PROVINCE OF BRITISH COLUMBIA

FINAL REPORT

OF THE

ROYAL COMMISSION ON STATE HEALTH INSURANCE AND MATERNITY BENEFITS

1932

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February 13th, 1932.

The Honourable S. L. Howe,
Provincial Secretary, Victoria, B.C.

Sir,—I have the honour to transmit herewith the Final Report of the Royal Commission on State Health Insurance and Maternity Benefits, addressed to His Honour the Lieutenant-Governor in Council as required by the "Public Inquiries Act."

The Appendices to the Report require some further completion, after which they will be bound and transmitted to you.

I have the honour to be,
Sir,
Yours faithfully,

C. F. DAVIE,
Chairman.

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To His Honour the Lieutenant-Governor in Council:

MAY IT PLEASE YOUR HONOUR:

We, the undersigned Commissioners appointed under Your Honour's Royal Commission of April 16th, 1929: (1) To inquire as to what laws relating to the subjects of maternity benefits and health insurance are in force in other Provinces of Canada or any other countries; (2) to collect facts as to the actual operation of such laws and as to how far they have been found satisfactory; (3) to inquire as to whether and to what extent the public interest requires the introduction of similar laws into the Province of British Columbia; (4) to estimate what would be the total annual cost to the people of the Province in regard to each of these subjects, and what portion of the annual cost would fall upon (*a*) employers of labour, (*b*) prospective beneficiaries, and (*c*) the general taxpayers; (5) to suggest methods by which the annual cost might be collected from the employers, prospective beneficiaries, and general taxpayers respectively; (6) and generally to inquire into any and all matters affecting the said subjects respectively,—

Have the honour to report finally as follows:—

INTRODUCTION.

1. We have already presented to Your Honour our First, or Progress, Report (Appendix A herewith), in which the authorization and composition of our Commission is set forth, together with a full explanation of the research up to that time undertaken, and which latter consisted of preliminary investigation as a basis for our further activities. Necessarily meagre as it was in respect of a practical solution of our inquiry, this first report nevertheless attracted a very considerable interest. The 825 copies originally run off were required to be supplemented by a further 3,250 copies in response to the demand from both within and without Canada. This is illustrative of the marked attention which is being paid to the subject-matter of State health insurance the world over, and particularly of the watchful interest displayed in other Canadian Provinces and in the United States.

2. We would say at the outset that we are fully cognizant of the serious nature of the task which has been imposed upon us, and of the extreme importance of bringing to bear upon our deliberations careful consideration and sound conclusions. We are frank to say that many intruding factors have—and in the very nature of things must have—made our purpose difficult of accomplishment. The distances between the homes of the Commissioners, which separated them for long periods, were not the least disturbing elements in a consideration requiring close application and frequent consultation. The fact that no existing system of State health insurance is to be found on this continent has also been a decided handicap, as we have been unable to make first-hand observation upon the practical working of any scheme, and have been mostly dependent upon secondary evidence obtainable from European centres. It will be readily appreciated that the picking-up of facts and the gathering of practical data can be accomplished with infinite more certainty and satisfaction by viva voce examination of personally affected witnesses than can be the case by perusal of written material.

3. The Commission also suffered a severe set-back in the lamentable death of its Secretary, the late C. H. Gibbons, who died suddenly last March. Our deceased Secretary had rendered valuable aid to our research, and at the time of his death was completing the compilation and collocation of material for this Report. His untimely death created a significant break in the continuity of our work. No new official could have been expected to undertake this secretarial detail without a previously acquired knowledge obtainable only by close following of the Commission's activities. The engagement of a new Secretary was therefore dispensed with; and the Commission entrusted the Chairman with the task of completing details from the point where the work was thus abruptly arrested. We wish to record here our deep appreciation of the outstanding helpful intelligence which the late Mr. Gibbons devoted to his duties, and to the untiring labour which he gave towards the by no means easy efforts which confronted him. His demise has been truly a serious loss.

4. However, notwithstanding these stern handicaps, we feel that we are able to approach the final phase of our endeavours with a practical response to the inquiries which we have undertaken.

5. The history of the development of State health insurance in the various world countries, both individually and collectively as a whole, is to be found in the reports of similar commissions and in the published studies of societies and labour bureaux, collected in the library of material in our possession and catalogued in Appendix B herewith. Accordingly, it is not our purpose to repeat what can be thus readily referred to, other than as may be necessary in the elucidation of any finding or argument as we proceed.

6. For the purpose of complying with the terms of our Commission, we propose to deal seriatim with the matters referred, the several divisions whereof appear sufficiently broad to exhaust all topics that may usefully be touched upon in an inquiry of this nature.

WORLD LAWS.

(1.) To inquire as to what laws relating to the subjects of maternity benefits and health insurance are in force in other Provinces of Canada or in any other countries.

7. A reference to page 7 of our First Report will indicate a part of what has been accomplished in this direction. The Digest of World Laws there referred to is comprised in two large volumes, being Appendix C herewith, and has been compiled very largely (although not completely) from the valuable studies and reports on compulsory and voluntary sickness insurance, as issued from the International Labour Office of the League of Nations at Geneva, Switzerland, in particular the Geneva Digests Nos. 111 and 112 in the bibliography (Appendix B). The various topics, such as "Scope of Scheme," "Benefits," "Financial Management," etc., which in the Geneva Digests are dealt with under separate sections, have in our Digest been grouped together as for each country. Further laws collected by our Commission from the countries of origin since the publication of the Geneva Digests have also been included in Appendix C, which, together with the Geneva volumes, form a complete reference to the whole law of sickness insurance the world over, down to the end of the year 1931.

8. The full text of the more recent laws on compulsory sickness insurance will be found amongst the material catalogued in Appendix B. Particular refer-

ence is directed to the Legislative Series of the International Labour Office, supplemented by the explanatory brochures intituled "Industrial and Labour Information," which are grouped, respectively, under Nos. 114 and 115. In order to ensure this information being kept up-to-date during the progress of our inquiry our Commission subscribed to these International Labour Office publications, which consist of reprints and explanatory memoranda of the most important world laws and regulations concerning labour. These indispensable publications are obtainable at the trifling cost of $22.50 per year, and, in our opinion, the subscription should be maintained so as to aid future deliberations upon this subject by avoiding any break in the continuity of information.

9. Furthermore, for facilitating reference to these laws, so far as they deal with compulsory health insurance, a comprehensive tabulation of the salient features of each will be found in the Tabulation Digests (Appendices D and E). These have been designed to enable any particular feature to be brought under observation at a glance, without the necessity of wading through pages of material.

10. To facilitate separate reference to maternity-benefit laws, a digest of these has also been compiled (Appendix F), accompanied by a Tabulation Digest thereof (Appendix G).

GENERAL OBSERVATIONS ON THESE LAWS.

11. As we are fully convinced of the futility of voluntary schemes of health insurance to adequately take care of a Province-wide scheme with benefits to be extended to all the population of a certain defined occupational group, our attention has been directed, in the main, to compulsory health insurance. It is perhaps only necessary, in confirmation of this view, to quote the first and concluding paragraphs from "The Development of Compulsory Sickness Insurance" as set out, respectively, at pages 10 and 12 of the Geneva Digest (No. 111, Appendix B) :—

> In spite of its valuable achievements, the voluntary-insurance movement has been found insufficient, and it has become clear that the way to secure general and effective protection against the risk is by making insurance compulsory.
>
> After forty years of experiment, uninterrupted effort, and success in all parts of the world, the cause of the compulsory principle seems now to be finally gained, and compulsory sickness insurance appears likely to occupy an increasingly important place in the social legislation of every country.

12. It will be noted that the following countries have some form of compulsory sickness insurance now in operation, namely: Austria, Bulgaria, Chile, Czechoslovakia, Esthonia, France, Germany, Great Britain and Northern Ireland, Greece, Hungary, Irish Free State, Italy, Japan, Latvia, Lithuania, Luxemburg, Netherlands, Norway, Poland, Roumania, Russia, Serb-Croat-Slovene Kingdom (Jugoslavia), and Switzerland.*

13. Both Australia and Belgium have conducted investigations leading to the introduction of compulsory schemes, going so far as to frame the necessary statutes in that respect. Up to the present, however, the Legislatures of these countries have not given effect to the recommendations; although it is likely that action soon will be taken by the Belgian Parliament, which has before it both a Government Bill and a Bill drafted by the Labour Party. Greece at the present time has

* In Portugal a compulsory sickness-insurance law was passed in 1919, but it has never been applied.
Since the preparation of this Report the Persian Government has placed in operation a sickness-insurance institution for all employees on road-construction, contributions being derived exclusively from the insured workers.

a special compulsory health insurance for workers in tobacco-factories; but it is anticipated that a Bill to establish a general scheme of compulsory health insurance will be presented to its Parliament this year.

14. It will be observed further that, with the exception of Japan, compulsory sickness insurance is, in the Old Land, confined to European countries, while on the whole of the North and South American Continents, Chile alone has embarked upon a compulsory scheme. In the United States numerous commissions have been appointed by various States for the investigation of social insurance, and, while individual reports strongly favour the scheme, it has not as yet been entertained by either the State Assemblies or the Federal Congress, which (doubtless owing to the high rate of wages heretofore applying in America) have left the burden of caring for sickness losses to the voluntary efforts of the people. Investigation has shown, however, that the masses are unable to meet the cost of sickness, and the American medical fraternity in particular has stressed the importance of spreading the average annual cost over long periods and over large groups of the population in order that the burden, which is overwhelming when met all at once, may be borne easily by division.

15. From a general view of the laws of those countries which have embraced compulsory sickness insurance, certain predominant principles more or less common to all may be noted.

16. There are few countries which deal with sickness insurance and maternity benefits alone; most of the schemes embrace, as a national social insurance whole, some such additional features as old-age pensions, unemployment insurance, funeral, family, and various other benefits.

17. Maternity benefits, however, is a concomitant feature of all countries having compulsory sickness insurance, such benefits being either included in a general sickness-insurance scheme or specially provided for as a separate institution.

18. The fundamental application principle of all compulsory sickness-insurance laws, as a very general rule, is confined to contracts of employment in respect of wage-earners. The extension of the law has not, however, reached the entire wage-earning population in all countries, the intensiveness of the different schemes varying greatly in this respect. Statistics indicate this variation to range from 15 to 86 per cent. of the employed population. The variations are accounted for by differences of administration—e.g., restrictions and exemptions in the classes of insured; and also by the percentage which the importance of the working population bears to the total population.

19. Whereas the original idea behind compulsory sickness insurance was compensation for loss of time (cash benefits), nevertheless present tendency in world practice embraces the broad principle that the efforts of insurance towards defraying the cost of actual sickness is the primary objective. Correlative therewith appears a practical application of the modern view-point regarding avoidable illness; and, side by side with curative measures, sickness insurance takes its part in the campaign against social diseases and for raising the standard of the people's health. This is notable in those countries where territorial organization facilitates such action. But in almost every system in the world to-day the cash benefit is still retained as a necessary compensation for stopped earnings.

20. The ordinary benefits in kind are usually medical aid, drugs, and hospitalization, together with such dental treatment as may be necessary. With the

expansion of recent laws, the list of benefits in kind becomes larger and includes special medical treatment. In most schemes the expenditure on benefits in kind is equal to that of cash allowances, and in some countries the former exceed the latter.

21. In most of the countries additional benefits in kind are granted to family dependents, which, of course, must be taken into account in deciding the amount of the contribution rates. This movement, which before the war was peculiar to only a few countries, has now become a strong feature, and in Europe as a general rule sickness insurance takes care of the family as well as the breadwinner.

22. Sickness-insurance costs are, in most practices, borne by the insured and the employer, supplemented, in some cases, with aid from the public treasury. Soviet Russia alone excepts both the insured and the State from payments. This, however, is relief and not insurance, and is viewed with disfavour by some workers in other countries, possibly for the good reason that insurance creates a right to demand benefits and justifies the insured in claiming participation in the management of administration.

23. The principle of the employer's contribution has been adopted in all countries except Switzerland and the former Kingdom of Besserabia, and can no longer be said to be open to argument, at any rate so far as world practice extends. The amount of this contribution varies in the different schemes. In a considerable number (Bulgaria, Czechoslovakia, Esthonia, France, Greece, Great Britain, Hungary, Irish Free State, Italy, Japan, Latvia, Lithuania, Netherlands, Jugoslavia) the employer's contribution is on equivalence with that of the insured. In only two countries (Chile and Poland) the employer's contribution exceeds the insured's; and in four countries (Austria, Germany, Luxemburg, and Norway) the insured's contribution exceeds the employer's.

24. Under the 1930 French " Social Insurance Act," sums paid as contributions either by employer or employee are deducted from the total income of said persons for purposes of taxation on income.

25. Contributions are not made by the State in Austria, Czechoslovakia, Esthonia, Greece, Hungary, Italy, Luxemburg, Netherlands, Roumania, Russia, and Jugoslavia.

26. The State contributes as follows: Bulgaria, Latvia, and Lithuania, equally with employer and insured; Chile, one-sixth; Germany, one-half of maternity for uninsured wives of insured men; Great Britain finances two-ninths of the total cost of benefits and administration; Irish Free State, two-ninths; Japan, 10 per cent. of total cost of benefits; Norway, two-tenths; Poland, one-half maternity and nursing only; Switzerland, variable.

27. From the foregoing, and by reference to the corresponding figures in the Tabulation Digest (Appendix E), it will be observed that: (1) The insured persons, in most practices, bear the chief burden, their contributions ranging from one-third to two-thirds of the total cost, and being seldom less, and nearly always either equal to or more, than the employer; (2) in approximately half the number of countries the employers pay half the total contributions, and roughly one-third in the remainder. In Russia only, the employer pays the whole cost; (3) the State contribution is irregular, both as to nature and amount, but is nearly always less, and never more, than any other contribution; and in a number of practices it contributes nothing.

28. The methods by which the administrative management of such laws is carried out vary widely in different countries and present a complex subject for the brief review undertaken here. As the question of administration bears an important relationship to the success, failure, or indifferent operation of such schemes, it becomes of paramount importance to appreciate the reason for the trend, in practice, towards territorially-raised insurance committees and away from mutual-aid societies, to which many of the countries entrust administration.

29. In this connection we feel that the situation is so admirably exposed by the editors of the Geneva Digest (No. 111, Appendix B) as to warrant us in reproducing so much thereof as is directly germane to the question of setting up insurance institutions:—

When the existing voluntary funds, whether friendly societies or trade associations, are sufficiently strong and numerous, the law which makes insurance compulsory may simply authorize them to act as insurers, and refrain from creating new institutions.

This case is rather rare. In spite of its vigorous activity, the friendly socities, employers, and trade-unions have not often succeeded, especially in rural districts, in building up a sufficiently close network of funds in all parts of a country. It is therefore necessary to set up new funds for those persons whom voluntary insurance has been unable to reach.

The compromise between a desire to systematize and an anxiety to safeguard existing funds results, in many countries, in a complicated and often incoherent congeries of institutions of different types, among which insured persons are distributed in widely varying proportions.

Thus, in Great Britain, where the management of insurance is entrusted to existing institutions, 46.5 per cent. of insured persons belong to friendly societies, 42.8 per cent. to industrial assurance approved societies, 9.9 per cent. to trade-unions, and 0.8 per cent. to employers' provident funds.

On the other hand, territorial funds, which do not exist in Great Britain, play an important part in Germany, while friendly societies are hardly developed: 71 per cent. of insured persons belong to territorial funds (local or rural), 24 per cent. to trade funds (works funds, guild funds, and mining funds), and only 5 per cent. to mutual-aid societies, known as substitute funds.

If one studies the movement of the membership of the different types of institutions in the course of the last fifteen years, one finds that in the majority of European countries the territorial funds have developed continuously and that trade funds, and especially friendly societies, have remained stationary, or have even lost ground.

This clearly marked preference for the grouping of all the insured persons in a particular area in a single institution is explained by the numerous and important advantages which this arrangement offers. In a territorial fund, in which all kinds of trades are represented, the good and bad risks compensate one another. The membership is stable, and is much less influenced by economic disturbances and unemployment crises, which might threaten the very existence of trade funds.

