logical Medicine of the University of Mysore, and in 1956 13 were admitted to the two-year course. This Institute is broad in its concept and ambitious in its aims, which cover not only negative aspects of mental health but as Rajkumari Amrit Kaur, formerly Minister of Health in India, has stated: "The positive aspect, namely, that of training the normal man of average mental calibre to gain control over his emotional equipment and intellectual power so as to promote the growth of an integrated personality." The task is large but is being tackled with so much enthusiasm that it is inconceivable that what is accomplished can be less than important.

In addition to these institutes, there is one for leprosy, and there are the Indian Cancer Research Centre, a Virus Research Centre at Poona, an Institute for Drug Research at Lucknow, and it is proposed to set up institutes of biology and for research into occupational health. Mention of the Institute for Drug Research brings to mind the demands which have been voiced by many sections of the Indian people for a revival of the indigenous systems of medicine—the Ayurvedic and the Unani—and of homoeopathy. The Government of India has appointed committees to study and report on these systems, and research aimed at assessing their various merits is in progress. Current opinion and pronouncements from leading Indian politicians indicate that it is unlikely that India will reject modern scientific medicine on any significant scale to return to the older systems and the whole pattern of recent medical developments supports such a view. Nevertheless, investigations are proceeding to determine to what extent indigenous systems can be developed and regulated for medical relief in the country, and in the interests of humanity it is to be hoped that in this as in all medical matters politicians and administrators can be constrained to accept facts instead of expressing and attempting to legislate on the basis of their personal opinions.

Among the institutes, as in the case of the medical colleges, those which have been long established continue to serve, and to serve well, the people of India and medical science generally. At Conoor, South India, the Nutrition Research Institute, originally founded by Sir Robert McCarrison, continues with an output of first-class work which will compare favourably with that from any similar institute in the world. The All-India Institute of Hygiene and Public Health, Calcutta, was established in 1933 and aims at the provision of first-class advanced instruction in the methods of preventive and social medicine, suited to India's peculiar problems. Its large staff includes eight professors. The Institute is affiliated to the University of Calcutta, from which its students may obtain Diplomas in Public Health, Maternity and Child Welfare, Dietetics, Industrial Health, Nutrition, the degree of Doctor of Science (Public Health), and the Mastership in Engineering (Public Health). Near Calcutta the Institute runs two rural community controlled practice units which are used both for teaching and for research. Long-established Indian research institutes which have gained international recognition in the field of preventive health include the Central Research Institute, Kasauli, the Haffkine Institute, Bombay, and the King Institute, Guindy.

Indian Council for Medical Research

No mention of medical institutions in India would be complete without paying tribute to the Indian Council for Medical Research. It would be presumptuous to attempt to review its achievements within an article of this kind, but it would only be just to say that through its conferences, publications, and the active support it gives to innumerable workers its stimulating influence permeates the whole of the Indian subcontinent.

Special tribute must also be paid to the work of the World Health Organization in India. It is everywhere active, supporting investigations into the causes of ill-health and providing measures to prevent it. Its special concern is with tuberculosis, nutrition, and maternity and child wel-

fare, and for the latter it has given its support in staff, in funds, and in kind to centres throughout the country. It is currently engaged in tackling the important problem of preventing anaemia, which causes so much ill-health, particularly among pregnant women in India and throughout the tropics.

The impression gained by visiting a large number of Indian medical establishments is one of tremendous and enthusiastic development, of confidence in the future and in the value of continuing co-operation between India and Britain in medical training and research, and of genuine appreciation of the medical legacy of the past era. Mistakes have been made, but there appears to be a very general feeling that the past is the past and that to err is human. Between British and Indian great mutual respect and good will have grown up, and this fund of good will is everywhere apparent in acts of kindness and hospitality which are continually being shown to the British visitor to India.

The experience on which this paper is based was obtained during a recent visit to India as a consultant to W.H.O., to whom I wish to express my gratitude for the facilities provided and for permission to publish. I wish also to thank Colonel M. L. Ahuja, Medical Adviser to the Indian High Commission, for much helpful advice and information.

THE PATTERN OF HEALTH ORGANIZATION IN CANADA

BY

ALEX. MAIR, M.D., D.P.H., D.I.H.

Professor of Public Health and Social Medicine, University of St. Andrews

AND

GORDON H. M. HATCHER, M.D., D.P.H.

