

Industrial Relations and Social Security

Improving Canada's Health

By L. RICHTER

WHAT is wrong with the health of the Canadian people? Didn't they pride themselves not so long ago on being a pioneer nation, a race of strong physique, a people sturdy and enduring? To those indulging in this rosy optimism the results of the physical examination to which all recruits for military training are subjected, will have been a very unpleasant surprise. Only 55.9 per cent of the recruits were deemed to be specimens of complete physical fitness and rated by the examining doctors class A, while no less than 17 per cent of the group found themselves in the lowest grade, E. Quebec and Nova Scotia were even below the average, but the showing for the whole Dominion was certainly bad enough.

The recruits for military training are as a rule in the prime of life. They represent an age group that is conspicuous for the absence of illness. If their physical condition is found so badly wanting, it is safe to assume that their families will be in even worse shape as older people as well as children are more subject to illness than young men between 20 and 25. This is what gives to the findings of the medical examiners an even greater significance. They indicate that in a large section of the Canadian people health conditions are below standard. This section comprises mainly the low income groups from which the majority of the recruits are taken.

Students of Canada's social problems have been aware of this situation long ago. They have also known that while depressed wages, bad housing and insufficient food are partly responsible for the evil, a major contributing factor has also been the inadequacy of health services available to these people. Compre-

hensive studies undertaken before the war have shown that 25 per cent of all Canadians did not get the medical attention they needed. But nobody at that time seemed to care about it. Now when it has become apparent that through this neglect the country's preparedness for defence has been impaired public interest, nay public indignation, is aroused. Speeches are being made, editorials published, and rumour will have it that even the Dominion government will take energetic steps in spite of the fact that the maintenance of health is a provincial responsibility. The evil is recognized: what can be done to remedy it?

COSTS OF ILLNESS UNEVENLY DISTRIBUTED

Before the war it was a common complaint that we could not get the goods and services which we needed, not because they were not available, but because our economic system was organised in such a way that producers and consumers often did not meet. We had an acute shortage of houses, while the construction industry was lying idle; a surplus of farm products, while city children were underfed. Doctors and patients are exactly in the same position. Those who are in urgent need of medical care must go without it and doctors well trained in their profession are not fully employed as, owing to a faulty organisation, they cannot give their services to those who should have them.

Constructive measures to improve this situation are not facilitated by a good knowledge of the conditions as they prevail in the field of health. Only in recent years have economists and sociologists given some attention to these problems. Industrial engineers can figure out by dollars and cents what it costs to produce a certain commodity or to keep a machine in good repair. But no science of human engineering has yet been devised to tell us what it costs to provide good health services for the community and to keep the individual fit—that is to give

EDITOR'S NOTE: A shortened version of this article written by the Editor of PUBLIC AFFAIRS, appeared some time ago in *Saturday Night*, the editor of which has been good enough to authorize the publication of the full text in PUBLIC AFFAIRS.

The drawing on the cover is by Mrs. Rita Allen, Toronto.

him so much in medical care that he will remain healthy. We are just beginning to ascertain facts and figures which will throw some light on these questions. Only in the last ten years have some major surveys been made in the United States and their results may be used to supplement the findings of a few studies so far undertaken in Canada.

It is not true, as many people think, that the doctors charge too much, that the costs of medical care are too high. They amounted in the United States before the war to \$123 a year per family, and this sum included doctors' fees, as well as the cost of hospitals, drugs and nursing. This was revealed by a nationwide survey undertaken by the Committee on the Costs of Medical Care.

Such averages, however, are very deceptive. They include the millionaire as well as the unskilled labourer. It is more important to see that in Canada a group of urban wage earners, making from \$800 to \$2400 a year the average yearly income of which was \$1400, spent for health maintenance per annum between \$46 and \$83 per family, or between four and five per cent of their total income. The drawing on the cover of this issue shows clearly how greatly even in such a comparatively homogeneous group the outlay for health maintenance varies between persons on different income levels. We are indebted for these findings to the Dominion Bureau of Statistics which in 1938 surveyed 1,135 British and 211 French families in the larger cities throughout the Dominion.