The territorial fund is particularly suitable for the organization of medical benefits. It facilitates the unification of the various branches of insurance. Unification renders administration simpler and less costly, and enables the means of action to be concentrated, so that medical equipment may be provided for each area, and may be used in common by both sickness and invalidity insurance. These considerations predominate in States which, like Bulgaria, Czechoslovakia, Soviet Russia, and the Serb-Croat-Slovene Kingdom, have aimed at co-ordinating the whole of their insurance institutions.

Whatever has been the basis of organization adopted, the management of insurance is always entrusted either to a State service or to autonomous institutions administered by insured persons alone, by insured persons and employers, or by insured persons, employers, and representatives of the public authorities.

State management is rare: it exists only in Bulgaria and to some extent in Japan (insurance offices). Even in these two countries State management may perhaps be regarded as only a temporary feature, intended to prepare the way for management by the parties

concerned when the development of trade-unions of workers and employers and the progress in the social education of the mass of the population shall have made it possible for them to assume the task.

Autonomous management by the parties concerned is the plan which has received almost universal favour; it seems to fulfil the conditions required for efficiency and to respond to the wishes of insured persons and employers. The system of autonomous institutions, working under the supervision of the State, is one which makes it possible at the same time to apply uniform legal provisions and to allow the free play of initiative in the adaptation of the activities of institutions to special local needs.

Participation in management is, in the eyes of employers and even more of insured persons, a necessary corollary to the payment of the contributions which is imposed upon them by law. It interests insured persons in the good management of insurance, increases their feeling of responsibility, enables abuses to be prevented by mutual supervision, gives to workers a sense of sharing in a collective effort, and in this capacity serves as a valuable agent for the education of the masses of the population in democracy.

To decide what share of influence shall be given to each party is no easy task, and the plan adopted varies according to the type of fund and from country to country. Friendly societies set up by the workers themselves are of course managed exclusively by their members. In territorial funds and even in trade funds, insured persons are generally more strongly represented than employers. The number of seats attributed to them, hardly ever less than half, is frequently as much as two-thirds of the total number, and sometimes even exceeds this proportion. A study of the movement of recent legislation reveals a well-marked tendency to increase the influence of insured persons in the management of insurance funds.

It may be concluded that the growing predominance of autonomous territorial funds administered by the parties concerned, and the attribution of an increasingly important share in the administration to the insured persons, are two of the most salient features in the evolution of the institutions of compulsory sickness insurance.

30. The nature of the sickness for which health-insurance funds become liable is not all-embracing. A mere pathological phenomenon is not in itself sufficient to constitute sickness, but there must be an abnormal condition calling for treatment. On the other hand, the origin of the complaint is immaterial, save in certain diseases produced by wilful fault, and even some of these (e.g., venereal diseases) are included in the German scheme. The new 1930 French law disallows "pecuniary benefit" (but not benefit in kind) to persons suffering sickness through wilful fault. Generally, in order that benefits may be obtained, the disturbance to health must be of a given severity. It is not sufficient if simple care is all that is required, and the symptoms should be such as to justify the belief that the state of health will become worse if the sick person is not treated or does not stop work.

31. The imposition of waiting periods in respect of cash benefits is regarded as an economical necessity in sickness insurance, and the laws of almost all schemes provide that cash benefits cannot be claimed until after the appropriate waiting period has been passed.

32. To quote the Geneva studies in this connection:—

For the insurance institution, the obligation to pay benefit for sickness lasting only a few days would be costly and difficult to fulfil. Short indispositions are frequent, and the institution would be overwhelmed with claims for benefit which, if accepted, would seriously increase its expenditure. The cost of examination and especially of supervision would be out of all proportion to the social service rendered to the insured. There is also a psychological argument in favour of a waiting period—namely, that it is not desirable to induce too great a sentiment of security among the insured by relieving them of their economic responsibilities, even for very short interruptions of work.

33. The following waiting periods in respect of cash benefits are in force in the countries named: Netherlands and Poland, 2 days; Austria, Czechoslovakia,

Esthonia, Germany, Great Britain, Hungary, Irish Free State, Japan, Latvia, Lithuania, Luxemburg, Norway, Roumania, Jugoslavia, Switzerland, 3 days; Chile, 5 days; Italy (new provinces), 5 days; France, 6 days.

34. As to its nature, the waiting period may be absolute or relative, or both. From the Geneva studies we read: —

> In the first case the sick person acquires the right to benefit only at the end of the period and irrespective of the total period of incapacity; in other words, the financial losses due to incapacity during the days of the waiting period are definitely borne by the insured. When the waiting period is relative, the sick person is similarly unable to claim benefit for indisposition of shorter duration than the period, but for longer periods of incapacity for work he becomes entitled to benefit with retrospective effect as from the first day of disablement.
>
> Moreover, the waiting period may be both absolute and relative; that is to say, absolute for a first short period of incapacity and relative for a longer incapacity, besides which the benefit may be paid retrospectively either from the first day of incapacity or from a subsequent day though previous to the end of the absolute period.
>
> When a relapse occurs within a specified period after the first attack of sickness, the waiting period is generally not applicable.

In Chile, Roumania, and Czechoslovakia the waiting period is relative.

35. The question of local residential conditions, after the insured has joined the insurance institution, becomes of importance only in cases where autonomous funds are set up in separate districts. In systems having a centralized system of insurance forming only one unit, the insured are deemed to belong to the insurance institution so long as they remain in the country.

36. The nationality of the insured as a qualification for admission to the insurance institution is, as a very general rule, disregarded in the plans now operating. In some countries, however, the admission of aliens into the scheme is contingent upon the country of those aliens furnishing reciprocal privileges, and this contingency varies for different benefits. (*See* pp. 50, 51, Geneva Digest No. 111, Appendix B.)

37. In most countries there is no maximum age-limit in compulsory sickness insurance, for the obvious reason that, at whatever age a person is engaged in employment, he is presumed to depend upon his work for livelihood, and therefore requires maintenance as well as medical aid when sick. In some countries, however, including Britain, the maximum age-limit is fixed at the age at which old-age pension is obtainable, it being thought undesirable that both sickness cash benefit and pension should be payable at the same time. In Great Britain the upper age-limit is 65, although the person does not cease to be insured, retaining the right to medical benefit for life whether or not he remains at work after reaching the age-limit; but he is debarred from the sickness or invalidity cash benefit. The minimum age is usually fixed at from 14 to 16, being the employment age. Some countries reduce the amount of contributions required from young persons who cannot command a full wage. Maximum age-limits are frequently imposed in the case of volunteers.

38. A person having been initially capable of work, and having become insured, the question arises as to whether he should continue to be compulsorily insured regardless of whether his capacity for work has diminished. Under the German law a person is exempted from compulsory insurance if in receipt of an invalidity pension. A voluntary exemption is also extended to workers who have exhausted their right to sickness benefit; this exemption may be for as long as they are unable to work. A similar voluntary exemption is extended to invalids under the Nor-

wegian scheme. Some other funds exempt persons whose earning capacity is seriously impaired as a result of chronic illness or infirmity.

39. In some countries the difficulty of meeting the needs of persons who are engaged for only short periods of work has been considered insurmountable, and persons whose engagement is less than a prescribed period are excluded. In a number of other countries, however, temporary workers are liable to insurance regardless of the shortness of their engagement. The considerations surrounding this phase of sickness insurance present a complex problem, and for the manner in which it has been worked out in different countries we refer to the Geneva Digest (No. 111, Appendix B), pp. 45, 46, 47, 48; and also to pp. 42, 43, 44, in connection with the subject-matter of occasional and subsidiary employment.

40. The following principles as to benefits have been adopted under the British plan: Benefits are payable in full until the termination of sickness and for four weeks after the insured becomes fit for work; with a limit of twenty-six weeks, after which he may claim disablement benefit. (*See* paragraph 109.)

41. The continuance of insurance on account of genuine unemployment is generous. Unemployed persons remain fully insured for all benefits for one year and nine months, although reductions (on account of arrears of contributions) in the amount of benefits may be made if such arrears are not due to genuine unemployment. A person who, before unemployment, has paid a certain prescribed number of contributions, and who is still unemployed after the expiration of the one year and nine months, will be granted a further year's insurance with sickness and disablement benefit, at not less than half-rates, providing he can prove that, when not sick, he has been available for, but unable to obtain, employment. If such person returns to employment during such extra year his full benefits are restored after he has been employed for twenty-six weeks.

42. A genuinely unemployed person is, therefore, given a continuous period of, approximately, two and three-quarter years before his insurance can be terminated, and if he returns to employment before the end of this period he avoids any break in the continuity of his insurance. Furthermore, no penalties are attached to insured persons on account of arrears of contributions while genuinely unemployed. This system seems too extravagantly generous, and no doubt partially accounts for the difficulties recently encountered in the maintenance of the British scheme. (*See* paragraph 160.)

43. Apart from genuine unemployment, unless the arrears are redeemed by payment of the required sum within the time allowed, an insured person who gets into arrears beyond four payments in any year is met with a reduction or suspension of cash benefits. So long as he remains in insurance the right to medical benefits is not affected by arrears.

44. In the new French law passed in April, 1930, there is no reduction in benefits by reason of arrears in contributions. An unemployed insured simply has no right to demand benefits if arrears exceed a certain number of payments. He is required to pay contributions for two months during the three months, or for eight months during the twelve months, preceding sickness; for this purpose any days of sickness for which benefit has been paid shall be reckoned as contribution-days. An unemployed insured person thus retains his rights for a maximum period of four months in any twelve, but the guarantee ceases for any given month as soon as the total payments made during that month have reached the equivalent

of twenty daily contributions. That is to say, not more than eighty daily contributions may be paid on behalf of the same insured person in a year.

45. Most of the compulsory sickness-insurance institutions provide continued insurance for such persons as cease to be liable to compulsory insurance, such, for instance, as when the insured leaves employment or when his income exceeds the maximum limit. This continued insurance is granted in response to the argument that a person who has been compelled to contribute for a considerable period should have the opportunity of maintaining his insurance when he is no longer compellable. If the scheme permits the admission of volunteers generally, the problem surrounding the question of continued insurance is answered to a great extent. For the practical application of the laws in this respect we refer to the Geneva Digest (No. 111, Appendix B), pp. 58, 59, 60, and 61.

46. Having thus briefly touched upon the general nature of sickness-insurance laws, we pass on to a detailed consideration of other matters to be specifically dealt with under the terms of our inquiry.

OPERATION OF WORLD LAWS.

(2.) To collect facts as to the actual operation of such laws and as to how far they have been found satisfactory.

Actual Operation.

47. As previously stated, it is nearly impossible to collect facts of operation first-hand at this distance from the countries operating the various schemes. We are therefore relegated to such written expositions as may be available. A compendious and comprehensive outline of the main operating features of most systems will be found in the Geneva Digest (No. 111, Appendix B). To recapitulate this excellently arranged information here would, in our opinion, be useless duplication. We shall therefore direct inquiry to the aforesaid reference, reserving some important features of administration, as applicable to local conditions, to the sections below dealing with "Operation" (paragraphs 167 to 174) and "Miscellaneous Observations" (paragraphs 177 to 190).

How Far Satisfactory.

48. From what material is to hand, we have every reason to believe that, generally, the various compulsory health-insurance schemes are operated satisfactorily and with great benefit to the population. In the British system there has developed in recent years a certain looseness and laxity in permitting undue encroachments upon the fund. So far, however, as concerns general world practice—and, in particular, beneficial effect upon the health of the people—there seems to be no question as to the efficiency of the schemes.

49. From England, Mr. R. W. Harris, formerly Assistant Secretary in the Ministry of Health, and now Chairman of the London Medical Service Sub-Committee, concludes an article in the Canadian Public Health Journal for February, 1931 (No. 69, Appendix B), with these words:—

> The employed population have secured in this great organized service (the British system) an enormous boon, and have received, and are receiving in increasing measure, the services of the general practitioners of this country for a trifling annual payment, under conditions which secure to the patients the advantages, without some of the disadvantages, of private medical practice.

50. From Germany, in an elaborate study of "The Benefits of the German Sickness Insurance System" (1928), by Dr. Franz Goldmann, of the Principal Health Office, Berlin, and Dr. Alfred Grotjahn, Professor of Social Hygiene, University of Berlin (No. 47, Appendix B), the concluding and final words are:—

> In the four and a half decades of its existence the German sickness-insuranee system has increasingly favoured the use of benefits in kind rather than in cash, and has emphasized the principle of prevention rather than that of compensation. Furthermore, it has extended to the whole family the benefits formerly granted only to the insured individual.
>
> In this way the German sickness-insurance system has become an exceedingly important—indeed, an invaluable—factor in promoting the health and working capacity of the German people.

51. This evidence from these two important European countries is fairly positive that the operation of compulsory sickness insurance is satisfactory there.

52. On the other hand, with the exception to be presently noted, our Commission, although having collected voluminous literature on the subject-matter of its inquiry, has not in its possession any suggestion or evidence of any kind indicating that any scheme operating under these laws is not on the whole satisfactory. There are, of course, objections to minor matters of administrative detail, ancillary to any plan of administration.

53. The lone exception, which does not come from Europe or from any country utilizing the scheme, has been voiced by an official of the Prudential Insurance Company of America, Mr. F. L. Hoffman.

54. At the earnest request of the Christian Scientists, we accorded a special hearing to Mr. Hoffman, and his evidence will be found in Volume 3 of Appendix H.

55. A perusal of this evidence discloses, however, that Mr. Hoffman's antagonism to the principle of State health insurance is based, not upon any authentic facts relative to the failure or success of European schemes, but rather upon a general argument in condemnation of the principle of compulsory State health insurance. So much of Mr. Hoffman's evidence as concerns general principles is interesting and of considerable value. For instance, his statement that a scheme which provides only for cash benefits converts it into an economic rather than a medical measure. This view is reflected in our recommendations, where we suggest that cash benefits (other than for maternity cases) should be included only after primary benefits in kind have been provided. (*See* paragraphs 111, 114, 197, 198.)

56. Other expressions, however, by Mr. Hoffman are clearly valueless in the light of present-day experience, and indicate that his study of European schemes has not been brought up-to-date. For instance, referring to the London Public Medical Service, which he suggests is apparently a voluntary contributory scheme, and has received the endorsation of the British Medical Association, he says: "There is a considerable amount of dissatisfaction with the workings of the British National Insurance Acts, both as regards their effect on the medical profession and on insurance."

57. That there was dissatisfaction on the part of the British medical profession at the outset of the British scheme is true, but that would not appear now to be generally the case. We refer again to the statement above of Mr. Harris, who is an official of this very London Medical Service mentioned by Mr. Hoffman; and also the following in the same article by Mr. Harris:—

I believe that the share accorded to the medical profession in the administration (of the National Health scheme) is unique. Comparing the English system with all the other Continental systems, the difference is very marked, and that is doubtless the reason why, compared with the Continental system, the doctors here are comparatively satisfied and in my opinion give a better service.

58. Mr. Hoffman has evidently not followed the later developments of the British system, one particular feature of which has been to give the medical profession an increasing share in the administration of the scheme, and which has largely removed the major dissatisfaction formerly prevalent amongst the profession, as has been conceded by the British medical profession. In this respect, we again quote from Mr. Harris:—

So far, however, as my judgment goes, the present system—which appears to be as much in the way of public service as the medical profession are prepared to accept, unless they can have the control more largely in their hands—has appeared to meet all the reasonable requirements of the profession. The large share which, as we have seen, they have in the administration, the complete freedom from interference where the exercise of professional judgment is involved, the right of the patient to choose his own doctor, and that of the doctor within wide limits to reject patients that he does not want, the simple and straightforward character of the requirements in regard to the certification and records—all combine to make the service as satisfactory to those engaged in it as can be expected, when proper allowance for human nature is made. This has been frankly placed on record on many occasions by the Insurance Acts Committee of the British Medical Association, though, of course, from time to time they reserve for continued criticism many matters of detail. It seems equally true that criticism of the service from those medical men not engaged in it is now confined to very few and occasional critics whose observations, often ill-informed and twisted out of any real resemblance to the facts as they are, make it difficult to treat them seriously.