Special Lecturer in Medical Care Administration, Department of Public Health, University of Toronto

The problems besetting young medical graduates in Great Britain to-day are well known. It has become increasingly difficult for them to enter general practice. Hospital registrars remain dissatisfied and unhappy, while the profession itself is involved in yet another of its recurring crises, in which it would appear that financial readjustments to inflationary trends can only be achieved by prolonged and acrimonious debate with politicians, and, what is perhaps more deplorable, by a further loss of public esteem. It is indeed a sad day when the affairs of the medical and dental professions become the subject of a Royal Commission (*Manchester Guardian*, February 21, 1957). Moreover, the appointment of the Willink Committee (*British Medical Journal*, 1955) "to estimate, on a long-term basis and with due regard to all relevant considerations, the number of medical practitioners likely to be engaged in all branches of the profession in the future, and the consequential intake of medical students required" would seem to add still further to the feeling of uncertainty with regard to the future of the profession in this country.

During a visit by one of us (A. M.) to Canada a few years ago, it was thought that a brief outline of the medical services and opportunities of that country would be of particular interest to colleagues at home. In the prevailing circumstances, and the renewed interest in emigration, particularly to Canada, it would seem appropriate to tell this story now. We certainly do not wish to underestimate the many difficulties confronting the medical practitioner in establishing himself in Canada. Nor, as modern Jeremiahs, do we seek to lament, "Is

there no balm in Gilead ; is there no physician there ? " Rather, this is an attempt to illustrate not necessarily a better but a different approach to medicine from that practised in Great Britain.

Canada in 1956, including the Yukon and North-west Territories, had a population of 16,080,791, mostly in the ten provinces of Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick (the four Atlantic Provinces), Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia. Medical and health organization, as in Britain, has been influenced by traditions of social and governmental organization as well as by the evolving pattern of disease. Public health organization, as distinct from hospital and general-practitioner services, had its origin at a time when communicable disease and sanitation were of paramount importance. It is therefore not surprising that in public health Canada has followed very closely the outline and spirit, even to the extent of reflecting the actual wording, of the English Public Health Act of 1875.

In its governmental organization it would not be entirely correct to liken a Canadian province to Scotland or Northern Ireland, each with its own measure of self-government or devolution. Rather, the relationship of the various provinces is more akin to that of the United States, where the Federal Government legislates for broad national or general purposes, while the constitution provides individual states (or provinces) concurrent or even exclusive jurisdiction over specified matters, including education and most health services developed to date. Constitutionally the Dominion or Federal Government is charged with the major governmental tasks, and it is only by subsequent judicial interpretation that the individual provincial governments have assumed unto themselves greater administrative and judicial responsibilities. This is the exact converse of the United States constitution, where the legal powers are vested in the individual states, but judicial interpretation has later extended the powers of the Federal or central authority.

Most important, the Federal Government holds the major powers regarding taxation and thus acquires more revenue than the Provinces. One other major difference is that in Canada, as in Britain, legislative and executive powers of government operate through the cabinet or parliamentary system, whereas in the United States the President or State Governors and their administrations exercise administrative functions separately from the legislative functions of the Federal or State Congresses. Canada has an appointed Upper House or Senate like our House of Lords, although it has no hereditary nobility. There is no upper chamber in most of the provincial governments. The upper chambers can hold public hearings on proposed legislation passed by the lower chambers. Members of the upper chambers are appointed for life by the Crown on recommendation of the government of the day, an alternative to the hereditary principle which, it is believed, finds increasing support in different political parties in Britain.

Before proceeding to describe the governmental health organization it must be emphasized that most of the health and medical services in Canada are not directly operated or even very closely supervised by the Central Government. The pattern of their services can be classified under four administrative headings: (1) public health services ; Federal, provincial, and local ; (2) hospital services ; (3) private practitioner services, both general and specialist; and (4) independent voluntary health agencies.

Public Health Services

Federal

Historically most public health responsibilities in Canada have developed as provincial activities. The only mention of health in the British North America Act of 1867, which forms the basis of their Constitution, assigned charitable institutions to the Provinces, and marine hospitals, quarantine, and immigration to the Dominion. The Federal Government has since developed extensive responsibilities for food and drug administration and control ; narcotic drugs ; veterinary matters ; the health of Civil Servants, immigrants, merchant seamen, Indians, and Eskimos ; and sanitary conditions in interprovincial and international transport.