If expenditure was limited to sums such as just mentioned, they could easily be absorbed in the family budget. But once more averages prove to be rather meaningless, for unfortunately charges for health maintenance are not evenly distributed over the population. They depend upon frequency and duration of illness in a family and figures for both fluctuate violently. According to the American surveys, nearly half of all families had no illness at all in the course of a year; but in every third family there is one case of illness, in every eighth family two cases, in every twentieth family three, and so

on. Nobody knows in advance to what extent he may be affected. One can therefore not budget for illness as one does for rent.

The poorer the family the more frequent is illness. Infant mortality, for instance, was five times as high in families with incomes of less than \$500 than in families with \$3,000 income. Moreover, nearly all surveys have disclosed that illnesses in low income families are of longer duration. That again is natural. A person who has to economize in food and fuel is easy prey for infection, and if a family can't afford to give the proper attention to the sick, it takes them longer to recover.

Families with a small income also received, as one would expect, less in medical care than families of greater wealth. The difference between the highest and the smallest income group surveyed by the Committee on the Costs of Medical Care was fifty per cent in the days of hospitalization and forty-one per cent in the number of calls from physicians.

There are two types of families which suffer under these conditions more than others: those with frequent illnesses and those with so-called expensive illnesses, that is illnesses requiring operations and hospital treatment. In both cases the family budget may be entirely upset and a thrifty family thrown into debt. The consequences will be that these families, as far as they do not go on relief, do not receive proper care or that they do not pay for it. In a survey in California it was found that 25 per cent of all medical services was unpaid and the contribution of many a young Canadian doctor to charity will be considerably higher. In the absence of reliable figures for Canada it may be mentioned that in the United States one-third of the physicians had a net income of less than \$2,500—and that in the boom year of 1929.

A POSSIBLE SOLUTION: SICKNESS INSURANCE

If all members of a group are exposed to a risk but only a few of them are likely to be actually affected, the way out of

the dilemma is to spread the risk over the whole group by means of insurance. Why has this method not been tried long ago for the risk of sickness in Canada where more insurance is carried proportionately than in any other country? What are the objections and how valid are they?

The main drawback is that the scheme cannot very well be operated on a voluntary basis. If everybody was at liberty to join or not to join, it is probable that many persons in good physical condition, especially young people, would stay out, while a great percentage of men and women with doubtful health and in the higher age groups would be attracted. The scheme would be overloaded with "bad risks" and might soon get into financial difficulties. This indeed has been the experience of several European countries which have experimented with voluntary sickness insurance on a nationwide scale. In order to avoid this danger two devices can be used which are quite customary, for instance, in life and automobile insurance: bad risks can be made subject to higher premiums or they can be excluded altogether. It is mainly the second method which is employed by voluntary sickness insurance schemes operating in this country. Policies are refused to applicants who on account of poor physique or former illness are likely to become a burden on the fund. In that way the financial stability can be well safeguarded. But the usefulness of sickness insurance as an instrument of social policy is impaired, for it leaves those unprotected who need medical care most, who would favourably respond to preventive measures and could be improved by an early treatment of their ills. There is no difficulty in including them without any examination in an insurance scheme which is compulsory. If the whole working population of a country, as is the case in Great Britain, or maybe all inhabitants of a town, or all the workers of an industry, or even of a big plant, are contributors, the law of large numbers comes in and solves the problem. That majority of the population which has no or few

illnesses throughout the year will easily make up for the comparatively few with an excessive demand for medical care.

A compulsory system for the same reason can easily extend its protection to the families of the wage earners. It need not grade the premiums according to the size of the family as a voluntary scheme must. It will either employ a small additional premium for persons with dependents, or, better still, will introduce a uniform premium for everybody large enough to take care of wives and children. By means of such a device unmarried and childless persons help to maintain large families in good health. That is what a "compulsory" system will do. One should perhaps call it a system based on solidarity.

