the first Blue Cross Plan was established in the United States, through 1937, when total enrollment passed the million mark, to the present time, when about 25 million persons in the United States and Canada are enrolled in voluntary hospital services plans, hospitalization insurance has become established as a significant factor in the health security of the people of North America. The value of hospitalization insurance to the families covered, to the medical profession, and to participating hospitals is now generally recognized.

Review of the enrollment experience in different states and provinces under voluntary hospitalization insurance indicates that this method of payment of hospitalization costs is not equally fa-

EDITOR'S NOTE: Dr. Rosenfeld is Acting Executive Director of tde Saskatchewan Hospital Services Plan.

vorable under all conditions. Voluntary plans have met with outstanding success in certain densely populated and highly industrialized states, such as Rhode Island, where over 60 per cent of the population is enrolled, whereas in rural and less highly industrialized areas, coverage has been far less extensive. The reasons for this might well be a subject for a separate and extensive study. It would seem feasible, however, to arrive by conjecture at a fairly accurate estimate of some of the basic factors underlying this experience.

Industrial and Rural Areas

It is likely that the same factors which contribute to the success of voluntary hospitalization insurance in industrialized areas operate in the opposite direction, creating difficulties in extension of such services, in rural areas. In a highly industrialized community, the population is concentrated in a relatively small area and a large portion of the population is organized in industrial groups of varying sizes. Industrial organizations provide a ready means of approach to large numbers of potential subscribers. Furthermore, many large industries, convinced of the value of hospitalization insurance in reducing economic and domestic difficulties and the amount of labour turnover, have come to contribute either part or all of the fees for their employees. By means of enrolling subscribers in groups, voluntary hospital insurance plans have been able to reduce the factor of unfavourable selection which almost inevitably exists when subscribers are enrolled individually. In other words, the hospitalization insurance plans are assured of getting a fair distribution of good along with bad risks, which makes it possible to offer coverage at a reduced rate. The cost of administration of group contracts is significantly lower than the cost of administration of individual enrollment partly because of the fact that industrial concerns assume a significant part of the burden of maintenance of records. Through payroll deductions, payments are automatically made at monthly intervals to the insuring agency. Such an arrangement has the dual effect of reducing administrative costs for the agency and of reducing the degree of initiative to be taken by the subscriber in enrolling and maintaining his account. To a large degree, industrial concerns do the recruiting for the plan.

In rural areas, where there is little, if any, industrial organization, the cost of coverage is necessarily higher. This is due to the fact that enrollment must, to a large degree, be done individually, thus increasing the cost of administration, and also because the plan must protect itself against unfavourable selection of persons covered, since persons who are most disposed to illness are more likely to join. The task of recruiting membership in such an area is greatly increased because there are no personnel officers or employees' associations to help with the work of education and selling of the idea of health protection through hospitalization insurance. Furthermore, rural populations are subject to wider fluctuations in income, making it more difficult for residents of such areas to protect themselves continuously over a period of time through purchase of hospitalization insurance.

Another factor of importance which tends to limit the ultimate extension of voluntary hospitalization insurance is the fact that only families in the moderate-income range can afford to carry such protection. It would be hazardous to estimate the peak coverage which voluntary hospitalization insurance may attain. It would appear fairly clear, however, that, particularly in rural areas, this peak will fall far short of general coverage.

The Saskatchewan Plan

Giving full recognition to the importance of health insurance, the Government of Saskatchewan brought in legislation in 1946 providing for the institution of a province-wide system of hos-

pitalization insurance. The program, which was inaugurated on January 1 of this year, enjoys very wide popular support. The residents of the province display a high level of interest in health problems in general and a very keen understanding and appreciation of the value of health insurance.

For an explanation of the attitude of the public on this question, one must look into the development of the province and its community and governmental institutions. The economy of the province is predominantly agricultural, the principal source of wealth being wheat. In its distribution, the population is principally rural, about 80 per cent of the population residing in communities of less than 10,000. The population of some 825,000 is scattered over an inhabited area of about 140,000 square miles, giving an average population density of less than 6 per square mile.