Most of these activities are concentrated within the Department of National Health and Welfare, the health portion of which was established in 1919. The major responsibilities for bovine tuberculosis and brucellosis continue to be the concern of the Department of Agriculture. The health of members of the armed Forces falls into the sphere of the Department of National Defence, while the medical care and welfare benefits of ex-Service men suffering from disabilities connected with their service come under the Department of Veterans Affairs.

Vital statistics are collected locally and provincially, and their compilation later into national figures is effected by the well-known Dominion Bureau of Statistics, which is within the Department of Trade and Commerce and not the Department of National Health and Welfare.

In the Act establishing the Federal Department of National Health and Welfare in 1944 this Department is charged with the responsibility for the health, welfare, and social security of the people of Canada, except for those matters within the exclusive jurisdiction of the provincial governments or which are by law assigned to other Federal Departments. In line with the spirit of this Act and the assumption of Federal health responsibilities, the Dominion Government began in 1948 a major programme of special grants-in-aid to the provincial health departments, and through them to hospitals, and to other health agencies within the provinces in order to improve and extend medical and health services. These grants are two or three times as large per capita as the corresponding health grants in the United States, but they still make up only a small proportion of the total provincial and local health expenditure. These measures were announced as the first step towards a nation-wide health insurance programme to be administered by the provinces, and financed jointly by the Dominion and each of the provinces. This programme has been discussed for many years, but its implementation has not yet really begun. These grants commit the Dominion Government to joint planning with each province to meet the major health needs within that province. In this way a national health policy is gradually being evolved with the Federal Government assuming a greater role in the health services of the future.

The first step in the national health insurance programme will probably begin early in 1959. This will likely be an extension of insurance for hospital care (excluding the services of doctors both in and out of hospital) for virtually the whole population of such provinces as enter into such an agreement with the Federal Minister of Health. The Federal Government legislation* authorized contributions of approximately 50% to hospital insurance plans administered by the provinces.

The three western provinces and Newfoundland already have programmes in operation that will likely require only some modification to meet the requirements of Federal financial aid (Hatcher, 1955). Other provinces, notably Ontario, the largest (one-third of the Canadian population) and most highly industrialized, have recently passed the enabling legislation and are negotiating the terms of Federal assistance. The

*Bill 320, 5-6 Elizabeth II. The House of Commons of Canada. King's Printer, Ottawa. April, 1957.

election in June, 1957, of Canada's first Conservative Federal Government in 22 years may lead to some changes in detail and timing, but now seems unlikely to change the basic pattern of these developments.

The terms offered by the Federal Government after a recent Dominion provincial conference, and embodied in recent legislation, include: (1) that a majority of the provinces with a majority of the Canadian population must participate; (2) that virtually the entire provincial population must be included; (3) that deterrent cash payments by hospital in-patients must be small enough not to cause financial hardship; and (4) that within a reasonable time out-patient laboratory and radiological diagnostic services for all income groups must be offered together with the hospital in-patient services, to help prevent unnecessary hospitalization.

It should be emphasized that the majority of Canadian hospitals are under voluntary boards, and even the local government hospitals do not usually employ salaried clinical staffs. These arrangements for hospital insurance have not and probably will not change the voluntary nature of the hospitals, except that most of their increases will not come through the hospital insurance programme. There will undoubtedly follow increased rationalization of hospital services, with attempts to meet minimum standards of service in all areas based on regional planning. Even with these developments, this does not mean that Canada will necessarily follow the pattern of the National Health Service in this country. Indeed, considering the extent to which private non-profit-making and commercial health insurance agencies have succeeded on a fee-for-service basis in providing cover in case of illness† it is unlikely that it would. Probably some years will elapse before the Government moves to provide physicians' services as additional benefits.

Provincial

Most Canadian Provincial Government health services are integrated into a single health department headed by a provincial cabinet minister. It is interesting to recall that the Province of New Brunswick was the first government in the British Empire to recognize the public importance of health by appointing as early as 1917 a cabinet minister as head of such a department. This example was followed by the Federal Government shortly thereafter. Among the major responsibilities of Canadian provincial health departments are the following:

1. *The licensing, supervision, and payment of money grants to all public general hospitals within each province.*—Practically all their general hospitals come into this category.