COSTS OF SICKNESS INSURANCE

A good many people, while admitting the beneficial results of sickness insurance, will contend that the cost involved would mean too heavy a drain on Canada's financial resources, especially during or after a world war. A number of questions are being raised by this argument such as: Do expenditures for building up the people's health constitute a financial burden, or are they essential costs in the same way as costs of maintenance in a railway system? Are improved medical care and preventive services not likely to reduce the outlay for relief and poor-houses? We must leave these questions unanswered, but we may point out that according to a study in Illinois, sickness was a cause or an accompanying condition in from one-third to one-half of all charity cases. We challenge, however, on financial grounds the contention that sickness insurance would mean an additional burden upon the Canadian people.

We referred previously to the fact that Canadian families with an income of between \$800 and \$2400 used four to five per cent of it for health maintenance. If this rate of spending was maintained under an insurance system, if instead of being a statistical average, it was made the basis of a levy, a sort of insurance premium, it could certainly not be said

that sickness insurance would cause new expenditures. It is true that the burden would be distributed among the wage earners in a different and, as we think, in a more just manner than before. It is also likely that employers and government would help them to carry the load. But if the levy does not exceed five per cent of the wage earners' income—and according to European experience this is altogether feasible—no new costs would be imposed on the Canadian economy which could hamper its competitive efforts in the world markets. Just in passing it may be noted that our chief competitors, England and the United States, have gone much further in imposing social insurance "burdens" on their economy than Canada.

ATTITUDE OF THE MEDICAL PROFESSION

The idea of compulsory sickness insurance has met with the strongest opposition, not from the workers and their unions, not even from manufacturer associations, but from the organised medical profession. It is no over statement to say that if it had not been for the fight put up by the American Medical Association, the Congress of the United States would have added sickness to the contingencies of old age and unemployment covered in the Social Security Act. Likewise the medical organisation in British Columbia is said to be not altogether blameless for the failure of the province's sickness insurance plan.

For Canada as a whole the situation is somewhat different. The Canadian Medical Association, more progressive than her American counterpart, has long recognized the principle of compulsory health insurance and has laid down the rules and conditions which in the Association's opinion are essential for its effective operation. This official stand of the organisation reflects probably the attitude of the medical profession throughout the country. Opponents are mainly to be found among specialists and older physicians with a secure practice, while the younger generation of doctors appears to be overwhelmingly in favour. This as well as

the position taken by the Canadian Medical Association are most valuable factors: for a harmonious cooperation of the medical profession is an indispensable prerequisite for the success of any compulsory scheme.

What the physicians are afraid of is regimentation of the insurance doctors by a government bureaucracy and reduction of the medical income. The first danger which seems not very menacing could be well met by using the experience of other countries in the administration of social insurance schemes and adapting it to the special conditions prevailing in Canada. The preservation of the people's health is a responsibility of the government as well as of the medical profession and an arrangement agreeable to both parties should find no insurmountable obstacles.

More serious is the second objection. The insurance scheme will undoubtedly have some influence on the scope and composition of the doctors' practice. If once more we look abroad for enlightenment, we may expect a certain redistribution of patients in favour of the younger doctors. It will not go very far if the scheme is limited, as it should be, to those who cannot very well take care of themselves, that is to the lower income groups. If, in addition, the previous expenditure of this group for the services of physicians and surgeons, expressed in a percentage of the family income, is used as a basis for the doctors' remuneration, if further government grants could be made available for specified cases, the medical profession as such would not incur losses, though the individual doctor may make more or less than hitherto out of his "poorer" cases.

Unquestionably health insurance will mean certain changes for doctors as well as for patients. Friction may be unavoidable until both parts have got accustomed to the new conditions. England's doctors have had their fights with government and insurance funds at the time the scheme started. But when a few years ago Dr. Douglas Orr, a Chicago 'psychi-

atrist went to England to interview the man in the street, as well as the panel doctor and government officials on the subject of health insurance he heard many critical opinions, many proposals for improvement, but—as he tells us in his interesting book—he did not encounter anybody who thought that the English people could do without health insurance. It has become an integral part of England's social life.