And finally:—

. . . notwithstanding all its defects and its missed opportunities, the service represents for the members of the medical profession an enormous gain on the conditions obtaining before 1911, for the reason, if for no other, that, in the treatment of the employed population of this country, every general practitioner is completely freed from any financial anxiety, while the exercise of his clinical judgment, and generally the intimate relations of doctor and patient, remain completely undisturbed.

59. Mr. Hoffman also says: "Health insurance in the United Kingdom has not improved the health of the wage-earner as was expected. The British death-rate is the same as the death-rate of this country and in all probability with a larger amount of general sickness among the working-people."

60. On this criticism we feel bound to accept the findings of the Royal Commission on National Health Insurance under the chairmanship of Lord Lawrence of Kingsgate. That Commission was appointed in 1924 to inquire into the British scheme generally. Their report was published in 1926, and on page 28 they say:—

In all these activities we have found, speaking broadly and with full consciousness of its limitations, such a contribution to the health and well-being of the community that we feel sure that a steady expansion in these services will mark our future social history.

And at page 12:—

We have received very little evidence directed against the scheme as a whole, nor have we any reason to think that there now exists any considerable body of opinion adverse to the principles of National Health Insurance.

Again, at page 13:—

In contrast to the paucity of evidence directed against the general principles of the present scheme, we received from many different quarters a large volume of evidence in its favour, testifying to the advantages in health and social security which have been derived under it.

For instance, the British Medical Association said that the evidence as to the incidence of sickness benefit does point to the fact that the scheme itself has almost certainly reduced national sickness, and we are quite sure that if the immense gain to national health includes immense gain to the comfort of the individual in knowing that he can have medical attention whenever he needs it, the gain is most marked.

61. A final, and the latest, word on this subject comes from the 1930 Annual Report (No. 67, Appendix B) of Sir George Newman, the Chief Medical Officer of the British Ministry of Health, who, at page 232, says that it is an "indisputable fact that the health of the people as a whole has immensely improved in recent years." This general statement is, of course, based upon the statistical evidence collected by the British Health Department, from which we have extracted the following with reference to the principal infectious diseases. The periods covered are from 1911 (when the British "National Health Insurance Act" was placed in operation) to 1930. The figures disclose a notable decrease in average mortality.

Name of Disease.	1911–20 Average.		1921–30 Average.		Per Cent. Decrease.
	No. of Deaths.	Rate per 1,000.	No. of Deaths.	Rate per 1,000.	
Cerebrospinal fever	715	0.019	417	0.011	42.10
Diarrhœa and enteritis	18,401	0.512	8,218	0.211	58.78
Diphtheria	5,058	0.141	3,270	0.084	40.42
Enteric fever	1,278	0.035	428	0.011	68.57
Influenza	21,641	0.590	14,372	0.369	37.45
Measles	9,868	0.275	4,241	0.109	60.36
Peurperal fever	1,184	0.033	1,108	0.028	15.15
Scarlet fever	1,706	0.047	885	0.023	51.06
Smallpox	14	0.000	25	0.001	.....
Tuberculosis (respiratory)	38,775	1.078	31,641	0.813	24.58
Tuberculosis (other forms)	12,621	0.351	7,738	0.199	76.38
Typhus	5	0.000	1	0.000	.....
Whooping-cough	6,538	0.183	4,429	0.114	37.70

Average decrease, 39.55 per cent.

62. In view of these authoritative statements, which are in direct opposition to those of Mr. Hoffman, we are disinclined to attach any practical value to his criticisms as directed against the beneficial effects of State health insurance as practised in Europe. That there will be defects in the working details of any such scheme is obvious. But the recognition of such defects should be an aid rather than a hindrance to the inauguration and sound establishment of a new system, which, in the light of past experience, can be designed to avoid the errors and pitfalls and undesirable features present at the inception of the older systems or revealed in their development. Mr. Hoffman's criticism is mainly directed to conditions which existed more than ten years ago, and which conditions have been steadily improved upon. This will be evident from the following concluding recommendations in the Majority Report of the Kingsgate Commission:—

That National Health Insurance has established its position as a permanent feature of the social system in this country, and should be continued on its present compulsory and contributory basis, subject to the various changes recommended below.

That medical benefit has been a valued and successful element in the scheme of National Health Insurance.

63. Finally, we refer again to the evidence of Mr. Hoffman in Volume 3, Appendix H, when he was closely questioned by members of our Commission. His evidence reveals, in our view, merely general statements backed up by no reliable facts.

IS A STATE HEALTH-INSURANCE LAW REQUIRED IN BRITISH COLUMBIA?

(3.) To inquire as to whether and to what exent the public interest requires the introduction of similar laws into the Province of British Columbia.

64. To obtain an answer to this inquiry, we made a general tour of the Province for the purpose of securing first-hand information as to the conditions in general and as to the express wishes of the people in particular. Thirty-three public meetings, involving twenty-one day and twelve night sittings, were held at the following centres: Chilliwack, Cumberland, Duncan, Fernie, Grand Forks, Kamloops, Kimberley, Merritt, Nanaimo, Nelson, New Westminster, Penticton, Port Alberni, Prince George, Prince Rupert, Revelstoke, Smithers, Trail, Vancouver, Vernon, and Victoria. Public notice of the meetings was published in all newspapers in the vicinities visited, inviting the attendance of any one who might be interested in submitting views to the Commission.

65. The evidence taken at these meetings will be found in Volumes 1, 2, and 3 of Appendix H, and discloses (*a*) an overwhelming desire on the part of the public generally for the introduction of both State health insurance and maternity benefits, and (*b*) the undeniable and acute necessity for such a scheme.

66. Oral evidence was heard from 292 witnesses. A list of these witnesses, with corresponding page of testimony, accompanies Appendix H. In addition to the many persons who did not speak in a representative capacity, but as individual observers, evidence was heard from representatives of the following bodies: Local sickness insurance associations, hospitals, medical profession, nursing profession, dental profession, health centres, pharmacists, the Canadian Legion, fraternal societies, trade-unions, farmers' institutes, women's institutes and unions, departmental stores, wholesale houses, industrial concerns, timber industry, boards of trade, municipalities, railways, life insurance companies, Christian Scientists, drugless healers, chiropractors, anti-vaccinationists, anti-vivisectionists.

67. Each meeting was prefaced with an opening introduction by the presiding member of the Commission, specifying the nature of the inquiry and outlining briefly the idea and scope of State health insurance. Meetings were purposely conducted in an informal manner in order to render hesitant speakers at ease, and the resultant free expression of views was eminently satisfactory.

68. (*a.*) It would be an unnecessary addition to our Report to quote excerpts from the evidence in confirmation of our finding that the public generally has overwhelmingly expressed a desire for State health insurance. An opening of the evidence volumes almost anywhere at random will disclose support. Suffice to say that, of the total witnesses who testified, scarcely one opposed the scheme. A very few limited their support with reservations as to practice details. There were, for instance, drugless healers, chiropractors, and supporters of other irregular practitioners, who made their support conditional upon their being admitted along with medical men as practitioners. Some Christian Scientists objected to enforced

medical service as regards themselves, but no opposition was voiced by wage-earners of that cult; the anti-vaccinationists expressed themselves against the medical profession generally, but not against health insurance particularly. There was only one person who absolutely opposed—namely, the aforesaid representative of the Prudential Insurance Company of America. (*See* paragraphs 53 to 63, inclusive.)

69. There are already a number of private health-insurance systems which have pioneered the introduction of a State health-insurance system in British Columbia, and which are unanimously in favour of such system being made Province-wide. The total number of companies represented in the list of such private schemes when a survey thereof was made in 1929 was ninety-six, with 58,272 employees, these inclusive of Canadian Pacific and Canadian National Railway employees, employees at all plants of the Consolidated Mining and Smelting Company (of Canada), Limited, the Vancouver Island and the Interior coal-mining companies, etc. Of these ninety-six companies, seventy-nine contribute in greater or lesser degree to the costs of services, which are chiefly primary benefits in kind, but also include cash payments during sickness in quite a number of industries, possibly one-third of the whole. Employees' dependents also are to a very considerable extent included in the protection of these various medical-contract schemes.

70. Tabulation with all details of private industrial medical contracts and similar employees' benefit schemes operative in British Columbia accompanies this report as Appendix I.

71. In discussion with the heads of the more important employees' medical or benevolent associations, we took especial care to ascertain whether they would be prepared to abandon their own smoothly running organizations and come in under the State health-insurance scheme if no increase in contribution charge were involved for similar benefits; and if they regarded the provision of cash benefits as necessary and essential. All were in favour of a State health-insurance system. Ninety-odd per cent. (the exception being the Consolidated Mining and Smelting Company (of Canada), Limited) professed immediate willingness to merge their private plans with a Province scheme. Roughly, two-thirds favoured the incorporation of cash benefits, but not if by so doing the successful introduction of a scheme limited to benefits in kind would be jeopardized—the Canadian Pacific Railway's Employees' Medical Aid Association pointing out that they had rejected efforts to incorporate cash benefits with their plans. Representations of the agricultural interests were entirely indifferent to the cash-benefits feature. Reference is directed to page 25 of our First Report, under the caption "The Provincial Situation," where will be found the record of voluminous written testimony in favour of a State health-insurance scheme.

72. (*b.*) The necessity for the introduction of a system of both health insurance and maternity benefits should be appreciated, and we therefore extract from the evidence some views in this respect:—

EVIDENCE ON GENERAL SICKNESS.

H. Thorndyke, Fraternal Order of Eagles, Vancouver: At present there is much suffering in the Province through people being unable to afford medical service. . . . Four or five years ago, while unemployed, I contracted erysipelas, and was charged $48 for eight day's services. You can imagine what a bill of that size means to the common worker. (Appendix H, Volume 2.)

Dr. J. H. MacDermot, B.C. Medical Association: The Medical Association recognizes that there is a public demand for some form of health insurance and that there are very strong reasons therefor. . . . There is an unfair burden on people of moderate means, of the wage-earning class, and as a result much avoidable sickness, much sickness that is treated unsatisfactorily, and much financial hardship resulting from sickness. (Appendix H, Volume 2.)

J. H. Smith, Street Railway Men's Association, Vancouver: We have men with us who have sought to protect themselves through the various societies, fraternal and otherwise, in time of sickness. The majority of these societies pay over a period of probably eighteen or twenty weeks; some a little longer. But after that point . . . you generally get less, and after a certain time, probably three to four months, a man is left almost as destitute as though he had never tried to protect himself at all. (Appendix H, Volume 2.)

Dr. G. A. B. Hall, Nanaimo: Lots of people will not call in a doctor because of knowing that they cannot pay him, and they do not like to call him on charity. There are many cases I know of where a person has been sick five or six days or a week, and had reached the stage where it was impossible to do without a doctor, whereas if the doctor had been called in sooner the case would have been much easier handled, and in some cases the life of the patient saved. (Appendix H, Volume 2.)

M. L. Proctor, Port Alberni: I do not think there can be any doubt as to the needs of this district when you take into consideration that the greater majority of employees are earning only 40 cents an hour, on which they cannot properly support their families, feed and clothe them, and pay doctor bills. They get along as long as everything goes all right, but as soon as that big doctor bill arrives they are up against it. I therefore think that every district such as this needs State health insurance. (Appendix H, Volume 2.)

F. Reid, Reeve of Surrey: Many of these people will refuse to go to hospital, knowing that if they do they will be called upon to pay the doctor. There are people actually suffering throughout the valley through lack of hospital and medical care. I believe compulsory insurance should be brought into effect. (Appendix H, Volume 2.)

R. L. McCullough, Matsqui: It takes me all my time sometimes to carry the burden of medical and dental care. . . . In so far as Matsqui is concerned, we would welcome State health insurance. It is the only solution of our pressing problem. (Appendix H, Volume 2.)

J. B. Watson, Board of School Trustees, Chilliwack: I know that the average farmer is unable to pay the bills as they come in if he has a family of any size. He might be able to manage with one child, but if he has half a dozen he cannot manage the sickness bills. (Appendix H, Volume 2.)

F. N. Emmott, Provincial Constable, Fernie: In the district between Kamloops and Blue River there is no doctor. . . . The doctor charges $1 per mile each way and $25 for the visit, with the result that the man as a rule cannot pay the doctor. The wife worries until she eventually winds up in Essondale. I know of such cases. There was one at Raft River and another in the Clearwater Valley. That woman died. (Appendix H, Volume 2.)

C. A. S. Attwood, Grand Forks: Few families can individually get away with the modern doctor's bill. (Appendix H, Volume 3.)

Dr. W. Truax, Grand Forks: My practice covers the territory contiguous to Grand Forks. I should say about 40 per cent. of my patients cannot meet their bills. (Appendix H, Volume 3.)

Dr. Walker, Penticton: From my view-point as a practitioner, a liberal estimate of the people in this municipality able to pay their medical bills without embarrassment would possibly be 10 per cent. I do not think that more than 10 per cent. of the people here can contemplate hospital and doctor bills without a shudder. (Appendix H, Volume 3.)

C. H. Orme, Mayor of Prince Rupert: Indigency is not especially prevalent in Prince Rupert, but the burden of sickness costs falls heavily on the labouring-class. It is, indeed, impossible for them to pay, no matter how they try. (Appendix H, Volume 3.)

S. V. MacDonald, Trades and Labour Council, Prince Rupert: Medical fees and hospital charges are now so high as to greatly burden the working-class; and some form of assistance is required to alleviate the existing conditions, particularly in outlying areas. Men engaged in development of new country are entitled to special consideration; and if this were afforded, the health standard would be raised to the public advantage. (Appendix H, Volume 3.)

Dr. Hankinson, Prince Rupert: I collect about 45 per cent. of my charges, or perhaps slightly less. I do not keep accurate account of all I do, but during the past ten years I have

accumulated many hundreds of accounts and many thousands of dollars in book debts. There are very many in the Interior unable, although not unwilling, to pay. They have nothing. (Appendix H, Volume 3.)

Mr. Marshall, Prince Rupert: A man with $2,500 salary or less, and three or four children, will find it pretty hard if he has a big hospital bill. With wife or children sick for six weeks or so during the year and having to go into a hospital for an operation, any one with less than $2,500 salary will find these bills burdensome and necessitating calling upon the capital of his savings for old age. (Appendix H, Volume 3.)

Dr. H. C. Wrinch, Skeena: Too frequently I have had to deal with people who, had State health insurance been in effect, would have been spared much suffering—people unable to meet the costs of medical care. Dreading the expense of such attention, many do not seek help from doctor or hospital when they imperatively need it. I have long since reached the conclusion that a State health-insurance system would be the solution of the problem of the people's health. (Appendix H, Volume 3.)

A. M. Patterson, Mayor of Prince George: The farmers, whom we sometimes call homesteaders, are in the greatest need of such a scheme as is suggested of any class of the people, especially in this community. The industrial worker has the Workmen's Compensation, and the man who is not working for some one is of course in a less advantageous position. (Appendix H, Volume 3.)

S. C. Burton, Royal Inland Hospital, Kamloops: It has frequently been said that only the very rich and the very poor can afford to be sick; the middle class is in a very unfortunate position. As has been remarked, when a man goes to the hospital he does not like the idea of going to a public ward and yet feels that he cannot go into a private ward. As a result many are afraid of increasing the medical expense when they most require the best attention, and this is a very serious problem with the great "middle class." (Appendix H, Volume 3.)

A. W. Duck, Kamloops: I have always felt that something in the nature of State health insurance would be a great thing for the country. The amount suggested of so much a month contribution is about the same as you would pay for the ordinary benefit society, and if kept up would be an insurance against hospital and doctor bills and I think it would be the grandest thing on earth. I do not think we would ever feel the costs of such insurance if the contribution amount is kept within reasonable bounds. I think this would be the best legislation that could be brought in and enforced in this Province, and I am confident that ninety-nine families out of every hundred think the same. (Appendix H, Volume 3.)