2. *Finance and in many cases the actual operation of the mental and tuberculosis hospitals in each province.*—In this regard one perceives great similarities in 1 and 2 to the responsibilities of local authorities in this country prior to the advent of our National Health Service in July, 1948, except that the province rather than the city or county is the "authority."

3. *The provision of specialist consultation services—for example, pathology, bacteriology, and serology—and the direction of general policies for environmental sanitation and the prevention of disease are carried out by provincial public health departments.*—Some of these responsibilities are delegated by the province to local health departments, especially health visiting and sanitary inspection. In all the provinces, except Alberta and Ontario, medical officers of health and health visitors are provincial "civil servants." In these two provinces and in all the large cities public health staffs are local authority employees as in this country.

4. *Provision of special assistance to private practitioners, especially in isolated areas, assistance in obtaining medical and health services to needy families, and the development of adequate medical and hospital services for the whole population.*—This miscellaneous category includes the provision of provincial laboratory and diagnostic services, which may be used by practitioners free or for a nominal charge. It also provides certain special medical-care programmes such as insurance for hospital

bills in the Provinces of Newfoundland, Saskatchewan, Alberta, and British Columbia, and for physicians' services in parts of two provinces. It provides medical care for the indigent population (our old Poor Law recipients) in two provinces (Newfoundland and Saskatchewan). In four others (Ontario, British Columbia, Nova Scotia, and Alberta) the government has contracted directly with the professions to provide this care. Special provision (hospitalization and/or physicians' services) is also made for all income groups for certain forms of chronic illness such as cancer in both Alberta and Saskatchewan, for poliomyelitis in most provinces, and for maternity hospitalization but not for physicians' services in Alberta.

Special mention should be made of Canadian workmen's compensation programmes. These are operated separately from the provincial health department in all ten provinces by government boards or commissions. Funds are collected entirely from employers. A workman is not entitled to sue an employer for damages arising out of industrial illness or accident. In turn the Canadian disabled workman is entitled to cash compensation in lieu of loss of wages, based on two-thirds to three-quarters of his average earnings prior to disablement subject to a maximum that is above average wages in most provinces and to a minimum which is above subsistence. Moreover, he is also entitled to comprehensive medical treatment services, including some of the most advanced rehabilitation programmes in Canada. He may choose any private practitioner, but later, depending on the disability, the Workmen's Compensation Board may refer him to a specialist or consultant. To varying degrees in different provinces, these boards exercise careful supervision of the quality of medical care being provided. Payment is made in such cases to doctors, hospitals, physiotherapists, and rehabilitation officers according to a schedule of fees. There is no limitation to the amount that may be spent on any one case.

In the western hemisphere this programme is unique. Only domestic servants and certain agricultural workers are excluded. Despite the comprehensive nature of its benefits, the administrative and other charges on employers are much less than in most American jurisdictions, because in the absence of litigation all the money is used for the administration and award of benefits to the disabled workmen. The programme dates from its inception in one Canadian province in 1913, and workmen, employers, doctors, and government alike attribute much of its success to the exclusion of courts and insurance companies from its operation. By contrast it is well to remember that the National Insurance (Industrial Injuries) Act, 1946, has not entirely removed the unpleasant features of former Workmen's Compensation Acts in this country. Since 1948 in Britain there has been a steep rise in the number of claims at common law against employers for negligence resulting in injury—legal proceedings which must still to some extent detract from the harmony essential between men and management in industry.

Local Authority Health Services

Local government is relatively weak in Canada by comparison with that in Britain, and no doubt is due to the inherent difficulties of attempting to administer large areas of sparsely populated country. The county system or its equivalent exists as a major local government unit in only three provinces, Ontario, Nova Scotia, and Alberta. So-called counties with limited powers exist in other provinces also. The basic unit of local government in most provinces is still the separate city or town in urban areas and the township or municipality in rural areas. As in the widely scattered and thinly populated parts of the Highlands and Islands in Scotland, these units, in terms of population, are too small for efficient local administration, and this has handicapped the development of local public health services. In the smaller provinces, as already mentioned, many of these services have of necessity to be provided centrally by the province.