HEALTH SERVICES IN RURAL DISTRICTS

Sickness insurance is a device meant mainly for wage earners and is most easily applied in urban districts. The premiums are deducted from the insured person's wages and transmitted to the insurance fund in the form of stamps or otherwise. All doctors and hospitals in the districts can if they like cooperate in the scheme and the patient has the right to choose among them.

Such a scheme leaves the farmer—as well as other non-wage-earners of small income—unprotected, and would need considerable modification in order to be operated in rural areas. But the underlying principle, the idea of providing by means of cooperative efforts services which the individual member of the group could not afford is in the country of even higher value than in the city and town. This is especially true for thinly populated areas with unfavourable communications. They do not easily attract doctors as the performance of of medical service is difficult and time-consuming and the reward meagre. Where in addition the population is poor, it might be altogether impossible for the doctor to make a living if he had to collect his fees from every patient.

It is in areas of such a character in Saskatchewan and Manitoba that the principle of cooperative medicine or social insurance, still hotly contested in other parts of the Dominion, has been put into practice for a good many years. It is not known as insurance: government officers and farmers refer to it as "the municipal doctor system" and they speak about it with great pride. It makes

available to the inhabitants of a rural municipality which chooses to adopt the system free services of a medical practitioner who is appointed and paid a fixed salary by the municipality. He devotes his full time to curative and preventive work without making charges except in a few meaningless cases. Hospitalization is also free under the scheme. The necessary funds are raised by a special levy on all ratepayers and collected together with the municipal dues.

The municipal doctor system has met with remarkable success and has served as a model for many similar organisations throughout the American continent. It is one of Canada's most noteworthy contributions to the progress of social medicine.

In a recently published report about the Manitoba scheme it was pointed out that as a result of its operation the areas concerned boast of fairly complete immunization programs against diphtheria and smallpox and that their death rates for mothers and children are more favourable than for the rest of Manitoba. One is reminded of the Chinese doctor who, according to the story, was paid only as long as his "patients" did not get ill.

Another interesting feature of the scheme is its remarkably low cost. To provide a population of 15,000 persons with medical and hospital services (without drugs) amounted in Manitoba to \$75,000 a year of \$5.00 per person.

THE TIME FOR ACTION

The final question arises: should health insurance be introduced as long as the war is on?

Weighty arguments seem to speak against it. The number of available doctors which even in peace-time is hardly adequate in proportion to Canada's population has been further reduced by the demand of the armed forces. The public authorities who will have to play their part in organising the new services are overburdened with other duties and not in a position to give the necessary attention to such an important new task. The constitutional problem needs clari-

fication, as under the B.N.A. Act matters of public health come under the provincial government, thus barring the way for an active participation of the Dominion.

Not to start operation while the war is on does not mean to be idle. Nothing would be more wrong. The soldier coming home from the battle front, the men and women who have devoted all their energies to the war effort are not likely to acquiesce with the conditions as they prevailed hitherto. They may put up with certain inequalities of opportunity, with an uneven distribution of wealth, but they will demand equality in the use of the essential health services, they will contend that safeguarding the people's health is no less a sacred obligation of the state than the protection of property.

It will help the war effort and strengthen civilian morale if people know that this is not a pious hope. All the necessary preparations should be made now during the war so that the plan can be put in operation as soon as peace comes.

