Saskatchewan Medical Care Insurance Scheme Appraisal of Current Position

A. D. KELLY*, M.B.

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The current situation in the province of Saskatchewan is intrinsically interesting, and an appraisal may be helpful to doctors in the United Kingdom who are being actively recruited to serve in that province.

Basis of Agreement

The crisis of July, 1962, was terminated by the Saskatoon Agreement and by the passage of twenty-two amendments to the Medical Care Insurance Act designed to make it more tolerable to the medical profession.¹ The important changes in the legislation provided for the right of doctors to practise "outside the Act"—i.e., to have no direct dealings with the Medical Care Commission; for the right of patients to claim reimbursement from the Commission for medical accounts incurred; for the recognition of certain "approved health agencies," which has ensured the survival of the profession-sponsored plans of voluntary prepaid medical care, and for more adequate representation of the profession on the Medical Care Commission. The Agreement recognized the principle of freedom of choice of patient and doctor; the right of doctors to determine the place and nature of their practice; the fee-for-service method as the usual way of providing professional remuneration; and stated that the Government had no intention of establishing a full-time general salaried Government medical service.

Brisk Demand

Fifteen months later, in October 1963, the 935,000 residents of Saskatchewan were seeking and receiving their medical care from the 947 registered and resident physicians, of whom 750 were in active practice. The current gross physician: population ratio of 1:910 is more favourable than the province has experienced in recent years and is not dissimilar to that which exists in the United Kingdom. The demand for service has been brisk, a finding which is characteristic of any new system of insurance, and it is a reasonable generalization to state that the public accepts the service and uses it freely. Doctors are busier than ever, and, with the remuneration of most of them fixed at 85% of the minimum provincial fee schedule, it seems likely that medical incomes will be appreciably higher.

Losses and Gains in Manpower

The tempestuous year 1962 demonstrated a very high degree of mobility in the medical population, since there were 228 arrivals and 239 departures, which, with fifteen deaths, produced a net loss of 26 registered practitioners by the end of the year. In 1963 (to 1 October) the trend has been reversed and 130 new registrants have been added. Departures have been fewer (47) and the medical manpower force has been augmented by a net gain of 83 registered physicians. Of the new registrants in the current year 25 qualified in Canada, 74 in Britain, and 31 at foreign schools. The medical population of the province now consists of 512 doctors educated in Canada and 435 whose academic training was

obtained elsewhere. The recent new registrants have been predominantly general practitioners, and one gains the impression that specialists in most categories are proportionately fewer, an impression which is supported by the registration of only seven Canadian and six British specialists in 1963. These figures do not sustain the prediction that a mass exodus would take place. However, a good many individual physicians have found conditions distasteful and have left for more congenial regions. The vacancies have been more than filled by newcomers, not necessarily of equivalent professional qualifications. The turnover of the past two years has produced some disruption of service and the loss of experienced doctors leaves the province the poorer.

Community Clinics

A phenomenon which is not unrelated to the political climate of the embattled province has been the establishment of consumer-sponsored community clinics at fourteen centres, now employing 39 doctors in groups which vary in size from one to eight. This development is supported by adherents of the Government and others who desire to have their medical services provided "inside the Act." The community clinic movement is regarded with some apprehension by many doctors who see in it the beginning of a salaried service and who state that the promotional methods of the lay sponsors verge on canvassing and solicitation for patients. These critics also point out that the proposed sharing of the expected surplus at the end of the year between medical staff and non-medical sponsors is ethically unsound. Physicians in Britain are being invited to accept appointments in these community clinics under terms which defray transportation expenses and provide a starting annual salary of the order of \$10,000-12,000, depending on professional qualifications and seniority. In considering the attractiveness of such offers of employment doctors in the United Kingdom should be aware that they would be aligning themselves with a system of practice which runs counter to the views of the organizations of the profession in Saskatchewan and that a degree of professional isolation may be a deplorable, but actual, consequence.

Isolated Areas

The Medical Care Insurance Commission is itself also seeking doctors in Britain not for employment in community clinics but for assignment to areas where the residents indicate their desire to have a doctor and where the need is established. Many of these practices are in relatively isolated communities formerly served by physicians working under municipal contract, a system which has been superseded under the Medical Care Insurance Act. The terms include a choice between a fixed-salary contract (minimum \$12,000 per annum) or a fee-for-service contract with guaranteed minimum of \$10,000 per annum; transportation to Saskatchewan for the doctor and his family; and a loan of \$2,000 to aid in the establishment of practice. There are unquestionably still areas of need in Saskatchewan where doctors can render useful service.

Without appearing too cynical, it is legitimate to state that a posting to many such needy communities has not proved attractive to native Canadians mainly because amenities are scanty. Furthermore, we believe that it is a basic medical freedom to decide where

* General Secretary, the Canadian Medical Association.

¹ See *B.M.J.*, 1962, 21 July, p. 174, and 28 July, pp. 249 and 251.

one desires to live and work, and the uncertainty of ultimate destination, which is characteristic of such offers of employment, constitutes, in my view, the greatest handicap to satisfactory settlement. Assisted passages and guaranteed remuneration should be regarded as inducements which are capable of proving expensive obligations, and in some circumstances they may impair the freedom of movement of the doctor who assumes them. I am told that already certain doctors who accepted salary contracts are converting to private practice as their contracts expire. My advice to colleagues in Britain interested in practice in Saskatchewan or anywhere else would be to travel at your own expense, examine the openings, decide where you would be happy to live and pursue a professional career, hang up your shingle, and only then send for your family.