In all provinces the old principle of the English and Scottish Public Health Acts of last century is still to be found in the appointment of general practitioners as part-time medical officers of health for small rural municipalities or

†It is estimated that such programmes cover about one-quarter of the total costs of physicians' services now, and a similar proportion of hospital costs, excluding physicians' services. This is in addition to the Government hospital and medical care plans.

townships. It is only within the past fifteen years that most provinces have taken the initiative in organizing large areas of local public health administration under full-time medical officers of health, and staffed by health visitors. Sanitary inspectors attached to these units are rarely professionally trained but they have usually taken special correspondence courses organized by the Canadian Public Health Association or by a provincial health department.

With regard to the functions of local public health departments, the major part of the work of a medical officer of health is concerned with sanitation, immunization, school health services, and certain aspects of health visiting in respect of tuberculosis and other communicable diseases. Practically no treatment is provided and the work is largely isolated from the general-practitioner and hospital services.

Local public health administration in Canada to-day is going through a critical stage. With grave limitation of professional activities and with only limited contact with other health agencies, the medical officer of health finds, as in Britain, that the traditional fields of sanitation and control of communicable disease are shrinking. Private practitioners are becoming increasingly competent in the provision of maternity and child welfare and other preventive health services. Bovine tuberculosis and typhoid fever have been largely eliminated through the pasteurization of milk and the purification of water supplies by filtration and chlorination; so too has diphtheria by the widespread use of toxoid. Either provincial governments will have to find and develop a more significant role for the local medical officer of health in the planning and administration of medical care and hospital services within the provinces or local and provincial public health work will cease to have much attraction for competent professional people.

Although most Canadian provinces have established health departments in cities and rural health units to cover the population in the outlying areas, closer study reveals that many of these outlying units are understaffed or staffed by general practitioners who are working on a part-time basis. The local medical officer of health in Canada does not enjoy the respect that his professional colleagues accord to clinical consultants and specialists, and in consequence his remuneration is less than that of either general practitioners or clinicians.

Hospital Services

Mention has already been made of the mental and tuberculosis hospitals. There were approximately five mental hospital beds per 1,000 population in 1953, and, as in Britain to-day, these hospitals are grossly overcrowded. Mental hospitals are usually owned and operated by the provincial government, and in all provinces, with the exception of British Columbia, they are administered through the provincial health department. Provision has also been made recently to establish special psychiatric units in general hospitals, a policy, of course, which is becoming increasingly popular in this country. Up-to-date statistics on tuberculosis hospitals in Canada are somewhat confusing owing to the recent and continuing fall in the tuberculosis death rate throughout the country. In some provinces tuberculosis mortality in 1955 was under 5 per 100,000 population, although the average throughout the Dominion was 9. In the country as a whole there are now more than seven beds per tuberculosis death. Canadians look forward confidently to the day when these hospitals may be put to other uses, particularly for the care of the chronic sick, the needs of which in Canada may appear more clamant than those of geriatrics in the mother country. Elsewhere the tuberculosis problem is not so favourable. The problem is still serious in Newfoundland, while the mortality rates in the Indians and Eskimos are still five to six times those of the white population.

Most general hospitals in Canada are classed as public general hospitals under provincial legislation. In one small province most of them are owned and operated by the provincial health department. In the mid-western provinces and in some large cities local governments or groups of local

governments own and operate general hospitals. However, most of the public general hospitals are owned and operated by lay or religious boards, similar to our former voluntary hospitals, and are operated as corporate non-profit-making bodies quite separately from the government. They are public also in the sense that they are open to all classes and races of patients. They are also eligible for government financial assistance and subject to government licensing and regulation.

There are approximately 5½ general hospital beds per 1,000 of the population under provincial supervision and nearly 6 if we include the Federal hospitals for ex-Service and armed Forces personnel.

The public general hospitals in most provinces are eligible for two kinds of government grants. The first is from the province through the health department. It amounts to so many cents per patient per day or so many dollars for public ward bed, or in some cases it may be a grant in the form of a lump sum. Secondly, in the majority of provinces the local authority or municipality in which an indigent patient resides is required by provincial law to pay to the public general hospital so many dollars per patient per day of care given to the particular patient. In provinces which still operate this traditional method of financing hospital care the greater part of the hospital revenue derives from payments made by individual patients who are able to pay at the time they are receiving treatment, or by voluntary and commercial insurance companies on their behalf.