Owner-Worker Co-operation In War Industries

Employer-employee relations in Canadian industry must be improved for the sake of increasing and accelerating war production if for no other reason. This was the gist of a remarkable address delivered at the annual convention of the Canadian Manufacturers' Association by Mr. Elliott M. Little, Director of National Selective Service and in private life General Manager of the Anglo-Canadian Paper Company. This speech may mark a turning point in the history of industrial relations in Canada. Hardly ever before has the right of labour to organize in a union of their own choice and to meet employers on a basis of full equality been stated so bluntly by a representative of the Canadian Government. So direct and uncompromising was his declaration that—to quote a leading Montreal newspaper—"to some (of his audience) it came evidently as a shock and a surprise." Some of the chief

passages of the address may be repeated verbatim:

While the Government could do much to help in such ways as finding and training workers, "we cannot regulate the efficiency in your plants", Mr. Little declared. "But all the minutes that are wasted in our plants are minutes donated to Hitler. Those minutes must be salvaged," he insisted . . . "The answer is in getting your employees to help you run your job," . . .

"You must go actively after their advice and the full use of their experience. They have intelligence and more than you give them credit for. Use it."

"Employer-employee relations can and must be improved. Without them maximum efficiency cannot exist. . . To those who don't want good relations or don't appreciate their value, I say the country cannot afford to have you as an employer at any time, particularly in the war time. You must change your ways.

"The suggestions which come from the men in the plant must not be shelved. The man on the machine or at the bench is just as resourceful, ingenious, more often than not, as the man who hires and fires him. Such co-operation is simply a matter of asking your men to accept some of the responsibility for seeing that a job is done." . . .

Asserting that the problem of personnel relations was a job for management, Mr. Little declared that "employers and employees have got to quit acting like foreigners to each other." He professed indifference as to whether a plant set up a production committee, a plant council or some other management-employee plan, but declared that management must be sincere and labor must be given equal representation, elected by secret ballot. In case of deadlock, final decision rested with the management, he said.

"This co-operation must not be made the tool of either labor or management," he warned. "I would remind you that the Government of this country has endorsed the principle of collective bargaining. You cannot use the sincere co-operation of labor to erect a barbed wire fence against trade unions. And unions must not use your co-operation as the open door to a closed shop." . . .

Settlement of Labour Disputes in Newfoundland

Labour relations have offered hardly any problem to Newfoundland in peace time but since the Old Colony has become a strategic point of such importance, since garrisons have been established there and fortifications and airfields, built in various parts, this picture has changed and the Newfoundland government has been obliged to issue a number of regulations for labour. They are very similar to those issued in the United

Kingdom under the Emergency Powers (Defence) Act.

Strikes and lockouts are forbidden in connection with any trade dispute until twenty-one days after the dispute has been reported to the Commissioner of Public Utilities. Only if the Commissioner in the meantime has not referred the dispute to settlement is the right to declare a lockout or to take part in a strike revived. For defence workers still stricter rules apply. Disputes between them and their employers which cannot be otherwise settled must be submitted to a Trade Dispute Board of three members. The award of the Board is binding upon employers and employees and may be made retroactive.

The Commissioner of Public Utilities is also given power to direct any person in Newfoundland to perform such services in that country as he considers a person capable of performing. The terms and conditions are to be fixed by the Commissioner who must have regard to the usual rates of pay for the performance of these services.

Unemployment and Health

It has been repeatedly stated that health conditions in Great Britain are, in spite of food shortage and other war conditions more favourable than before the war. According to an address given by Sir Alexander Macgregor, the Medical Officer of Health for the City of Glasgow, this is largely due to the absence of unemployment. Speaking before the Society of Medical Officers of Health in London, Sir Alexander explained that unemployment was generally recognised to be a fertile source of sub-normal health or of actual mental or bodily ill-health. Where social conditions were such that work and wages were plentiful,

a reduced incidence of these ill-defined mental and physical disorders that were apt to be engendered by an aimless life might confidentially be expected. The evidence available supported this view. If to these social advantages be added a high purpose in life, the general effect was such as to afford an explanation of the fact much commented upon, namely, the surprisingly small incidence of neurosis in spite of conditions that might have been expected to produce them in considerable volume. Present-day conditions had, in fact, greatly reduced the prevalence of these ailments, especially among the male population. What this experience meant was that progress towards social security was progress towards better health.



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