Dr. O. J. N. Willoughby, Kamloops: I do not wish to go into the matter of fees, although they may seem high for the average working-man. It is hard for the doctors to have to charge a high fee. It is a part of our work which is distasteful, and it would by a happy thing for the Province if we could treat every one alike and did not have to send them in bills and compel them to struggle the rest of their lives to pay them. (Appendix H, Volume 3.)

Mrs. Arnot, Vernon: The family finances are often crippled for years through the occurrence of one or two severe illnesses in the family, and we know of many cases of little children who go without medical care and who suffer from bad teeth or bad tonsils or twisted limbs because their parents haven't the money and perhaps are too independent to run up an account that they cannot see their way to settle. (Appendix H, Volume 3.)

Dr. H. E. Young, Superintendent of Health, Victoria: Many people who should go to the hospital do not go because they are not looking for charity and they know that the charges, plus the medical fee, are entirely beyond their means. People who are down and out, indigents, can get all these for nothing; people who have plenty of money to pay can get them, but the great mass of the population—the working-man, the salaried man, and the small business-man—is not in a position to get any of these things. The result is that impairment of the health is left until it is an absolute necessity before any one is called in, which results in far more surgical work than otherwise would be required. Before the physician is called in, the disease has got to a point where it has become aggravated and has probably affected every organ in the body; whereas if the man had gone to the hospital in the first place, that would have been avoided. It is that class of self-respecting man who does not want charity who is suffering most, as a rule, the small-salaried man. (Appendix H, Volume 3.)

G. A. Dyson, Life Insurance Agent, Victoria: I am one who knows about the hard road many have to travel, and I want to say this: that there was never a time in the history of

the world, or particularly of British Columbia, when the need for State health insurance, inclusive of maternity benefits, was so great as it is to-day. (Appendix H, Volume 3.)

EVIDENCE ON MATERNITY SICKNESS.

Mrs. Hodgson, Vancouver: I think non-practical nursing is where we lose so many mothers and babies. It is impossible for the majority of families to-day to pay $35 a week for a trained nurse, and few families can put down $25 before the mother can go to the hospital. It seems to me an outrage that a woman cannot have proper care and treatment during such a crisis as maternity. (Appendix H, Volume 2.)

Mrs. Manifold, Women's Navy League, Vancouver: Not so long ago in our own neighbourhood there was a woman who had no money at all. Her baby died because she was undernourished and did not have medical attention. There are lots of women where that has happened, with the husband out of work and the mother insufficiently fed. (Appendix H, Volume 2.)

Mrs. N. Attenborough, Beaver Women's Institute, Vancouver: I know of a concrete case near my home, of a pregnant woman who has not even engaged a doctor because she cannot afford to pay him. (Appendix H, Volume 2.)

Dr. L. Jones, Revelstoke: They do not employ a medical man first because they cannot afford to, nor can they afford to come to town and enter the hospital. Thirdly, in many cases, they take a chance. If everything goes all right, it is all right. If it doesn't, there is a hurry call and the situation may be serious for mother and child. A certain number always will take a chance in maternity cases. (Appendix H, Volume 2.)

G. Remmison, Manager, Canadian Bank of Commerce, Revelstoke: I have known where the life of the mother was lost simply because money was a matter beyond her resources. (Appendix H, Volume 2.)

Dr. E. C. Arthur, City Medical Health Officer, Nelson: I have had experience myself in districts such as this, where the lives of mothers have been lost through lack of necessary finances. (Appendix H, Volume 2.)

Dr. Walker, Penticton: If maternity benefits were applied, a much larger percentage of mothers would have their children in the hospital, which is of course much to be desired. (Appendix H, Volume 3.)

Mrs. Anna Grundall, District Nurse, Woodpecker: We have many maternity cases, quite a few of which I have worked with, and we have been unable to get medical aid for them because the homes are absolutely out of funds. . . . I have had many patients removed to my own home to better accommodate them. (Appendix H, Volume 3.)

Dr. A. G. Price, Medical Health Officer, Victoria: One of the great advantages of this scheme should be the inclusion of maternity benefits. I have known case after case of operations being brought on, abortion operations, not because of fear of the pains of labour, but because of the dread that there was not enough money available to sustain the expense of such an event. I have known case after case where such things have happened. . . . I think that the maternity benefits should constitute the most important part of any thoroughly useful State health-insurance system. (Appendix H, Volume 3.)

73. Admitting the desire and the necessity for the institution of measures for the purpose of relieving people of limited income from the burden of sickness costs, the question properly arises, in what way will compulsory health insurance remedy matters? This, we feel, has been answered, as will now appear.

74. From the medical testimony adduced, four factors strike us as of baneful consequence arising from inability to pay sickness costs. The first and most serious would appear to be the possible evil effects of procrastination in seeking medical advice. The evidence discloses that many reputable citizens, in both maternity and general sickness cases, refrain from calling in a medical practitioner because their honesty forbids them to incur an expenditure they cannot meet. This may lead the sick person to do without medical treatment altogether, which may result in aggravation of the illness and in an increase in the length of treat-

ment when finally undertaken. In other cases procrastination may be the thief, not only of time, but of life; for there are many maladies which, if taken at the inception, are easily curable, but which, if left too long, are easily fatal.

75. Secondly, the great advantage of periodical medical examination and the expansion of the modern-view practice of "prevention first and cure afterwards" was strongly stressed by Dr. H. E. Young, the Provincial Superintendent of Health, who, in giving evidence before the Commission, said:—

. . . In such a scheme, I would provide for the active development of preventive measures. . . . Prenatal work particularly is a most important work. There should be periodic examinations of everybody every six months, or at least once a year; and that should be all included in the tax. . . . In my department, in carrying out that medical examination of school-children, it is appalling the number of defects we find in these children. These defects are laying the foundation for organic diseases in middle life; and we know that when a boy goes out suffering from these defects, or a girl, that he or she is never going to produce probably more than their own maintenance, and very often not that. He is a drifter. He marries. His family becomes dependent on the State, or friends, and as an economic asset he is a charge on the State. We are investing millions of dollars in the education of the children. Is it good business to turn out one-third of your population where we know that we will not get a return on the dollars invested? You would not do it in your own business. We can do a wonderful work in the first years of early life such as will have incalculable effect on succeeding generations. In the meantime we are losing on the production end. We are spending millions to build hospitals to provide accommodation for people who should not be in there. Thirty per cent. of the people in hospitals to-day should not be in there, and would not be in there, if proper methods had been adopted. We are spending about $900,000 this year in *per capita* grants to hospitals, in addition to the income from liquor of 25 cents a day. The Government is committed for three or four million for capital expenditures, and the demand is for more. We are holding a big commission on the Vancouver General Hospital. They put up two big buildings there, and the net result of that big expenditure is only an increase of forty beds. Where is that going to lead? It is becoming such a drain on the Consolidated Revenue of the Province that it is very soon going to equal the education charges; and the people cannot stand it. What is the use spending it after the mischief is done? Why not begin with prevention? They are spending $6,000,000 in British Columbia and they are giving me about 15 cents *per capita* to prevent disease. That is something that the public should consider. . . .

Dr. Gillis: I would like to ask Dr. Young a question—he is the one man who could answer it properly: Do you think the time is ripe, doctor, in this Province, for a system of health insurance?

Dr. Young: Yes, I do; yes, sir. (Appendix H, Volume 2.)

76. A third disquieting factor is the mental worry accruing to a patient as a result of inability to pay his medical or hospital bill, and which may have a serious effect in preventing the patient from achieving that tranquillity of mind so essential to proper recovery from illness.

77. The establishment of a system whereby, for the payment of a small contribution per month, such patients would have those contributions capitalized for them, to the end that medical and hospital fees would be paid, would result in a far-reaching remedy in the health and security of the insured.

78. In this connection the evidence will repay further examination:—

Dr. Hankinson, Prince Rupert: A small monthly payment will centainly be agreeable to most of them, because it is, after all, the big hospital bill and the big doctor bill that stares them in the face as soon as they are able to sit up in bed. That is the thing that knocks people on the head; and it (the bill) does not get any smaller. (Appendix H, Volume 3.)

S. C. Burton, Royal Inland Hospital, Kamloops: The mental worry of a poor chap who is running up a big hospital and doctor's bill is about the most terrible thing an individual can

put up with; and, on the other side, the patient who is sick and incurring these bills is subject to such mental worry that in many cases I think it prevents their recovery at all. (Appendix H, Volume 3.)

Mrs. Fischer, Social Welfare Agent, Council of Jewish Women, Vancouver: There is much distress through sickness, and women not in good circumstances are very frightened as to the coming child, and their health is consequently undermined. They worry about the bills that will be coming in on account of the confinement, and then to economize they take in these untrained nurses that have been spoken about. (Appendix H, Volume 2.)

Mrs. Manifold, Women's Navy League, Vancouver: I am greatly in favour of State health insurance and maternity benefits because I think there can be nothing of more value to the expectant mother than to know that there is some way by which her confinement would be looked after, so that she need not worry. Worry is one thing very deterimental to a pregnant woman. I am among the working-class a lot and as soon as a mother is pregnant the first thing she thinks of is the question, "How am I going to foot the bill?" And from the first month on it is continual dread and worry, a condition very bad for her. I am much in favour of this scheme. (Appendix H, Volume 2.)

79. A fourth, but by no means the least, consideration arising upon this phase of the discussion is that a properly organized plan of compulsory insurance provides the only reliable means of effectually preventing an epidemic. On this point Dr. Young said:—

. . . In 1927 they spent $1,500 for isolation expenses, sending children to Vancouver. The schools were disrupted; epidemics were prevalent. We would begin in September with 97 per cent. of an enrolment, and in June it would be down to 72 per cent. I persuaded them to take in the full health community. In 1927 we had reduced that isolation charge to $1,000; and in 1928 it was down to $100. We have not had a school closed for three years. We have not had an epidemic for three years. . . . In many respects we do not enforce the laws as we should. I do all I can, but I am spending money, hand over fist, to correct mistakes which should never be allowed in any civilized community. . . . There was a case of small-pox developed outside of Nanaimo. It was reported after the mischief was done. It was a school-teacher, and she went to the doctor and said: "Can I go back to school?" and he said "Yes." It was a mild case. The result was, before that thing was checked, it cost my department $2,500 and Nanaimo $2,000, and the whole thing could have been stopped for $5.

And note the following by Dr. Woods Hutchinson in the State of California's Report of the Social Insurance Commission (p. 35, No. 117, Appendix B):—

Health insurance would provide the ideal and only means of immediately detecting and promptly stamping out an epidemic, such as Spanish influenza, and other acute contagious diseases. At the first sign the insured individual will naturally go to his doctor, because he thinks he owes him money and because he is paid in advance. The doctor can thus detect an infectious disease in its early stages, and can promptly make his way to the house of the first victim and examine all the members of the family, to see if any of them show signs. If not, he can isolate them, and in diseases for which we have a vaccine, vaccinate them, and stamp out the epidemic before it has time to get a foothold. (Appendix H, Volume 2.)

EVIDENCE ON HOSPITALIZATION.

80. There are, however, other considerations which fall within the scope of our inquiry as to what extent public interest requires the introduction of State health insurance.

81. The welfare of the hospitals of the Province is closely linked with the scheme under review.

82. The evidence submitted from eleven hospitals was to the effect that uncollectable debts ranged from 25 to over 50 per cent. of the earnings, and that these debts were incurred by people who, because of poor circumstances, had not the means to pay for hospital accommodation. Questioned as to whether, if these

debts were paid, the hospital could carry on with expenditure meeting revenue: for seven hospitals it was admitted that with all debts paid they could do without the Government grant, and for three others that they could do with a much reduced grant.

83. This being true, the solution seems obvious. If these unfortunate hospital debtors were insured in a scheme whereby their hospital bills would be met, the hospitals would be relieved of much present embarrassment, and the State would be largely relieved from the necessity of augmenting hospital income by grants from its revenue. The following excerpts from the hospital evidence are pertinent:—

Miss Jackson, Matron, King's Daughters' Hospital, Duncan: If all coming into the hospital paid, we should be able to care for our expenses. (Appendix H, Volume 2.)

E. S. Withers, Manager, Royal Columbian Hospital, New Westminster: Undoubtedly it would relieve the Government of at least a large proportion of its expenditure for the upkeep of hospitals if a scheme of State health insurance were effected which would make it possible for people to pay their hospital bills. (Appendix H, Volume 2.)

J. E. Leslie, President, Chilliwack Hospital: I think the people in the Chilliwack Valley would accept this system (State health insurance). They would get better hospital treatment and at half the present cost. (Appendix H, Volume 2.)

M. L. Grimmett, Chairman, Nicola Valley General Hospital: I think the rates we are charging now would perhaps carry us if we could collect all our accounts. (Appendix H, Volume 2.)

H. Scales, Secretary, Revelstoke Hospital: If all would pay their bills, or could pay them, we would not need the Government grant. (Appendix H, Volume 2.)

Mr. Burdett, Kimberley District Hospital: We have no bad debts in our hospital, owing to the fact that we are working under the employees' contract scheme. It is reasonable to assume that if such a scheme operated generally throughout the Province, the hospitals would have a comparatively easy time. (Appendix H, Volume 2.)

J. C. Forbes, Secretary, Kootenay Lake General Hospital, Nelson: If we could collect all our bills we would have a surplus and could almost do without the Government grant. (Appendix H, Volume 2.)

Mr. Kettle, Penticton General Hospital: If all our patients paid us $2.50 a day we would get on splendidly. (Appendix H, Volume 3.)

S. C. Burton, Royal Inland Hospital, Kamloops: Of course that situation is to some extent met by the various grants, but with 35 per cent. of patients' bills unpaid a deficit is inevitable. If that 35 per cent. were paid, we could finance our hospitals very nicely, and I do not think we would have to apply to the Government for help. (Appendix H, Volume 3.)

84. As a consequence of the foregoing, we find, unreservedly, that public interest requires the introduction into the Province of a system of State health insurance and maternity benefits.

FINANCIAL CONSIDERATIONS.

(4.) To estimate what would be the total annual cost to the people of the Province in regard to each of these subjects, and what portion of the annual cost would fall upon (*a*) employers of labour, (*b*) prospective beneficiaries, and (*c*) the general taxpayers.

85. Having ascertained the urgent necessity for some such assistance as above, we have turned our attention to the question of how the same might be financed so as to become an immediately practical plan. While recognizing to the full the

undeniable beneficial effects of a health-insurance scheme as a cardinal factor in the welfare of both State and community, nevertheless it would be idle for us to recommend such a scheme unless we were of the firm opinion that we could satisfactorily submit an intelligent answer to the financial considerations germane to any discussion surrounding an estimation of costs to all parties concerned.

86. Actuated, no doubt, through contemplation of the constantly increasing financial burden consequent upon the elaborate system of social-welfare legislation now obtaining within the Province, many employers of labour, as well as those who keep an eye upon the state of Provincial finance, view with perturbation any suggestion that social services should be further added to. Such a state of mind is natural and logical, having regard to increasing taxation in the particular light of present-day conditions of industrial and financial depression. We have accordingly approached this phase of our inquiry in full appreciation of the exigencies for restraint which confront us, and giving studied consideration to the following statement made to us by Mr. E. D. Johnson, the Deputy Minister of Finance:—

> At present we have exhausted all the avenues of expenditure bordering on this particular matter. It might be brought within reasonable limits financially, but if it is to involve an appreciable additional cost it will be impossible for the Province to carry it out. (Appendix H, Volume 2.)

After prolonged and mature deliberation, in which every reasonable opposing suggestion or doubt has been thoroughly canvassed, we have finally concluded that a scheme of compulsory health insurance can be placed in immediate operation in the Province with, in some plans, a concomitant reduction in the amount now paid by the State and employers for health services, and in others with inconsequential addition to any burden now borne. Variations of the scheme, involving greater benefits and, consequently, greater costs, will, of course, have the effect of adding to the present obligations of those who may be incorporated in the scheme as sharing contributors. It is all a question of how far the benefits shall go, and the scheme can be made inexpensive or expensive accordingly.

87. The financial plans about to be presented are reared upon an actuarial foundation, the processes of which will be explained step by step; and, from the whole, such features may be selected as may be considered desirable in the light of prevailing conditions.