Private Practitioner Service

Canada had 15,651 doctors in active practice in 1954, giving a ratio of one doctor to 948 persons. In England and Wales (Census, 1951) there were 42,285 doctors in practice, giving a ratio of one doctor to 980 persons. A recent survey of practitioners and specialists in Canada (Department of National Health and Welfare, 1955) shows the number of general practitioners, general practitioners in one or other specialty, specialists, and others (see Table I). It will be seen that there are 6,246 doctors practising as specialists, of whom 4,182 have higher degrees. The figures given are exclusive of 380 doctors who are in the armed Forces, but include 708 immigrant doctors who have entered Canada in the three years since 1951.

TABLE I.—*Canadian Doctors, 1954*

Type of Work	Certificated*	Non-certificated	Total June, 1954
Private practice:			
General	389	6,378	6,767
Specialist	3,375	1,175	4,550
Other medical work:			
Specialist†	807	889	1,696
Other	24‡	2,614	2,638
Civilian physicians: total	4,595	11,056	15,651

* By the Royal College of Physicians and Surgeons of Canada.

† Does not include administration.

‡ All are on postgraduate study courses.

Note.—By certification is meant the possession of one or other of the higher degrees in a particular specialty as in this country.

Although the total number of doctors for the whole of Canada has risen from approximately 5,500 in 1901 to 16,031 in 1954, there has been very little change in the population/doctor ratio, being 972 in 1901 and 948 in June, 1954. The Provinces of British Columbia, Ontario, and Quebec have since 1911 shown consistently more favourable ratios—777, 858, and 1,005 respectively—than any of the other provinces. The under-doctored areas would appear to be Newfoundland with a ratio of 2,117, New Brunswick with 1,436, Nova Scotia with 1,280, the Yukon and Northwest Territory with 1,688, and the rural areas in almost all provinces.

Age Distribution

The median age of doctors in Canada, which had ranged between 43.4 and 44.2 years since 1931, dropped to 42.8 years in 1954, which is the same as that for England and

Wales in 1951. The proportion of medical practitioners in Canada in 1951 aged 25 to 54 years was 74.7%, while in England and Wales in the same year it was 78.3%. In Canada by 1954 the percentage of practitioners 65 years and over had dropped from 11.4 to 9%, while the proportion aged 25 to 54 years had increased to 76.7%, suggesting that the increasing numbers of young graduates from Canadian medical schools and young immigrants from abroad are tending to lower the mean age of medical practitioners in the Dominion. A comparison of age structure of doctors practising in the two countries in 1951 is given in Table II.

TABLE II.—*Ages of Doctors in Canada and in England and Wales in 1951*

Age in Years	Canada		England and Wales	
	No.	%	No.	%
—25	28	0.2	1,513	3.5
25–34	3,564	25.2	12,537	29.3
35–44	3,953	27.9	11,046	25.8
45–54	3,059	21.6	9,923	23.2
55–64	1,946	13.7	5,088	11.9
65 and over ..	1,533	11.4	2,732	6.3
Total	14,163	100	42,839	100

Graduates of Canadian Medical Schools

Graduates from Canadian medical schools amount to almost 900 a year compared with more than 2,000 annual accessions to the *Medical Register* in England, Wales, and Scotland (Hood, 1953). The number graduating from Laval Medical School, Quebec, has increased considerably. The first 54 medical students graduated from the new medical school at the University of British Columbia in 1954. A further 30 graduates are expected this spring as a result of the extension of the medical training at the University of Saskatchewan to a full medical course.

Migration of Medical Graduates

Very little information is available from Canada about emigration of doctors. Data which are available for emigration from Canada are complicated by extensions of stay for postgraduate training and by decisions to remain in the United States after taking postgraduate training there. Information is available regarding immigration to Canada since 1951. For the three years to 1954, 708 immigrants have gone to Canada to practise medicine.

The bulk of these immigrants were in the 25–34 and 35–44 age groups (see Table III). Of the total of 708, 79.5%

TABLE III.—*Immigrant Doctors to Canada Since June, 1951, and Still in Canada at June, 1954, By Age Group, for Provinces*

Age Group	N.F.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Yukon and N.W.T.	Total
Under 25 ..	1	—	—	—	—	—	—	—	—	—	—	2
25–34	26	2	4	7	46	70	21	29	37	50	3	295
35–44	9	4	7	4	14	92	30	44	34	30	—	268
45–54	2	—	5	—	3	29	7	10	11	5	—	72
55–64	—	—	—	1	2	10	2	2	4	—	—	21
65–69	—	—	—	—	—	1	—	—	—	1	—	3
70+	—	—	—	—	—	—	—	—	—	—	—	—
Not given ..	7	—	—	—	4	20	3	2	6	4	1	47
Total	45	6	16	12	69	222	64	87	93	90	4	708

were aged 25 to 44 years. Almost a third of the group were resident in Ontario; only 69 had settled in Quebec. One-third are now in general practice and the majority of the remainder are in the "other" category comprising those employed by hospitals in duties equivalent to specialists or senior registrars.