Because of the great distances which separate many of the rural communities from the larger centres, and because communications are frequently very poor during the long winter months, residents of such communities have had to plan very carefully and pool their resources in order to provide minimal services and security. This resulted in the institution, over twenty-five years ago, of a scheme for the provision of medical care to rural areas, which has come to be known as the "municipal-doctor system." By levying a tax within a rural municipality, it has been possible for many of these communities to secure the services of a physician on a contract basis. Such plans have been administered by municipal councils, which, in turn, are elected by the residents of the municipality. Provision of services of this nature has undoubtedly been a significant factor in educating the public to its present level of understanding of the nature and values of health insurance.

Another development of significance in this regard has been the construction of hospital facilities, made possible by the pooling of resources of residents in an area which often includes several municipalities. Other systems which have grown up in the province include local hospitalization insurance schemes and mutual medical and hospital benefit societies.

The development of a province-wide system of hospitalization insurance and its widespread acceptance among the residents of the province is, therefore, a natural outgrowth of the previous decades of application of the principle of health insurance on a local level.

Broadly defined, the objectives of the program are:

1. To remove the economic barrier to adequate hospital care and to protect families from the economic and social effects of severe illness.
2. To introduce factors which would gradually effect an improvement in hospital facilities.
3. To assure efficient use of available facilities.

The Saskatchewan Hospitalization Act as enacted in April, 1946, provides for a province-wide hospital services plan, to be directed by the Health Services Planning Commission, an already existing agency of the Provincial Government, responsible to the Minister of Public Health.

The administration of the plan is carried on by The Saskatchewan Hospital Services Plan (SHSP) an agency established by the Health Services Planning Commission and responsible to it. The Saskatchewan Hospital Services Plan has a number of administrative divisions—for records, accounting, education, etc., and one for field operations. This later function is to maintain contact with hospitals and tax collection offices by means of travelling field representatives, who explain procedures and policies. The section also maintains liaison with field representatives of the Department of Social Welfare in securing care

of aged and homeless and in investigating complaints.

Benefits

The Act broadly defines the form which benefits may assume, but leaves to the Minister of Public Health discretion in determining the scope of benefits to be provided. This procedure has proven to be sound, since it provides sufficient elasticity to allow for the modification or extension of benefits as data are accumulated concerning the cost of service and the feasibility of such extension. Services which are paid for by the SHSP on behalf of beneficiaries admitted as in-patients to recognized institutions, on the recommendation of a duly qualified medical practitioner, may be summarized as follows:

1. Public-ward, or minimum, accommodation, limited only by termination of medical necessity. (Extra cost of private or semi-private accommodation must be borne by the patient.)
2. Operating-room and case-room facilities.
3. Surgical dressings and casts as well as other surgical materials.
4. X-ray and other diagnostic procedures.
5. Anaesthetic agents and the use of anaesthesia equipment. (Professional service required in administering benefits in items 4 and 5 are included only when such persons are employed by the hospital.)
6. All other services rendered by individuals who receive remuneration from the hospital. (The services of private-duty nurses are not included as benefits.)
7. Drugs, biologicals, and related preparations which are of recognized value and clinically approved, including certain essential endocrine preparations and simple vitamin preparations for oral use, are provided. Certain new expensive drugs, (streptomycin, amino acids, penicillin in oil and wax), and patent medicines are not provided.

A wide range of benefits including most of the essentials of good hospital care are thus provided at the expense of the SHSP, effectively assuring Saskatchewan protection against the heavy economic burden of prolonged hospitalization. It is noteworthy that benefits start immediately upon payment of the required amount of tax except in the case of late payment subsequent to February 1, 1947, in which case a month waiting period is imposed. Furthermore, pre-existing conditions are not excluded.

The benefits enumerated above are covered in full on behalf of beneficiaries of the plan hospitalized within the province, where payment is made at an inclusive rate, which will be further described below. The same benefits are paid for on behalf of cases hospitalized outside of the province at usual service rates, up to an average daily maximum of $4.00 per day, for a maximum period of sixty days in a year. There is no restriction on choice of hospital.

Eligibility

Eligible for benefits are all persons who have lived in the province for a period of six months and who have registered and paid their tax. Certain classes of persons may be exempted from taxation and/or benefits, by order of the Lieutenant Governor in Council. These groups have been defined in a manner that would complement government services, either municipal, provincial or federal, which have already been established for the purpose of providing hospital care. Agencies of provincial or municipal government which had previously been responsible for payment of costs of hospitalization for certain individuals, are now responsible for payment of the hospitalization tax on behalf of these same persons. It then becomes the responsibility of the SHSP to pay the cost of hospital care.