88. From an exhaustive consideration of these various problems, and having in view the necessity of the scheme being confined, in its infant stages, within the channel of sound economy, we offer certain general recommendations. It will be understood that any scheme of the nature under review must feel its way at first; must crawl before it walks, and must walk before it runs. To what extent it may subsequently expand will depend upon the soundness of its administration and the progressiveness of its development, a scientific combination of which should result in the future establishment of many desirable features, perhaps, at the outset, unobtainable. Any recommendations put forward by us at this time must therefore be recognized in the light of present conditions, and not by any means as suggestive of limitation upon future expansion.

89. Research tending towards the ascertainment of the cost of providing for sickness insurance requires as a basis the determination of (*a*) the classes of persons who are to be served, (*b*) the manner in which their contributions shall be levied, (*c*) the number of such persons, (*d*) the nature of the benefits to be granted,

and (*e*) the amount of contributions required, together with the proportionate rate to be assessed upon the contributories.

(*a.*) CLASSES OF PERSONS TO BE SERVED.

90. On this highly important question, as to whom should be included in a State-controlled compulsory sickness-insurance scheme, a variety of ideas have been submitted in evidence. As usual in these matters, there are two extreme schools: In the one, are those who propose a limitation of the scheme to the poorest classes only; and in the other, those who would extend the service to the whole population, regardless of occupation or fortune. Between these extreme schools suggestions have come from others for the inclusion of manual workers only; and some favour extending the scheme to salary-earners also, up to a certain maximum income. Then, again, there are those who think the scheme should be made to embrace not only the manual workers, but also any one who may wish to enter it voluntarily. Furthermore, there is to be considered whether, and to what extent, the benefits of the scheme should include the dependents of insured persons.

91. We are of the opinion that, in order to successfully introduce an economically and fundamentally sound scheme, only those persons should be compulsorily included at the outset whose contributions can be assured of collection whilst the contributor is engaged in employment. The ability to collect contributions instantly is of the very prime essence of the contract which the State enters into with a compulsorily insured person. To include persons in the insurance scheme, payment of whose contributions could be obtained only after delay, or perhaps not at all, would tend to seriously undermine the financial structure of the insurance edifice and would be a breach of contract as well as of faith with those insured persons who have been guaranteed certain benefits in return for their compulsory payments.

92. We are aware of the difficult problems which arise concerning the throwing-open of the scheme to unemployed people in poorer circumstances, to whom the benefits would be an incalculable boon, such as farmers and others who are not employed by any person. We have already indicated the boundary-line beyond which, from the compulsory view-point, we feel it would not be safe to go. It is possible that, as the scheme developed, adequate measures might be found which would be feasible of introduction so as to open the plan to those not obliged to enter at first. For instance, it was suggested that the farmers' contribution might be made reasonably certain of collection by imposing it as a tax on the land. We offer no comment upon the feasibility or desirability of this suggestion, which we feel must be left for solution to the body which may be entrusted with the administration of a health-insurance scheme.

93. Regarding voluntary contributors, we would point out that the British practice restricts this class for those *employed* contributors who, on ceasing to be insurable, desire to continue their State insurance. No other volunteer is allowed into the British scheme, and the Kingsgate Commission recommended against any extension of the class. The reasons which prompted that Commission to this recommendation were mainly three: (1) The absence of an employer and, consequently, of any machinery by which collection of contributions could be made; (2) to give a continuing right to uninsured persons to come in as voluntary contributors would not be practicable without a grading of contributions; (3) experience has shown

that the majority of such voluntary contributors do not keep up payment of their contributions for more than a few years, and that out of a total membership of two and a quarter millions in one particular society there were only 2,023 voluntary contributors, and the tendency was for them to soon drop out of insurance.

94. There are, however, admittedly sound reasons for allowing volunteers into a sickness-insurance scheme. Many persons working on their own account, such as small shopkeepers, handy-work men, farmers, etc., who operate under no contract of labour, are clearly in no better economic situation than wage or salary earners.

95. That there would be grave danger of embarrassing the financial structure of a sickness fund if voluntary contributors were admitted without restriction becomes obvious. In such case a volunteer might have an illness which would consume the fund far beyond the amount of contributions he had paid, and as there would be no obligation upon him to continue his contributions he could thus leave the fund in the lurch. It follows that similar action by any number of people would be disastrous. In no country having compulsory sickness insurance are volunteers admitted without the imposition of both economic and physiological restrictions.

96. Voluntary contributors, therefore, in our view and recommendation, should be hedged with sufficient restrictions to ensure that they cannot menace the safety of the fund. This can be accomplished in a variety of ways, such as, on the economic side, by restricting waiting periods for a certain number of months before benefits can be claimable, a reduction in the maximum period of benefits until a certain total sum has been contributed, etc. And, on the physiological side, specification of an age-limit and the production of a certificate of good health. For suggestions in this respect we refer to Part III. of the 1930 French "Social Insurance Act," affecting volunteers (No. 42, Appendix B), and to the Geneva Digest (No. 111, Appendix B), pp. 61 to 63.

97. Deposit contributors under the British plan are not voluntary contributors. They are employed persons who are compulsorily insured but who will not or cannot join approved societies. They are not a factor in the plans we are presenting.

98. The next consideration under item (*a*) is whether the compulsory features of the scheme should embrace every employed person or only those manually employed, and up to what maximum income. We entertain the view that, at the outset, the compulsory scheme should be confined to all regularly employed persons, both manual and otherwise, who are in receipt of such income only beyond which the burden of sickness costs can be expected to be borne without discomfiture. In other words, we would not only apply the compulsory features of the scheme in its inception to those who do not necessarily require its benefit. In determining the amount of income to be struck, we have, after consideration of the evidence, fixed the sum at $2,400, believing this to represent a reasonable amount below which the extra costs of sickness would commence to seriously pinch upon the yearly budget. Ordinarily, an inclination would arise to discriminate between married and unmarried employees with reference to deciding the maximum income over which persons would be exempt from the compulsory provisions of an insurance institution. Naturally, it will cost a married person more for family upkeep, including sickness, than will be the case for an unmarried person, and it may be argued that if the insurance scheme will embrace married persons up to $2,400 income, single persons,

with less living expenses, should be subject to a less maximum income. It should be pointed out, however, that the considerations applicable to the question of dependents is involved in the higher contribution costs payable for this extension of services. (*See* paragraph 99, and Plans C, D, and E, page 40 *et seq.*) The income-limit, therefore, affects only individual employees and is divorced entirely from the question whether such employees are married or single. Otherwise, in deciding the benefits for all men of a certain occupation, a single man of less than $2,400 income would not receive the benefits which the more fortunate married man in receipt of such income would receive for himself alone, notwithstanding that the single man might individually, in certain circumstances, more urgently need the benefit.

99. With reference to including the dependents of insured persons as concomitant beneficiaries with the insured, there can, of course, be no question as to the desirability of doing so. It must, however, be borne in mind that for every benefit added to the scheme the cost to the insured will be increased. So that the matter must finally boil down to this: How much are the insured prepared and able to pay for the inclusion of their dependents? In the various plans submitted below, the extra costs for this service will appear.

100. The question of extending benefits to dependents of insured persons includes, necessarily, a consideration of the further question as to the justification or otherwise of exacting contributions from employer and State respectively. We feel that these considerations can, with better advantage, be deferred until after a general idea has been formed of the nature of the plans about to be submitted. (*See* paragraphs 146 to 150, inclusive.)

(*b.*) MANNER OF LEVYING CONTRIBUTIONS.

101. We have now for consideration whether contributions from the insured person should be levied on a percentage of income or at a flat rate. If the benefits were distributed in proportion to the amount contributed, there would be some reason for levying contributions on a sliding scale according to income. But inasmuch as the benefits under our proposals are the same for the low as for the high wage-earner, the flat rate of contribution would seem to us to be the equitable one. This is the system in force under the British scheme and we recommend its adoption for British Columbia.

(*c.*) NUMBER OF PERSONS TO BE COMPULSORILY INCLUDED AS INSURED.

102. To further complete the requisite factors for the determination of the capital required for the operation of a compulsory health-insurance scheme, there remains to be ascertained the number of persons who will be included in the group of employed persons in receipt of a net income not exceeding $2,400 per year. This involves the ascertainment of the population of the Province, and the further segregation as to the number of those employed at a remuneration of not more than $2,400 per annum.

103. On December 1st, 1931, the Dominion Bureau of Statistics released the official population census figures for British Columbia as 689,210. However, apart from the total number, no further statistical data are yet available; hence, to elicit the various population factors necessary to formulate the financial plans incidental

to this scheme, it became necessary to analyse the 1921 census and subsequent data supplied by the Dominion Bureau of Statistics, and to co-ordinate therewith statistics gleaned from the Dominion and Provincial Labour Departments as well as from trade reports. These various figures have formed the basis for the segregation of statistical groups (e.g., sex and occupational distribution) as applied to the 1931 population.

104. The population of the Province having been set at 689,210, it becomes necessary to determine what percentage of this population can be classed as gainfully employed. The statistics of the Provincial Department of Labour show that some 5,065 employers who made statutory returns to this Department had employed during 1929 some 121,937 persons. However, these returns covered only a portion of industrial and trade institutions, and did not include the activities of transcontinental railways, Dominion and Provincial Government employees, wholesale and retail firms, delivery, cartage and teaming, warehousing, butchers, auto transportation, ocean service, express companies, farming, professional, etc. This lacking information was supplied from the 1921 Dominion census returns, which give the percentage of gainfully employed in all occupations at that time. By applying the Dominion Statistician's formula as to expansion in population, together with necessary modifications as derived from Dominion and Provincial Labour Bureaux and published reports of trades-unions, aided by the 1931 census figures available, the computations reveal that there are some 268,700 persons gainfully employed in the Province.

105. By reference to the aforesaid statistical data, it appears that out of this total of 268,700, 75.39 per cent., or 202,570 persons are in receipt, through their labours, of net yearly incomes not exceeding $2,400. However, only a portion again of this latter number constitute wage or salary earners. From a further study of available statistics, it would appear that some 77.2 per cent. of these gainfully employed are in receipt of wages or salary. Hence, for purpose of our proposals, provision would be required to be made for 156,380 employees.

106. It is important here to note the statement which appears on page 3 of the Report for 1930 of the Workmen's Compensation Board to the effect that about 175,000 workmen are protected by the Board. This figure has been arrived at by dividing the estimated pay-roll of industries subject to the Act by the approximate average earnings of the workmen who have been injured. It will thus be seen that in the case of an employee who, for instance, transfers from one industry to another three times in the year, that employee may be reckoned as three men in computing the population protected by that Act. Furthermore, if a workman is injured more than once during a year, he will, in the above computation, add to the number of population as many times as he is injured. It follows that the figure of 175,000 cannot be used as an estimate of the number of indivdual workmen employed.

107. Should dependents be included in the plan, the total number of beneficiaries would then amount to 375,310 persons, on the basis of each employee representing a unit of 2.4 persons, which is the Dominion Statistician's estimate of the average number of persons dependent upon a single wage-earner's income. It becomes necessary to observe that this unit of 2.4 does not represent the average number of persons to a family, which is 4.03, and which latter cannot be utilized in this computation for the reason that the family group includes, in many cases, more

than one wage-earner, and also excludes unmarried persons as a family unit. By comparison with figures supplied by the British Ministry of Labour, this family group of 2.4 provides a wide margin of safety. Under the British scheme of health insurance, the Ministry of Labour places the number of dependents for each insured man at 1.5 and for each insured woman at 0.15, making the total number of dependents slightly more than the total number of insured persons. In our reckonings the dependents exceed the number of insured persons by 218,930.

(*d.*) NATURE OF BENEFITS.

108. The next factor for consideration on this branch of the foundation for the financial structure is the determination of the nature and scope of the benefits to be provided.

109. To aid in the formation of a conclusion on this matter, it will not be out of place to compare the benefits provided under the British scheme. These are, broadly:—

(1.) Medical benefit, which covers general (as distinguished from specialist) medical treatment, including medical and surgical supplies.

(2.) Sickness benefit, which is a cash payment of $3.60 a week for men and $2.88 for women, and which the insured can dispose of as he pleases; duration of this benefit is for the period of sickness and for four weeks after the insured becomes fit for work, but in no case to exceed twenty-six weeks.

(3.) Disablement benefit, which provides a continuance of cash benefit after the right to sickness benefit has been exhausted, but reduced to $1.80 per week for both men and women.

(4.) Maternity benefit, which provides a cash payment of $9.60 for assistance to the confined wife of an insured man. If both man and wife are insured, this benefit is doubled.

(5.) Additional benefits, which may be provided out of the surplus of any approved society, and may take the form of increasing the cash benefits, payment of specialist or other sickness treatment, such as dental, ophthalmic, hospital, or convalescent-home treatment.

110. It will be noted that, apart from the medical benefit and such additional benefits as the surplus funds (if any) of approved societies may furnish, the British health-insurance scheme is entirely a cash-benefit proposition—hospitalization, for instance, being a deferred benefit and one which may possibly never be granted out of the fund. Much of the hospitalization, however, in Great Britain is free, as many hospitals there are endowed institutions. Consequently, in that country provision, by the insurance institution, for hospitalization is not a primary necessity.

111. It is our view that a payment in cash, apart from maternity assistance, might be deferred until after hospitalization and medical treatment has been provided. Payment of cash as an adjunct to such benefits in kind is a legitimate aim in compensating, at least partially, for the economic loss incurred by the insured through enforced absence from work consequent upon sickness. In addition to medical aid and hospitalization, the wage-earner requires resources to replace the wages which he loses while ill and upon which he and his family depend. In the case of a single man who is in hospital, where he is fed, the economic loss is not so pronounced. But for the married man, whether ill at home or in hospital, as

well as for the single man ill at home, the time-loss benefit plays an important rôle. Strictly speaking, a cash benefit (other than maternity) is not health insurance, but a form of unemployment insurance, and where it is a primary benefit the encouragement to become or remain ill in times of unemployment may make it an undesirable feature. (*See* paragraph 160.) However, if properly guarded by the restrictions heretofore mentioned (paragraphs 30 to 34, inclusive), together with a properly organized supervision against malingering, we think this feature can be introduced safely, and is one which should, if economically possible, be part of any scheme.

112. For maternity-welfare the cash benefit stands upon an entirely different footing. The objection that one might incline to sickness in order to secure a cash benefit obviously will not apply to maternity cases. On the other hand, factors arise in the consideration of confinement treatment which can be met properly only through the medium of payment in cash. Quoting again from the authoritative Geneva studies:—

> Rest is indispensable to expectant mothers and pregnancy can only follow its normal course and be attended with satisfactory results if proper prenatal care is ensured; and this obviously implies abstention from work before confinement. . . . The mother after her confinement obviously needs rest and care, and is consequently unfit for work for some time after that event; while the new-born infant also requires the care and presence of its mother, who should be able to feed and nurse it. The conditions under which newly-born infants are fed, and an opportunity for their mothers to submit them to periodical medical examination, are essential features of any system of child-welfare. Both in the interests of the mother and of the child all these requirements must be fulfilled.

113. Practically and logically, a cash payment is the means to this end. The insured woman's ordinary treatment and hospitalization for confinements should, in the progressive development of a health-insurance plan, be covered by the medical and hospitalization benefits. From the Geneva studies we find that "in all countries having a sufficiently developed system of compulsory sickness insurance, the latter performs the functions of maternity insurance as well." (*See also* paragraph 140 below.) But the mother should, in addition, be placed in possession of a little extra cash the better to provide the comforts of life, which every one will admit to be most desirable at this critical stage, in the interests of both mother and child.

114. Convinced that benefits in kind are best calculated to further the welfare of insured people, we recommend that if it should be necessary from the standpoint of financial expediency to introduce the most inexpensive plan, hospitalization and medical treatment be accorded first consideration.