Procedure for British Medical Graduates Who Intend to Emigrate

Licensure in Canada is a provincial responsibility, although most provinces have reciprocity with each other through a common licensing examination, or rather series of examinations, known as the "Dominion Councils." These examinations cover the usual medical school subjects. A few pro-

vinces have reciprocity with the *British Medical Register*, while others, notably Quebec and British Columbia, present obstacles to the British immigrant doctor in the form of residential requirements or very high fees.

The licensing body in each province, vested with authority by the provincial legislature over medical practice requirements, is independent of both medical school faculties and health departments. In some provinces the secretary of the Provincial Medical Association is the registrar of the licensing body. Most doctors from Britain wishing to practise in central or western Canada should be prepared to sit examinations in the clinical subjects at least, and a year's internship in an approved Canadian general hospital is of value and sometimes mandatory. For further details a letter should be addressed to the Registrar, College of Physicians and Surgeons, in the capital city of the province.

The licensing bodies are not to be confused with the Royal College of Physicians and Surgeons of Canada (in Ottawa), which grants specialist certification and Fellowship, and is not a licensing body at all. The right to treat patients in hospital is accorded by the board of that hospital, and to an increasing extent is granted only in accordance with specialist qualifications. The immigrant doctor wishing to perform surgery or administer anaesthetics in one of the better hospitals in a large centre of population should consider obtaining specialist qualifications. British medical graduates possessing specialist degrees or qualifications should certainly inquire of the Royal College of Physicians and Surgeons of Canada about their status in Canada.

Specialists in Canada who restrict themselves largely or wholly to a given specialty do not depend entirely on referrals from other physicians, but will see patients un-referred. This is particularly true in paediatrics and obstetrics, and in other specialties where the patient feels herself or himself competent to identify the portion of her or his anatomy that requires attention.

Those planning to enter general practice in Canada should remember that domiciliary midwives are almost unknown outside Newfoundland, and that it is difficult to build a good general practice in most parts of Canada to-day unless one is competent to do one's own obstetrics. It is exceptional for a physician to purchase the goodwill of a practice. The customary method is simply to put up one's plate. Group practice is uncommon in the larger centres of Eastern Canada, but physicians lacking the resources to develop a practice of their own at once might start as an assistant or junior partner of an established practitioner. Either form of association would be invaluable in learning Canadian ways, and the Canadian Medical Association (St. George Street, Toronto) or its Provincial Divisions would be helpful in finding such a position.

Independent Voluntary Health Agencies

The names of the independent voluntary health agencies are legion and no attempt is made here even to enumerate them, much less to mention their pioneering work in demonstrating health needs and developing effective patterns of lay, government, and professional co-operation to meet these needs. Tuberculosis, mental health, crippled children, and bedside nursing have had special voluntary agencies for many years, and more recently cancer, heart disease, rheumatism, and arthritis are health problems for which there are special voluntary agencies. The practising doctor should co-operate with these agencies in order to give his patients the best possible service. In the area in which a doctor establishes practice he should inquire about the voluntary agencies that are active and how his patients can use their services.

Special mention should be made here of the voluntary insurance plans providing practitioner services. These are to be distinguished from the Blue Cross plans which pay hospitals for services rendered, and from commercial insurance companies that pay cash amounts to the patients on certification (usually a special form or a receipted bill) by the doctor who rendered the services.