Persons who are eligible to receive hospital care at the cost of the Dominion Government, (i.e., Treaty Indians, and veterans within one year of discharge), are exempted from both taxation and benefits. Where persons are allowed only limited care by an agency of the Dominion Government, they are eligible for limited benefits under the Plan, designed to complement the range of services for which they are otherwise eligible.

The importance of assuring equal opportunity to receive hospital care has been the guiding principle in establishing provisions governing eligibility and exemption. Every effort has been made to avoid duplication of coverage for the same condition, and to adjust liability for taxation in an equitable manner.

Registration and Taxation

Of prime importance in the process of taxation and administration of benefits is a record of the residents of the province. This data was accumulated by a registeration started in September, 1946. It was conducted by local authorities, by means of a house to house canvass in cities and towns, and by registration of residents at the municipal office in villages and rural municipalities. In local improvement districts, (where there is no local government organization), this function was discharged by the L.I.D. Inspector.

Taxes are collected by the same agencies. This procedure has proven to be administratively sound. Municipal secretary-treasurers in rural areas know most of the residents in their jurisdiction, have effective channels for the dissemination of information, and are in a good position to offer sound advice concerning policies and procedure. Local municipalities or their agents receive 5 per cent of the tax collected as remuneration for their service.

The Act provides for an annual tax of $5.00 payable by or on behalf of each resident, $30.00 being the maximum for families regardless of size. "Family" has been defined as "the taxpayer and all dependents under 21 years of age." Families whose tax exceeded $15.00 were permitted to make divided payments, a minimum of $5.00 no later than December 31, 1946, and the balance by June 30, 1947.

Penalties have been provided for failure to make payment of the tax but as yet have not been imposed. In general, public response has been excellent, a total in excess of three and one-half million dollars having been collected up to the end of March.

Method of Payment To Hospitals

Hospitals within the province are paid at an inclusive rate (regardless of service rendered in individual cases) arrived at by an objective evaluation of the facilities and services provided by the hospital. This method is an adaptation of the "Units of Credit" system for the payment of hospitals recommended by Dr. Harvey Agnew.* A schedule for the rating of hospital facilities was drawn up by the Health Services Planning Commission in co-operation with the Saskatchewan Hospital Association and is used by Health Services Planning Commission inspectors. Hospitals are paid in proportion to the total number of points assigned at a rate of $.65 for each 100 points assigned for the first 10 days of care, $.60 for the second 10 days, and $.55 per 100 points for each patient day thereafter. Thus, if a hospital receives a rating of 800 points, it is paid at an inclusive rate of $5.20 a day for the first 10 days' care, $4.80 for the second 10 days, and $4.40 per day for care beyond 20 days. This method of payment has proved to be a significant factor in inducing hospitals to improve their facilities. By the end of March, 1947, hospitals in one part of the province have received an average increase in rating of 40 points

*Harvey Agnew, M. D., "A 'Units of Credit' System for the Payment of Hospitals." The Canadian Hospital, November, 1943.

since the time of the initial grading, a fact which would indicate that marked progress is being made in the attainment of the second objective, "to introduce factors which would gradually effect an improvement in hospital facilities."

Although provision is made for hospital care as long as it may be medically indicated, it is important that certain controls be established to guard against abuse. Accordingly, hospitals are required to submit a report on all cases hospitalized more than 21 days, which bears a record of the physician's obsertions and an estimate of the additional amount of hospital care which will be required. Additional reports are required at monthly intervals after 60 days of hospitalization, to be submitted with bills for payment on account. Doubtful cases are referred to the medical consultant, who may request additional information. Special problems may be referred to the Division of Field Operations for further investigation.