115. After providing the employee with the above benefits, consideration of applying them to dependents properly arises. The modern view-point in this connection is thus expressed in the Geneva studies:—

> The wage-earner who is the father of a family runs the risk of sickness not only in his own person, but in that of his dependents living in the household. The illness from which his dependents may suffer imposes upon the wage-earner an expense in the shape of the cost of medical attendance and medicine, and, moreover, may endanger the health of the entire family, including the head, who may thus be rendered incapable of earning. Hence the question of medical aid for dependents is of the greatest social importance, and provisions to this effect are included in sickness-insurance schemes.

116. We have endeavoured to show in the plans submitted below how this can be done and at what added cost.

(*e.*) AMOUNT AND SHARING OF CONTRIBUTIONS.

117. The final factor for consideration in the presentation of a financial plan centres upon the process by which will be raised the necessary fund to provide the aforementioned costs; and the manner in which the contributions may be shared by the contributing groups, if it should be desired to supplement the insured person's contributions.

118. The problem, accordingly, is: (1) To provide the cost of medical treatment and supplies, hospitalization, and maternity benefits for that group of employed persons in the Province whose individual net income does not exceed $2,400 per year, contributions being levied at a flat rate for all insured persons; (2) to provide the cost of extending benefits to dependents of insured persons; and (3) to provide the cost of a cash or time-loss benefit for insured workers during incapacity through sickness.

119. Statistics on the average duration of individual periods of sickness are indispensable for the purpose of ascertaining what sum is to be raised for providing the cost of benefits, and it has been necessary for us, with the aid of the Provincial Statistician, to construct reliable morbidity tables. The Austrian morbidity tables, which are based upon observations made from 1906 to 1910 for the Austrian compulsory-insurance funds, are, according to the Geneva studies, based on sufficiently wide experience to be acceptable as sound, and are the tables recommended in those studies. The male morbidity table has been compiled on an annual average membership of 2,000,000 insured males and a total of approximately 95,000,000 days of sickness. The female morbidity table covers an average annual membership of 650,000 insured women and 19,000,000 days of sickness. Excepting where specifically included as hereinafter mentioned, days of sickness by reason of confinement are excluded. We have discarded the English actuaries' table because it is based upon the experience of a friendly society (the Independent Order of Odd Fellows, Manchester Unity) from 1893 to 1897, before compulsory health insurance was introduced into Great Britain. The restrictions or other features which might make a considerable variant in this table are unknown to us; and the morbidity rates are very considerably lower than the Austrian table. We have, therefore, thought it safer to utilize the latter as the main basis for our morbidity tables. In order to bring these tables into closer demographic relation with this part of the world, the experience tables of insurance companies on the North American Continent have been consulted, and on these bases our tables have been constructed for the determination in British Columbia of the probable annual number of days of incapacity through sickness and accident, allowing a three-day waiting period and a maximum length of benefit of six months. It will be observed that the morbidity rate for these three tables is lowest at around age 16. In the European tables the lowest morbidity rate centres around age 25. This higher average of health in British Columbia for age-group 16 is, very possibly, accounted for by the better health-giving conditions surrounding the life of early youth in this part of the world. "Slums," sweating-shops, and other enforced child-labour, which may be said to be entirely non-existent here, are not the least amongst factors tending towards greater sickness morbidity in those parts of the world where the same exist, and which, in the Old Land, are to be found in the places of denser population.

Our morbidity tables follow:—

Morbidity Tables segregated as to Age Population.

Males.

Age.	No. of Persons.	Rate.	Total Days' Incapacity.	Age.	No. of Persons.	Rate.	Total Days' Incapacity.
Up to 9....	67,605	6.82	461,066	Up to 41....	6,475	7.17	46,426
„ 10....	6,251	5.45	34,068	„ 42....	6,213	7.41	46,039
„ 11....	6,090	5.38	32,764	„ 43....	5,764	7.64	44,037
„ 12....	5,882	5.24	36,062	„ 44....	5,248	7.86	41,249
„ 13....	5,692	5.17	29,427	„ 45....	5,105	8.02	40,942
„ 14....	5,504	5.13	28,236	„ 46....	4,866	8.21	39,950
„ 15....	5,230	5.13	26,830	„ 47....	4,444	8.47	37,641
**Total....	*92,254*	*7.03*	*648,453*	„ 48....	4,183	8.71	36,434
Up to 16....	5,088	5.12	26,051	„ 49....	4,490	8.95	40,186
„ 17....	4,946	5.19	25,670	„ 50....	4,453	9.17	40,834
„ 18....	4,803	5.23	25,119	„ 51....	4,374	9.36	40,940
„ 19....	5,238	5.51	28,861	„ 52....	4,192	9.60	40,243
„ 20....	5,830	5.57	32,473	„ 53....	4,203	9.62	40,432
„ 21....	5,843	5.63	32,896	„ 54....	4,159	10.17	42,297
„ 22....	5,910	5.67	33,510	„ 55....	4,017	10.55	42,379
„ 23....	6,366	5.75	36,605	„ 56....	3,569	10.94	39,045
„ 24....	6,997	5.78	40,443	„ 57....	2,485	11.42	28,379
„ 25....	7,145	5.82	41,584	„ 58....	2,574	11.91	30,656
„ 26....	7,418	5.95	44,137	„ 59....	2,366	12.27	29,031
„ 27....	8,024	6.05	48,545	„ 60....	2,605	12.82	33,396
„ 28....	7,177	6.01	43,134	„ 61....	2,681	13.17	35,308
„ 29....	7,299	5.97	43,575	„ 62....	2,559	14.01	35,851
„ 30....	7,758	6.06	47,013	„ 63....	2,402	14.79	35,526
„ 31....	7,528	6.19	46,598	„ 64....	1,699	15.38	26,131
„ 32....	7,265	6.31	45,842	„ 65....	1,596	16.06	25,632
„ 33....	7,498	6.40	47,987	„ 66....	1,482	16.51	24,467
„ 34....	7,829	6.56	51,358	„ 67....	1,383	16.97	23,470
„ 35....	7,884	6.71	52,902	„ 68....	1,269	17.92	22,740
„ 36....	7,514	6.73	50,569	„ 69....	1,109	18.68	20,716
„ 37....	7,110	6.78	48,206	„ 70....	1,029	19.47	20,034
„ 38....	6,629	6.83	45,276	†*Total....	*270,218*	*7.67*	*2,072,351*
„ 39....	6,153	6.87	42,271	71 up.....	5,930	23.70	140,541
„ 40....	5,936	6.96	41,315	Gr. Total..	368,402	7.767	2,861,345‡

*Total (ages 1 to 15)	92,254	7.03	648,453
†Total (ages 16 to 70)	270,218	7.67	2,072,351
Age 71 up	5,930	23.70	140,541
‡Grand total	368,402	7.767	2,861,345

MORBIDITY TABLES SEGREGATED AS TO AGE POPULATION—*Continued.*

Females, excluding Confinements.

Age.	No. of Persons.	Rate.	Total Days' Incapacity.	Age.	No. of Persons.	Rate.	Total Days' Incapacity.
Up to 15....	*109,308*	*4.85*	*530,144*	Up to 45....	3,127	7.71	24,109
,, 16....	5,605	4.09	22,924	,, 46....	3,147	7.93	24,956
,, 17....	5,585	4.16	23,234	,, 47....	3,117	8.06	25,123
,, 18....	5,624	4.24	23,846	,, 48....	3,116	8.29	25,832
,, 19....	5,626	4.36	24,529	,, 49....	3,077	8.41	25,878
,, 20....	5,611	4.73	26,540	,, 50....	2,888	8.56	24,722
,, 21....	5,641	4.98	28,092	,, 51....	2,776	8.54	23,707
,, 22....	5,662	5.21	29,499	,, 52....	2,683	8.61	23,101
,, 23....	5,667	5.42	30,601	,, 53....	2,417	8.63	20,859
,, 24....	5,709	5.49	31,342	,, 54....	2,009	8.67	17,418
,, 25....	5,717	5.57	31,844	,, 55....	1,877	8.85	16,611
,, 26....	5,756	5.61	32,291	,, 56....	1,783	8.96	15,976
,, 27....	5,794	5.44	31,519	,, 57....	1,688	9.08	15,327
,, 28....	5,810	5.57	32,362	,, 58....	1,670	9.53	15,915
,, 29....	5,834	5.46	31,854	,, 59....	1,610	9.62	15,488
,, 30....	6,114	5.63	34,422	,, 60....	1,520	9.72	14,774
,, 31....	6,341	5.78	36,651	,, 61....	1,426	10.15	14,474
,, 32....	6,583	5.97	39,300	,, 62....	1,283	10.23	13,125
,, 33....	6,422	6.24	40,073	,, 63....	1,145	10.81	12,377
,, 34....	6,181	6.45	39,867	,, 64....	1,004	11.28	11,325
,, 35....	5,955	6.69	39,839	,, 65....	837	12.07	10,103
,, 36....	5,818	6.70	38,980	,, 66....	751	12.34	9,267
,, 37....	5,804	6.71	38,945	,, 67....	723	12.85	9,291
,, 38....	5,751	6.73	38,704	,, 68....	657	13.47	8,850
,, 39....	5,705	6.74	38,452	,, 69....	623	14.11	8,791
,, 40....	4,924	6.77	33,335	,, 70....	633	14.49	9,172
,, 41....	4,228	6.86	29,004	*Total*....	*206,850*	*6.557*	*1,356,411*
,, 42....	3,463	7.11	24,622	71 up.....	4,650	18.24	84,816
,, 43	3,220	7.34	23,635	Grand			
,, 44....	3,113	7.56	23,534	total	320,808	6.145	1,971,371

	No. of Persons.		Rate.	No. of Days.
Ages 16–49	174,849,	excluding confinements at	5.9809	1,045,738
Ages 16–49	174,849,	including confinements at	8.4655	1,480,170, or 434,432 more.
Ages 16–70	206,850,	excluding confinements at	6.557	1,356,411
Ages 16–70	206,850,	including confinements at	8.65768	1,790,843
All ages	320,808,	excluding confinements at	6.145	1,971,371
All ages	320,808,	including confinements at	7.4992	2,405,803

MORBIDITY TABLES SEGREGATED AS TO AGE POPULATION—*Continued.*

Females, including Confinements.

Age.	No. of Persons.	Rate.	Total Days' Incapacity.	Age.	No. of Persons.	Rate.	Total Days' Incapacity.
16	5,605	4.49	25,166	34	6,181	9.35	57,792
17	5,585	4.86	27,143	35	5,955	9.39	55,917
18	5,624	5.27	29,638	36	5,818	9.20	53,525
19	5,626	5.45	30,656	37	5,804	9.11	52,874
20	5,611	7.33	41,129	38	5,751	8.83	50,781
21	5,641	7.18	40,502	39	5,705	8.44	48,150
22	5,662	7.81	44,220	40	4,924	8.27	48,991
23	5,667	9.32	52,816	41	4,228	8.06	42,138
24	5,709	9.49	54,178	42	3,463	8.02	27,773
25	5,717	9.67	55,283	43	3,220	8.02	25,824
26	5,756	9.81	56,466	44	3,113	8.02	24,966
27	5,794	9.74	56,434	45	3,127	8.01	25,047
28	5,810	9.57	55,602	46	3,147	8.23	25,900
29	5,834	9.36	54,605	47	3,117	8.36	26,058
30	6,114	9.33	57,044	48	3,116	8.59	26,766
31	6,341	9.28	58,844	49	3,077	8.54	26,278
32	6,583	9.37	61,683				
33	6,422	9.34	59,981	Total....	174,847	8.4655	1,480,170

120. The manner of making the necessary computations by the aid of these tables is as follows: The population of the Province has been divided according to ages from 1 to 71 years and onwards, and also according to sex. The total number of incapacity days (population for each age multiplied by corresponding age rate of morbidity) for male and female has been divided by the total Provincial population, which gives the average Provincial morbidity *per capita*. These calculations were made for each year from 1921 to date, applying the Dominion Government Statistician's formula for increase in population as finally corrected by the 1931 census. The morbidity for confinements will be found in a separate table. The result of these computations shows the following average rates of morbidity for the groups covered in the plans presently to be submitted:—

All Ages:

Males	368,402 at average of 7.767	2,861,345
Females (excluding confinements)	320,808 at average of 6.145	1,971,371
Total	689,210 at average of 7.01	4,832,716
Males	368,402 at average of 7.767	2,861,345
Females (including confinements)	320,808 at average of 7.499	2,405,803
Total	689,210 at average of 7.642	5,267,148

Ages 16–70:		
Males	270,218 at average of 7.67	2,072,357
Females (excluding confinements)	206,850 at average of 6.557	1,356,411
Total	477,068 at average of 7.187	3,428,762
Males	270,218 at average of 7.67	2,072,357
Females (including confinements)	206,850 at average of 8.6557	1,790,843
Total	477,068	3,863,200
Ages 1–70:		
Males	362,472 at average of 7.526	2,720,804
Females (excluding confinements)	316,158 at average of 5.967	1,886,555
Total	678,630 at average of 6.789	4,607,359
Males	362,472 at average of 7.526	2,720,804
Females (including confinements)	316,158 at average of 7.341	2,320,987
Total	678,630 at average of 7.429	5,041,791

It should be borne in mind that the length of morbidity periods in a health-insurance scheme is very largely dependent upon administration. Reference is directed to paragraph 30, wherein appear the principles which should guide an insurance institution in determining whether an interruption to health is of sufficient severity to warrant the interposition of the insurance fund. A too frequent laxity in permitting undue encroachments upon the fund will, obviously, raise the morbidity periods.

Hospitalization Costs.

121. Hospitalization costs may be safely figured by dividing the annual total days' morbidity into the annual total hospital costs throughout the Province. This will give the average *per diem* cost of hospitalization in relation to morbidity. It is a safe and generous estimate because the total *per diem* morbidity will obviously include sickness periods passed at home as well as those passed in hospital. Analysing these costs over a period of years from the hospital statistics furnished by the Provincial Secretary's Office (Appendix J), the *per diem* cost of sickness incapacity is found to be cents 84.47. The following comparative analysis of current hospitalization costs will disclose the fair accuracy of this figure: The all-age total morbidity, including confinements, for the 1931 census population of 689,210 amounts to 5,267,148 days (paragraph 120). The total hospital costs for 1930 amounted to $3,883,156 (Appendix J). To this figure an allowance must be made for an increase in hospital costs for 1931. The average increase in hospital costs per annum from 1923 to 1930 amounts to $207,000, which gives $4,090,156 as the total estimated hospital cost for 1931. This last-mentioned sum, divided by 5,267,148, gives cents 77.66 as the average *per capita per diem* cost of hospitalization. To this should be added at least 10 per cent. for increased attendance consequent upon the greater hospitalization facilities which will be provided by a health-insurance institution, bringing the *per diem* cost to cents 85.42, which

figure is within 95 cents of the amount computed according to the statistics available.

122. Were hospital statistics available for 1931, it would be possible to arrive at the exact *per diem* cost, but the amount at variance is so small that, for all practical purposes, and until definite statistics are obtainable through the operation of a sickness-insurance plan, the figure of cents 84.47 would seem to be a reasonably safe and accurate amount.

Medical Costs.

123. The *per capita* cost *per diem* for medical and surgical treatment has been computed at cents 66.88. Briefly, the details of this computation are as follows: The average *per capita* cost of medical care in Austria, together with the Austrian schedule of medical and surgical fees, was obtained from the Austrian statistics. This schedule of fees was compared with and transposed into the corresponding fees as obtaining in British Columbia, the latter being very considerably higher. Fees for the most prevalent illnesses were taken as a basis. The Austrian *per capita* cost was then multiplied by this percentage of increase in the local medical fees, and the approximate *per capita* medical cost for the whole Provincial population was found to be $5.11. This sum, divided by the average morbidity rate of 7.64, gives cents 66.88 as the average *per diem* cost of medical and surgical attention.

Pharmaceutical Supplies.

124. For determining the cost of this service, analysis has been made of like costs in England on a *per capita* basis, as derived from the National Health Insurance balance-sheet. A comparison and equalization of cost of said supplies as between British Columbia and the Old Land was arrived at, thus ascertaining the *per capita* cost here. And, finally, an estimated requirement of cents 13.73 *per capita* per day's incapacitation was found to be required.

FINANCIAL PLANS.