Except for parts of the Maritimes and Quebec, in every province there is at least one voluntary insurance plan for medical services in the home, surgery, and hospital, sponsored by the Provincial Medical Association. Medical practitioners are asked to enter into a contract with this plan, agreeing to accept payment from the scheme directly on submission of a bill by the physician to the plan for services rendered by him to an insured patient. The schedules of fees used by the plans are close to the minimum recommended by the Provincial Medical Associations, and, with some variations from province to province, physicians agree to accept these fees as payment in full for their services. In Quebec, Ontario, Manitoba, and the Maritimes, Blue Cross plans also pay physicians for services in hospitals only, on a somewhat similar basis, although the physicians more often make additional charges to the patients. About one-quarter of all payments to physicians in Canada are now made through voluntary or commercial insurance companies. Through the extension of such plans the Canadian Medical Association hopes to anticipate a Government health service.

In conclusion, it is generally accepted that there are immense opportunities for young people, both lay and medical, who wish to emigrate to this young and vigorous Dominion. Nevertheless, in the last resort it must remain a highly individual and personal matter involving difficult decisions of adjustment to a new climate no less than to a new culture. As Dr. Geggie (1955), a Canadian returning home after seven months in Britain, wrote: "Lest the picture look too bright, let me point out that no doctor, except the dead one, knows security in Canada. The foreign doctor must be willing to conform with Canadian ways and to cater night and day to a very demanding public. Nor is a higher degree, including British degrees, of any great assistance. The Canadian doctor has to prove himself to his public—and a very discerning public it is."

Summary

An outline is given of the administration of the health services of Canada. Reference is made to recent hospital insurance developments.

Governmental public health services operate at Federal, provincial, and local levels. These services at the local level are poorly developed by comparison with those of Great Britain.

Hospital services, both voluntary and provincial, have many features in common with the situation as it existed in this country prior to the advent of the National Health Service, except that financing is more of a public responsibility in Canada, and administration of the institutions more often a voluntary function.

Private practice perhaps displays features of combined general and specialist service to a greater extent than was ever the case in this country.

In 53 years there has been little change in the population/doctor ratio in Canada.

Particulars of numbers, age, and province of settlement are given for immigrant doctors between 1951 and 1954.

We are grateful to Dr. Joseph Willard, Director of the Research Division of the Department of National Health and Welfare, Ottawa, for making available to us much of the statistical information and for his suggestions in the writing of this article. Of course, responsibility for the opinions expressed is our own.

ADDENDUM.—To make terms and titles intelligible as regards the Health Service in Great Britain, some licence may be evident in terminology. The Canadian equivalents are: health visitor = public health nurse; local authority = local government; senior registrars = senior interne; general practitioner = physician (usually an all-embracing term in Canada).

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A PRESCRIPTION FOR HEALTH*

BY

R. W. LUXTON, M.D., B.Sc., F.R.C.P.

Consultant Physician, Crumpsall Hospital and the Christie Hospital and Holt Radium Institute, Manchester

Some years ago an advertisement for a famous retail chemist included the arresting phrase "Prescriptions dispensed with deadly accuracy." I make no such claim for to-day's prescription, because, on this subject of health, the thinking of the medical profession is worse than inaccurate, it is confused. We doctors know a good deal about disease, but not much about health; indeed, we have to be more interested in disease than in health. Symbolic of the confusion is our describing as the "National Health Service" what is actually the "national ill-health service." Typical also is the fact that we regard health as merely the absence of disease. At this meeting of doctors and clergy I would urge that we look on health not as the absence of something wrong, but as the presence of something right. Health is the whole man at his best. A real health service will arise when there is understanding and collaboration between all those whose vocation is to bring man to manhood—doctors, clergy, educationists, social workers, and many others, including politicians.

These introductory remarks you may regard as the letter-heading of the prescription form. If you will

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pardon a play on words, they indicate the *premises* on which the prescription is written, and are commonly the only section to be legible. The illegible portion includes the list of ingredients with doses, an instruction to the dispenser, an instruction to be passed on to the patient, the name and address of the patient, and, finally, the name of the prescriber. Of the many ingredients which could be introduced into a prescription for health, I have chosen six—wholesome food, sound habits, right environment, creative work, the promotion of active resistances, and daily meditation. Before discussing other sections of the prescription, I will give some consideration to each of the six ingredients. To do so is not only sound therapeutics, it is sound homiletics.

The Ingredients

Wholesome Food

It is clear to science that the human engine requires certain general categories of fuel if it is to function—proteins, fats, and starches, and also vitamins—and that physical and even mental diseases, disorders of nutrition, will arise if these needs are not met. Further, lack of balance in the intake of normal foodstuffs can sometimes promote physical disease. For example, the excess of fatty foods in our civilized dietary