I have remarked that general practitioners constitute the majority of recent medical immigrants. General practice on the Canadian prairies demands a degree of self-reliance and professional training, particularly in obstetrics and minor and traumatic surgery, which is absent or deficient in many applicants interviewed in the U.K. Appointment to the medical staff of a hospital is almost essential but is not automatic. It is based on a record of training, competence, and experience such as to constitute reasonable assurance that the incumbent is capable of carrying out the medical responsibilities which will confront him even in the twenty-five-bed community hospital where he may be the only doctor.

Increased Support for Voluntary Schemes

The atmosphere in Saskatchewan may fairly be described as politically charged. The protagonists in the recent struggle cling tenaciously to their beliefs and many people continue to oppose the Medical Care Insurance Act on ideological grounds despite the fact that they use it as the only service available. A measure of such opposition may be taken from the figures of the two doctor-sponsored voluntary prepayment medical plans which in June 1962 had 290,000 persons enrolled and in October 1963 533,204, a figure which represents more than half the population of Saskatchewan. The tangible benefits of subscribing to a voluntary

plan in the face of a compulsory plan are very few indeed, and it may be taken that this remarkable increase in enrolment indicates a substantial preference for the voluntary approach.

The financial status of the Saskatchewan venture into compulsory health insurance is as yet not determinable. The first annual report covered only a few months of 1962 and the figures of revenue and disbursements for the calendar year 1963 will not be available for several months. One significant fiscal development, however, occurred in September 1963, when the Government announced that personal premiums, which were planned to provide about one-quarter of the revenue of the fund, were to be reduced by 50% for 1964. As might be anticipated, this announcement was hailed by many as evidence of economical operation, financial soundness, and a buoyant economy, and by many others as motivated by political considerations with an eye on the provincial election which must be held in 1964. I believe that unexpectedly high revenues have permitted a substantial tax reduction which is a tried and true method of wooing any electorate.

Voters Unenthusiastic

Although I was determined in this account of medical life in the heartland of Canada to avoid references to politics, I find that this is almost impossible in any Canadian discussion of health insurance under Government auspices or, as our journalists term it, "Medicare." This disclaimer permits me to inform British readers that during the past year this country has experienced a federal general election and four provincial elections. In each of these campaigns candidates of the party in power in Saskatchewan have pointed out with pride to their medical care plan and promised, if they formed a Government, to introduce a similar plan federally and/or provincially. The voters did not respond to this appeal, and there is little prospect that in the foreseeable future Saskatchewan-style health insurance will become the prototype elsewhere in Canada. With due allowance for any inherent bias, I present these facts, views, and interpretations as an intelligent reader's guide to Saskatchewan.

G.P.'s Role in Hospital of Future

A meeting of the Members was held at the Royal College of Physicians last November to discuss "Increasing Specialization in Medicine, with Particular Reference to the General Practitioner in the Hospital of the Future." Sir CHARLES DODDS, P.R.C.P., was in the chair. Speakers were Sir JOHN RICHARDSON (St. Thomas's Hospital), Dr. G. S. C. SOWRY (Edgware General Hospital), Dr. J. H. HUNT (Hon. Secretary, College of General Practitioners), Dr. H. G. MILLER (Royal Victoria Infirmary, Newcastle upon Tyne), and Professor W. S. PEART (St. Mary's Hospital). About 100 Members attended.

G.P. and Hospital

Sir JOHN RICHARDSON said that there could hardly be any discussion concerning the future of the profession which ignored the trend to specialization in hospital practice and the problem of the general practitioner's relationship to the hospital. He proposed to speak of this latter subject and to leave the question of increasing specialization to later speakers. He held the view that for those whose practice was largely

in people's homes such hospital contact was essential, and this necessity would remain however general practice developed in the future. In trying to establish the size of the problem he had sought the help of Sir George Godber, who had informed him that on 30 September 1961 there were 2,318 general practitioners working in cottage hospitals and paid from the staff fund, and 4,064 paid as clinical assistants or for sessional work of some kind in hospitals. Sir George had concluded that the proportion of doctors engaged in general practice who carried out some kind of hospital appointment was about one in four. The Gillie Report gave figures up to the end of September 1962. These showed that the number of practitioners working in paid appointments in hospitals, excluding those attending patients in G.P. hospital units, was at that time 3,408.

Prospects of Expansion

There were therefore already a lot of general practitioners working in hospital, but the question arose as to whether the hospital

services could absorb many more practitioners on a part-time basis. If such facilities were to be extended it was essential that the arrangements must be equally acceptable to both sides and that the practitioners should be satisfied with the financial provisions made for them. There should be no justification for cries of cheap labour or any feeling on either side that a favour was being conferred.

Recent surveys had shown that the trend in practice was towards partnership or the formation of groups, and this would surely make it easier for doctors to work part-time in hospital if they so wished. Sir John emphasized that the advantages which accrued to the general practitioner from working in hospital were different from those which he obtained from postgraduate education in the form of lectures and demonstrations. The more fundamental benefits of actually working in hospital required a major and sustained personal effort. They were attainable in no other way, since they could only derive from doing useful work in a hospital team which was employed on a thoroughly professional job in an atmosphere of up-to-date vitality. Perhaps all practitioners would not wish to do this sort of work; this could only be shown by experience. What was clear was that those who did wish to do it ought to spend a minimum of two years in the registrar grade after completing their resident appointments.