Financing

It is estimated that hospitalization of beneficiaries will cost about $6,000,000 during the year, use of hospital services at a rate of about 1.5 days of care per resident being anticipated. This has been the experience of hospitalization insurance plans which were operating in parts of the province before the institution of the province-wide program. A cost of administration of about $600,000 has been estimated for the first year. Services as well as administration are paid out of the Saskatchewan Hospitalization Fund, whose income is derived from taxation and from grants of the provincial government. Government grants will include previous subsidies to hospitals for the care of the general public, provincial relief recipients and cancer cases, a sum totalling $1,125,000. Additional funds as required will be made available by the Province Treasurer from the general revenue of the province.

Comments

Although the Plan has not been in operation long enough to evaluate the effectiveness of the procedures adopted, it is a source of encouragement that over 800,000 persons have registered, (some 315,000 family units), and that collections are approaching the estimated amount. During the first 3 months of operation more than 35,000 persons were hospitalized under the plan. This would indicate that the first objective of the plan, of spreading the burden of hospital care throughout the community and of reducing the economic barriers, is being attained. The active interest of hospitals throughout the province in improving facilities is evidence that strides are being made in achieving the second general objective. Measurement of progress toward the attainment of the third objective of the Plan,—assuring efficient use of hospital facilities—must await a longer period of observation. Experience so far indicates that additional facilities for the care of the aged and chronically ill will be required, so that space in general hospitals may be reserved for those cases requiring active hospital care.

Many problems have been brought into sharp relief which were not anticipated, or not clearly defined at the start. Policies and procedures are being constantly modified in order to guard against similar difficulties in the future. Several of these problems are worthy of note at this time.

Although three months had been provided for tax collection, many persons, either because of bad weather, or because of common human failings, delayed payment of their tax until the last few days in December. This caused a piling up of clerical work required to establish records, which coincided with the initiation of the program in January. In future years, it is planned to conduct tax collection during the months of September, October, and November, in order to coincide with the time other taxes become due, and in order to provide time for the adjustment of records before the start of a new year.

The practicability of the tax schedule has been questioned. The feeling has been expressed that a graduated tax, decreasing for each additional member of the family, would be more equitable than the present provision for a tax of $5.00 for each member of the family up to a maximum of $30.00. Provision has been made in recent amendments to the Act for the possible readjustment of the rate of taxation.

Initially, residents of the unorganized northern part of the province were not included under the Plan, as it was thought that paucity of hospital facilities and inadequate means of transportation, would make it too difficult for them to secure benefits in the event of illness. However, a great deal of interest has been manifested by residents of the north, and by an amendment they may be included on a voluntary basis until such time as administrative methods can be evolved for general coverage of the area.

The program may be viewed as a potentially significant social experiment, in addition to its immediate values in meeting a need of the people of Saskatchewan. Through the system of records which have been established, important data concerning the need for hospital services, the cost of rendering such service, the quality of service and the further need for hospital facilities should be available. Such data will be of value for the Health Services Planning Commission as well as for other governmental units. Furthermore, the Saskatchewan experiment in providing hospitalization for the entire population of a province should forward a valuable source of information for agencies outside the province planning programs of health insurance.

Noteworthy has been the cooperation of the Saskatchewan Hospital Association, the College of Physicians and Surgeons as well as the associations of rural and urban municipalities in defining problems and recommending solutions which would assure efficient operation of this service to the community.

Health Services in Australia

By Wilfred Prest

IN the early years of the century Australia acquired a reputation as a land of advanced social legislation. The depression of the 1930's, however, revealed that Australia had fallen behind Britain and certain other European countries in the provision of social services, and she did not make good her deficiencies quite so rapidly as the sister dominion of New Zealand or even the United States. The reasons for this are partly political and partly constitutional, and it has taken the upheaval of the Second World War to provide both the opportunity and means whereby the gaps can be filled.

EDITOR'S NOTE: Mr. Prest is Professor of Economic of the Faculty of Commerce at the University of Melbourne.

Powers of the Commonwealth

In the provision of health services the powers of the Commonwealth Government were until very recently limited under the Constitution to quarantine matters and the provision of invalid pensions. A system of invalid pensions for those suffering from permanent disabilities was instituted in 1910. Receipt of the pension is subject to a means test and the maximum rate of pension payable is at present 32/6 per week. The total number of invalid pensioners is about 58,000, or 0.78 per cent of the population. In 1912 the Commonwealth also introduced a maternity allowance of £5. Until 1931 the number of claimt ants was about 130,000 per annum, bu-