125. Based upon the aforementioned statistics, we now present for submission and study five plans, any one of which may be adopted as a whole or varied by the addition, or alternative selection, of different features of each plan.

126. *Plan A—Benefits for Employees only, excluding Maternity.*

156,380 employees at an average morbidity rate of 7.18 days *per capita* per year (average applying to ages 16 to 70) ..... 1,122,808 days.

		Total Cost.	Cost *per Capita.*
1,122,808 days at 84.47c. for hospitals		$948,435	$6.06
1,122,808 days at 66.88c. for doctors		750,934	4.80
1,122,808 days at 13.73c. for pharmaceutical supplies		154,161	.97
		$1,853,530	$11.83
10 per cent. for Administration*	$185,353		
2 per cent. for Contingency Reserve	37,070		
		222,423	1.42
		$2,075,953	$13.25 per yr. or $1.10 per mo.

* *See* paragraph 145.

On basis of:	State, 2/9 of Total Cost.	Employers, 2/9 of Total Cost.	Employees, 5/9 of Total Cost.	Cost to each Employee.
Hospitals	$210,762	$210,762	$526,911	$3.39
Doctors	166,874	166,874	417,186	2.67
Pharmaceutical supplies	34,258	34,258	85,645	.55
Administration and Reserve	49,426	49,426	123,571	.79
	$461,320	$461,320	$1,153,313	$7.40 per yr.
		$2,075,953		or 62c. per mo.

127. This is the most inexpensive plan submitted, although it may be rendered still more inexpensive by the elimination of any particular benefit. It covers benefits for the employee only, all of which are in kind. The total *per capita* cost of $1.10 could, in the great generality of cases, be totally borne by the employee without any embarrassment. On the basis of the above tripartite contribution, and if, as recommended (paragraph 190), the State health fund took over the Workmen's Compensation medical service fund, there would be a considerable saving to the employers in respect of the amounts now contributed to the latter. For the year 1930 the following amounts were paid out by the Workmen's Compensation Board for the services mentioned, namely:—

Medical fees	$487,240.40
Hospitalization	278,423.09
Drugs	2,577.99
Surgical appliances	5,155.98
	$773,397.46

Of this, the employers contributed 60.5 per cent., or $467,905. So that there would be a saving of $6,585 on basis of employers paying two-ninths of State health costs under this Plan A.

128. The aggregate costs to employers under this plan must, however, necessarily still further lighten the amounts which they now contribute to the Workmen's Compensation Fund, for the reason that there will be many more employers than in the case of the Workmen's Compensation Fund. There will be, for instance, employers of salaried officials who are not included in the Workmen's Compensation Fund. So that a very significant saving to the employers becomes immediately possible. It should be pointed out that in all the plans submitted, total morbidity is covered, accidents being included.*

129. This Plan A, however, covers no benefits for dependents, which a number of private industrial institutions now provide, and it is not likely, therefore, to meet with universal favour from the workers.

* In connection with the State's contribution, reference is directed to the discussions in paragraphs 141 and 149 to 161, inclusive.

130. *Plan B—Employees only.* (On previous basis, but including a maternity benefit of $25 to an insured person or wife of an insured person.)

		Total Cost.	Cost *per Capita.*
1,122,808 days at 84.47c. for hospitals		$948,435	$6.06
1,122,808 days at 66.88c. for doctors		750,934	4.80
1,122,808 days at 13.73c. for pharmaceutical supplies		154,161	.97
8,809 confinements at benefit of $25 each		220,225	1.41
		$2,073,755	$13.24
10 per cent. for Administration	$207,375		
2 per cent. for Contingency Reserve	41,475		
		248,850	1.59
		$2,322,605	$14.83 per yr. or $1.24 per mo.

On basis of:	State, 2/9 of Total Cost.	Employers, 2/9 of Total Cost.	Employees, 5/9 of Total Cost.	Cost to each Employee.
Hospitals	$210,762	$210,762	$526,911	$3.37
Doctors	166,874	166,874	417,186	2.67
Pharmaceutical supplies	34,258	34,258	85,645	.55
Maternity benefits	48,939	48,939	122,347	.78
Administration and Reserve	55,300	55,300	138,250	.88
	$516,133	$516,133	$1,290,339	$8.25 per yr. or 69c. per mo.
		$2,322,605		

131. This plan is similar to the foregoing, with the exception that it includes a maternity benefit of $25 per confinement at an added cost to the employee of 14 cents per month if employees were to pay the whole cost, or 7 cents per month on the five-ninths basis. It could be still further cheapened by reducing the maternity benefit by half. The number of confinements has been easily ascertained from the statistics of births in the Province.

132. *Plan C—Benefits for Employees and their Dependents.* (No allowance for maternity costs apart from cash benefits.)

375,310 employees and dependents at an average morbidity of 7.01 days *per capita* ..... 2,630,923 days.

		Total Cost.	Cost *per Capita.*
2,630,923 days at 84.47c. for hospitals		$2,222,341	$14.21
2,630,923 days at 66.88c. for doctors		1,759,561	11.25
2,630,923 days at 13.73c. for pharmaceutical supplies		361,226	2.31
8,809 confinements at benefit of $25 each		220,225	1.41
		$4,563,353	$29.18
10 per cent. for Administration	$456,335		
2 per cent. for Contingency Reserve	91,267		
		547,602	3.50
		$5,110,955	$32.68 per yr. or $2.72 per mo.

On basis of:	State, 2/9 of Total Cost.	Employers, 2/9 of Total Cost.	Employees, 5/9 of Total Cost.	Cost to each Employee.
Hospitals	$493,853	$493,853	$1,234,635	$7.90
Doctors	391,012	391,012	977,537	6.25
Pharmaceutical supplies	80,272	80,272	200,682	1.28
Maternity benefits	48,939	48,939	122,347	.78
Administration and Reserve	121,688	121,688	304,226	1.94
	$1,135,764	$1,135,764	$2,839,427	$18.15 per yr. or
		$5,110,955		$1.51 per mo.

133. This plan becomes more elaborate, and includes the extension to dependents of hospitalization, medical and pharmaceutical services. Medical treatment for confinements is not included, although a cash benefit of $25 is provided. The plan can be cheapened by excluding from extension to dependents any particular service and by cutting down the maternity benefit. As an illustration, let us suppose a decision to furnish hospitalization for employees and dependents, and medical service (including pharmaceutical supplies) for employees only, together with a maternity benefit of $12.50. The total cost, inclusive of 10 per cent. administration and 2 per cent. reserve, would be $3,626,053, or $1.93 per month per employee, if bearing the whole cost. On a basis of the cost being shared as to two-ninths by, respectively, State and employer, the annual contributions would be: State and employer, $805,790 each, and the employee, $12.88, or $1.07 per month.

134. It should also be noted here that the age of dependents is from 1 to 70, and not from 1 to 16. Consequently, if our recommendation to limit dependents to age 16 be adopted (paragraph 199), a further saving in costs will be made, and the statistics figured on provide a safe margin.

135. *Plan D—Benefits for Employees and their Dependents.* (Allowing for maternity costs in substitution for cash benefits.)

		Days.
200,625 males at average morbidity of 7.767 days *per capita*		1,558,254
174,695 females at average morbidity of 7.499 days *per capita*		1,310,038
375,310		2,868,292
	Total Cost.	Cost *per Capita.*
2,868,292 days at 84.47c. for hospitals	$2,422,846	$15.49
2,868,292 days at 66.88c. for doctors	1,918,313	12.27
2,868,292 days at 13.73c. for pharmaceutical supplies	393,816	2.52
	$4,734,975	$30.28
10 per cent. for Administration $473,497		
2 per cent. for Contingency Reserve 94,699		
	568,196	3.63
	$5,303,171	$33.91 per yr. or
		$2.83 per mo.

On basis of:	State, 2/9 of Total Cost.	Employers, 2/9 of Total Cost.	Employees, 5/9 of Total Cost.	Cost to each Employee.
Hospitals	$538,410	$538,410	$1,346,026	$8.61
Doctors	426,290	426,290	1,065,733	6.81
Pharmaceutical supplies	87,515	87,515	218,786	1.40
Administration and Reserve	126,264	126,264	315,668	2.02
	$1,178,479	$1,178,479	$2,946,213	$18.84 per yr.
		$5,303,171		or $1.59 per mo.

136. Plan D allows hospitalization for maternity cases in addition to including such cases in the general medical service, at an increased total cost of $192,216, or 16 cents per month additional, with the insured bearing the whole cost.

137. As previously intimated (paragraph 113), medical confinement treatment should be included in the ordinary medical service when extended to dependents, in the same way as it is included within the scope of the medical service in the case of an insured woman in Great Britain. The actual delivery operation is of no greater consequence than many other operations now included in the usual medical service. That there will be a higher rate of attendances during pregnancy than at other times is, of course, true, and this higher rate of confinement morbidity has been provided for in the computations under this plan.

138. That the confined mother should receive something in addition to mere medical treatment is the concerted view of modern maternal-welfare thought. In this connection, the Kingsgate Majority Report says (p. 147) :—

> We do not feel that the payment merely of the fee is an adequate content for a maternity benefit in a developed scheme of health insurance.

The inclusion, therefore, of hospitalization in such cases, in addition to medical treatment, is a wholesome provision, and in accordance with the dictates of humanity, as has already been pointed out (paragraphs 112 and 113).

139. Many variations of the foregoing plans can be suggested to comply with the economies necessary to be observed in order to fit in with the financial resources of the parties to be affected as contributors. The following is the plan which, in our view, will ideally serve the requirements of the occupational groups insured. This plan embraces, in addition to the benefits provided under Plan D, a time-loss cash payment of $1 during incapacity owing to illness. It will scarcely be possible of fulfilment if the insured is to bear the whole burden. But it should be capable of accomplishment, in normal times, by an equitable sharing of contributions, and is the plan which, whenever possible within the economies required, we recommend :—

Plan E—Benefits for Employees and their Dependents. (Allowing for maternity costs and time-loss cash benefit.)

		Days.
200,625 males at an average morbidity of 7.767 days *per capita*		1,558,254
174,695 females at an average morbidity of 7.499 days *per capita*		1,310,038
375,610		2,868,292

		Total Cost.	Cost *per Capita.*
2,868,292 days at 84.47c. for hospitals		$2,422,846	$15.49
2,868,292 days at 66.88c. for doctors		1,918,313	12.27
2,868,292 days at 13.73c. for pharmaceutical supplies		393,816	2.52
Time-loss—156,380 employees at 7.67 days × $1		1,199,434	7.67
		$5,934,409	$37.95
8 per cent. for Administration	$474,752		
2 per cent. for Contingency Reserve	118,688		
		593,440	3.79
		$6,527,849	$41.74 per yr. or $3.48 per mo.

On basis of:	State, 2/9 of Total Cost.	Employers, 2/9 of Total Cost.	Employees, 5/9 of Total Cost.	Cost to each Employee.
Hospitals	$538,410	$538,410	$1,346,026	$8.61
Doctors	426,290	426,290	1,065,733	6.81
Pharmaceutical supplies	87,515	87,515	218,786	1.40
Time-loss	266,540	266,540	666,354	4.26
Administration and Reserve	131,874	131,874	329,692	2.11
	$1,450,629	$1,450,629	$3,626,591	$23.19 per yr. or $1.93 per mo.
		$6,527,849		

140. With maternity costs covered as to both medical and hospital services, the maternity cash benefit might be omitted. In this connection, J. H. McVety, President of the B.C. Hospital Association, giving evidence before us, said:—

> So far as maternity benefits are concerned, I should make this part of the general scheme, granting no cash at all. Provide for medical and hospital care and have the maternity benefit part of the general scheme, recognizing maternity as a sickness.

141. It is anticipated that the State's contribution will be shared by the Dominion Government (*see* paragraphs 187, 188), and in view of the large number of persons for whom hospitalization will be provided, the percentage of loss from non-paying patients will be greatly reduced, and the necessity for annual Provincial and municipal grants to hospitals will thereby be very much minimized. Assuming that the Dominion Government will contribute one-half of the State grant, or $725,315, the Province and municipalities would effect a saving of $712,905 over what they now contribute towards hospitalization. The employers' contribution, on basis of two-ninths, is approximately $982,724 more than was paid in 1930 for medical, hospital, and drug services under the "Workmen's Compensation Act." Note in this connection, however, paragraphs 128, 146, 147, and 148.

142. The contributions to be paid by the insured in this plan may seem somewhat high, but by comparison with the benefits to be obtained as against those received in other countries, the cost is surprisingly low and indicates the beneficial possibilities to be obtained from a scheme of group insurance operated without view of profit-making.

143. In Great Britain, for example, the insured men contribute only 78 cents per month, but the benefits are correspondingly less. These cover, as of right, medical treatment and supplies, time-loss of only $3.60 per week, reduced to $1.80

for further disablement period, and maternity benefit of $9.60 if wife is uninsured herself. Additional benefits, such as hospital treatment, are granted only out of the approved societies' surpluses (if any).

144. Furthermore, when hospital treatment is given, the cash benefit is suspended in the case of single men without dependents.

145. It becomes of importance to make mention of the somewhat high cost of administration, which we have set at 10 per cent. The Workmen's Compensation Board states its cost of administration at 2.08 per cent. The following factors have to be taken into consideration in differentiating between the administration of the Workmen's Compensation Board and that of a sickness-insurance institution: First, whereas the Workmen's Compensation Board administers its medical services in isolated cases through the information of a medical practitioner, aided by occasional supervision by an inspector, in a health-insurance institution the extensive services covering a great number of persons at the same time will unquestionably require the setting-up of local regional committees and supervisors, which will greatly increase the cost of administration. Secondly, a large proportion of the Workmen's Compensation administration consists of merely paying out moneys, the cash (or compensation) end of that Board's business being more than twice the amount of the medical end. For instance, during 1930 the Board paid out in cash compensation to workmen $1,837,155.30; whilst for medical aid (physicians, hospitals, drugs, etc.) it paid out only $773,397.46. In administration under a sickness-insurance scheme the reverse will be the case. For instance, in Plan E, $1,199,434 will be spent in cash and $4,734,975 for services in kind. The cost of administering services in kind, which cannot be controlled from head office, will be very much greater than administration of cash benefits. We have taken this factor into consideration in reducing the administration cost under Plan E by 2 per cent. from the other plans, where the time-loss cash benefit is absent. In an actuarial calculation of costs of administration of the foregoing Plans A, B, C, and D, the percentages allowed for administration concerning pharmaceutical supplies and cash maternity benefits would be considerably less than what would be provided for hospital and medical administration costs. We have, however, no definite means of ascertaining what these various administration costs will be, and the figures cannot be correctly ascertained until the scheme decided upon be placed in operation, after which the necessary statistics will be available from year to year, thus enabling administration costs to be accurately ascertained. In the meantime, for want of this information, we have computed the costs at 10 per cent. upon all services, thinking it better to strike an average cost which can subsequently be pared down, rather than one which may require an upward revision. Finally, it may be pointed out that in Great Britain the cost of administration of national health insurance is 15 per cent., due to the dual distribution of services—approved societies administering cash and additional benefits, while the ordinary services in kind are administered through medical committees. By elimination of this dual administration we are of opinion that the total administration cost can be brought considerably below 15 per cent.

146. This would seem an appropriate occasion to refer to arguments for and against the inclusion of, respectively, the employer and the State as contributors to the fund. The employer: The conclusion seems well founded, and the practice of

most countries supports, that industry is responsible to a certain extent for the existence of occupational risks. This conclusion is based upon the principle that the employer sets on foot certain activities and surrounds himself with an organization of workers and machinery, the working of which may result in damage, apart from any question of fault on the part of the owner. Hence, the costs arising from compensation for industrial accidents should be included in the general liabilities of the undertaking, and consequently devolve upon the employer.

147. In the case of sickness, especially the sickness of an employee's family, the question of the employer's responsibility is more open to argument. A. Linstedt, in a Swedish report, says:—

> Apart from diseases arising out of industrial accidents and diseases due to occupational conditions, it is difficult to find any adequate argument to justify the responsibility of employers in regard to diseases which are no more prevalent among wage-earners than among other members of the community.

148. We, however, incline to the view that there are equally sound arguments for including the employer as a contributory towards sickness insurance: (1.) Side by side with occupational diseases, there are many others which are incidentally connected with the occupation engaged in. Among the influences which employment will lend against health, the following readily occur: Tuberculosis contracted by reason of a dust-creating industry; the overworking of certain muscles and organs; enforced painful attitudes; eye-strain due to poor lighting; facility of infection consequent upon close grouping of employees subjected to imperfect ventilation and improper heating; general fatigue caused by excessively prolonged or intense work. And so one could go on instancing dozens of conditions which, while not the immediate cause of disablement, are nevertheless the proximate cause of undermined health which ultimately leads to costly illness. All these conditions, and many others, being directly attributable to employment, the cost of insurance for same is surely as chargeable against the employer as in the case of accident arising from such employment, if the cost of maintaining and replacing "human capital" is chargeable to the industry which uses it. (2.) Industry gains by removing the factor of uncertainty in the daily attendance of the employee and the economic loss attendant thereon. The added impetus to good health consequent upon prevention-sickness practice, together with the shortening of illness duration by "nipping sickness in the bud" (evidence of Dr. Young, paragraph 75), are factors, the practical application of which must redound to the economical gain of industry. (3.) Compulsory employer's contribution equalizes the conditions of economic competition between employers who set aside part of their resources for health schemes of their own and those employers who take no steps to guarantee their staff against these risks. (4.) Employers now subconsciously contribute a great deal towards meeting the costs of sickness. In many cases, particularly in the salary-earner group, no deduction in remuneration is made when an employee absents himself for short periods of illness. Furthermore, the local community needs for charity and hospital drives absorb large amounts of money, which would be avoided, or greatly minimized, were an organized health-insurance system placed in operation. We have already indicated that the employer's contribution to sickness-insurance funds is universal in all countries operating such institutions, excepting Switzerland and the former Kingdom of Besserabia in Roumania (paragraph 23). (5.) Finally, we quote the economic argument of the Canadian Manufacturers' Association, appear-

ing in the report of that Association's Industrial Relations Committee, adopted unanimously at the 1930 general meeting:—

> Your Committee finds that there is growing interest among employers on the subject of health insurance. Experience in England, Germany, and the United States shows that sickness causes more time-loss than all other causes put together; it is said to cause five times as much as accidents. The cost to the community, both directly, by way of expenditures on hospitals and medical services, and indirectly, by way of loss on productive capacity, is estimated, for Canada, at $300,000,000. In view of the fact that a very large proportion of this could be saved if for the present haphazard system there could be substituted a system of State health insurance contributed to by the employees, employers, and the State, and primarily directed not so much as to relief as to cure and, above all, to prevention of sickness, your Committee feels that the question is one which should engage the attention of all the members of this Association.

149. The State: There are many obvious grounds of justification for the State aiding the general sickness fund, as is now common practice in Europe (paragraphs 22, 26, 27). The chief reason, perhaps, lies in the obligation of the State to take care of pauperism, and, when a person of small means has alone to meet the cost of sickness, that cost becomes a frequent cause of pauperism, and one of the most frequent causes of the impossibility of escape from pauperism. *See* Geneva Digest (No. 111, Appendix B), p. 410, quoting the 1909 Report of the British Royal Commission on Poor Laws to the following effect:—

> It is probably little, if any, exaggeration to say that, to the extent to which we can eliminate or diminish sickness among the poor, we shall eliminate or diminish one-half the existing amount of pauperism.

Nor is this the only argument. It is a generally accepted maxim that improvement of the standard of public health forms a necessary part of the general activities of the State. This proposition has found definite expression in British Columbia, where the State maintains public-health centres and contributes (in conjunction with municipalities) well over one and one-half million dollars annually towards the maintenance of health institutions. The expenditures for 1930–31 in such connections, as ascertained from the Provincial Secretary's Department, were:—

Provincial statutory grants to hospitals	$806,994.18
Provincial special grants to hospitals	75,881.50
Provincial aid to resident physicians	16,054.49
Provincial health centres	149,768.75
Municipal grants to hospitals	555,345.41
Total	$1,595,044.33

150. The truth is (as we read in the Geneva studies) that sickness risks constitute a whole for which no individual can be regarded as entirely responsible, but which affects every individual, his family, his environment (employment), and the community (the State) at large.

NO INCREASE IN TAXATION.

151. In concluding this part of our Report, we wish to lay particular emphasis upon what we consider to be the fallacy of opposing a health-insurance plan on the ground that it will be another social service to add increase to taxation and further burden upon what is stated to be the already overburdened condition of employers. If the matter be approached from a calm and analytical view-point, it will be discovered that the introduction of a health-insurance plan in this Province will fur-

nish the solution to a number of financial problems which at the present time are little less than staggering.

RELIEF TO HOSPITALS.

152. Let us examine, for instance, the situation of the hospitals, most of which are carrying on under severe handicaps; living, so to speak, from hand to mouth; and able to survive only by the aid of Government and municipal grants and private donations. The principal reason for this state of affairs, as gathered from the evidence submitted and as borne out by hospitalization statistics, is the inability to collect the dues of many patients. An average of at least 50 per cent. of bills payable to hospitals are uncollectable, owing, in the great majority of cases, to the utter inability of these patients to find the fees. Were hospitals in the position of being able to select their risks, this handicap would obviously not exist. But the situations arising from day to day are such as to render hospitals powerless. People suddenly stricken, whether as a result of accident or ordinary illness, are rushed to hospital, which is the only place, in a great many cases, where the life of the patient can be saved. No one can imagine a hospital official meeting an incapacitated man or a confined woman on the steps of the hospital and denying admission unless fees were paid or secured. Risks can be selected in this way in some instances, but in the majority of cases such a procedure is unthinkable; and even were State-aided hospitals to be empowered to do so, human kindness would still make it unthinkable.

153. For the year 1930, fees received from patients for sixty-six operating hospitals in the Province constituted 51.6 per cent. less than the cost of operating. To assist in meeting this deficit, grants were obtained from the State and from municipalities totalling $1,415,780,* and there still remained a deficit of $130,907. Accordingly, it is clear that the taxpayers of the Province are contributing annually a large sum of money for the hospitalization of those patients who cannot pay. For the same year, the total number of days' treatment was 1,015,380 days, which, at the average *per capita* daily cost of $3.80 (total treatment-days divided into total hospital costs), would have furnished $3,858,444 had all dues been collected; and which would have reduced the total grant required from outside sources to $24,712 as against $1,415,780 received in 1930 from the Provincial Government and municipalities. It will, accordingly, be perceived that had all hospital dues been paid in 1930, there would have been a saving to the general taxpayer of not less than $1,391,068.

154. Let us now turn to a consideration of the effect upon hospital financing were hospitalization provided by a compulsory health-insurance plan. By reference to the table submitted under the aforesaid Plan E (paragraph 139) it will be found that the annual total hospital cost for the 375,610 persons is provided for at $2,422,846 under the fairly high average morbidity rate of 7.63. Now, these 375,610 persons represent the total population to be cared for under Plan E, the total population of the Province for which the hospitals have to care being 689,210. The actual number of persons who took hospitalization for 1930 was 65,740, or 9.77 per cent. of the total Provincial population. 10.92 per cent. of Plan E population (*see* paragraph 165) is 41,037. So that we have, side by side, two groups of persons

* The hospital charts (Appendix I) are erroneous in that they do not include in patients' fees the Dominion subsidy, but locate it as a grant. The Dominion contribution is not a grant; but a payment of fees by that Government for Indian patients. It should therefore be added to the amount of patients' fees.

for whom hospitalization is to be found and for which they should pay—namely, health-insurance population, 41,037, and hospital population, 65,740. On a basis of 15½ days' stay at $3.50 per day,* health-insurance population *will* pay $2,226,257 (15½×$3.50×41,037). Hospital population should pay $3,566,395; but hospital population pays only $2,081,055 (patients' fees plus Dominion Government contribution as per Appendix J). It is short $1,485,340 for the sole reason that it has not collected its dues, and therefore has to resort to Government and municipal grants.

155. We find, therefore, that 65,740 people are hospitalized at a cost of $3,833,156 (Appendix J). Of this, a State health-insurance scheme will take care of 41,037 persons, contributing $2,226,257, and the remaining 24,703 persons will require to contribute the balance of $1,656,899. For the year 1930 the hospitals should have collected $3,566,395 for 65,740 patients at $3.50 per day. Of this sum, however, they collected only 58.35 per cent. With a State health institution taking care of 41,037 of this hospital population, and consisting of the people in receipt of the smaller incomes, it can properly be assumed that the remaining 24,703 will consist, in the main, of persons in better financial circumstances, and therefore the percentage of collections should be considerably higher than 58.35, and should be close to 100 per cent. Allowing, however, for no more than 75 per cent. of collections, this group of 24,703 persons will contribute $1,242,674 (24,703×15½ days× $3.50=$1,656,899×75%=$1,242,674). Adding together $2,226,257 (health-insurance payment) and $1,242,674 (remaining hospital-population payment) plus $155,411 (donations and miscellaneous received by hospitals for 1930), we have a grand total of $3,624,342, or only $258,814 less than the total hospital cost for 1930, which deficit would likely be wiped out altogether if a proper system of advisory supervision over hospital management were instituted by the Government. Under the above circumstances, the Provincial Government and municipal grants, which for 1930 totalled $1,415,780, would not be necessary, and a reasonable proportion of this amount would be available for the State's contribution to whatever health-insurance plan might be established.

156. A comparison of financing as between hospitals in mining towns which have hospitalization contracts and hospitals in localities where there are no such contracts demonstrates that the latter suffer greater losses than the former. The following examples, taken at random, afford an illustration:—

	Total Cost.	Patients' Fees received.	Loss.	Percentage Loss.
Cumberland	$26,869.00	$17,931.05	$8,937.95	33.35
Fernie	24,791.43	15,946.77	8,844.66	35.83
New Westminster (Royal Columbian)	179,602.73	71,639.38	107,963.35	60.11
Vernon	49,785.70	22,404.93	27,380.77	54.99

157. Cumberland and Fernie have local health-insurance plans which furnish hospitalization, while New Westminster and Vernon are negligible contract localities.

* Public-ward cost, which is all that a health-insurance institution can be expected to furnish.

158. From this is to be deduced the fact that hospital losses are less in those localities where hospitalization contracts are in force. And this is borne out by the evidence of Mr. Burdett, referred to in paragraph 83.

159. The foregoing disposes of the suggestion that health insurance necessarily means a further taxation to the people or expenditure by the State. It also fairly indicates that the provision of hospitalization for employees and dependents (some 375,610 persons), together with such volunteers who would join the scheme, would revolutionize hospital finance and furnish a definite solution to the present embarrassing problem.

160. And in this connection we feel that a last word of warning should be stressed against reposing credence in the statements of those persons who, in order to bolster up an argument against the principle of State health insurance, seize certain facts which are merely indicative of bad management and by no means the result of inherent defects in the principles and practical application of such a scheme. We refer, particularly, to suggestions to the effect that the British scheme has proved its unsoundness because unable to meet the present conditions of unemployment. The fallacy in this criticism lies in the assumption that benefits must be given to the insured regardless of the collection of contributions, thus turning the scheme from one of insurance into one of philanthropy. That the British scheme has somewhat failed in this respect is only too true. This failure, however, is not due to fundamental defects in the scheme as such, but to defective administration in unwarranted prolongation of benefits as well as improper granting of medical certificates. The following from the previously referred to 1930 report of the Chief Medical Officer of the British Ministry of Health decisively indicates wherein defective administration has been responsible for the difficulties encountered in Great Britain:—

> The experience of 1930 has again emphasized that the health-insurance scheme cannot be maintained, still less can it expand, unless it is administered on strictly economic and actuarial lines. If the doctor or the insured person ignore that fact nothing but difficulty will emerge, or if they ask from the scheme more than it can reasonably yield, nothing but disappointment will result. For instance, if the doctor furnishes certificates incorrectly or unreasonably extends the period of incapacity, or prescribes excessively, or provides something akin to "public assistance" to the patient on request, he may be performing a service of charity or even indirectly of medical aid—but he is rendering a direct disservice to the whole system of health insurance. If, on the other hand, the insured person demands from the system advantages in benefit, privilege, or relief quite outside the contractual rights under the Act, or if he asks for aid on economic rather than medical grounds, he may indeed be asking for something which is beneficial to his health, but he is making a demand, however reasonable in itself, which makes an insurance system a mere method of financial relief, and uses the doctor as a relieving officer instead of a physician. If and when the insured person acts in this way he is being unjust to his fellow-contributors as well as unfair to his doctor. Faced with the indisputable fact that the health of the people as a whole has immensely improved in recent years, we are met with the strange but true evidence that at the same time the sickness claims under the "Health Insurance Act" have rapidly increased, and it is difficult to escape the conclusion that these claims are an illustration of the all too widespread tendency at the present day of trying to get "something for nothing," or at least some advantage which has not been earned or worked for, is not included in the scheme, and to which no adequate or equivalent contribution has been made by the insured person.

161. It must always be borne in mind that the benefits to be derived from insurance must be strictly gauged upon the actuarially calculated morbidity for which the insured person is paying. If such person be accorded benefits upon

some other basis, such, for instance, as charity, the system must necessarily fall to the ground sooner or later. Furthermore, the British scheme being largely a cash-benefit proposition (paragraph 110), the disposition towards malingering in times of unemployment becomes accentuated.

Computation of Averages.

162. The factor of highest importance in the inauguration of any insurance scheme is necessarily that of safety in the computation of averages. According to whether this factor has been correctly diagnosed depends the soundness of the financial structure upon which the plan is built. If the computations which design the foundation for the financial edifice are faulty, by permitting the entrance of any element of doubt, just to that extent will the future of the plan be in question.

163. Until any new plan be actually placed in operation, so that yearly statistics will be available, it is impossible to arrive at a definite approximation of the least cost necessary for maintaining the institution. It is possible, however, to definitely ascertain the maximum cost, and if, upon inception, the scheme is operated upon that basis, its success will be assured, and a grading-down of costs can be subsequently brought about accordingly as expedience may direct.

164. In the plans submitted we have endeavoured to ensure the factor of safety in all computations. By comparison with the costs of general hospitalization in the Province, our computations will indicate an apparent unnecessarily wide margin of safety. The reason for this should be understood. To illustrate: According to hospital statistics, out of a total Provincial population of 672,747 for 1930, a percentage of 9.77 thereof, or 65,740 persons, acquired hospitalization, and their stay at hospital averaged 15½ days. If this ratio of 9.77 per cent. were applicable to the plans we have submitted, a very considerably lesser sum would be sufficient for the services to be furnished. For various reasons, however, this ratio of 9.77 per cent. cannot prevail for our plans. If, for instance, we take 9.77 per cent. of the 156,380 population provided for in Plan A, we get 15,278 persons as the average number of persons who will attend hospital. Allowing 15½ days to each, we find their stay in hospital will be 236,809 days. Multiplying these days by $3.50, the average day charge for all hospitals (other than private wards), we find these 236,809 days would require $828,832 for the total hospitalization; whereas in Plan A we have allowed $948,435 for this service. Certain factors, however, enter into the computations surrounding Plan A which are not applicable to general hospitalization. For one thing, Plan A group is not similar to the group which attends all hospitals, and will have a higher percentage of persons taking hospitalization than is the case with the ordinary hospital population, for the reason that Plan A comprises no persons below 16 years of age. Their attendance, therefore, will average 7.18 days as against 7.01 (all ages), because they have been denied the lesser morbidity of ages 1 to 16. Consequently, instead of their hospital stay being 15½ days, it will be the number of days which bears the same relation to 15½ days as 7.18 bears to 7.01, which is 15.87 days, which gives a group of 17,075 persons ($948,435÷15.87×$3.50=17,075), or 10.84 per cent. as against 9.53 per cent. The correct computation, therefore, will be 17,075×$3.50×15.87=$948,435.

165. Plan E will have a still higher percentage of persons taking hospitalization, the average morbidity for this group being 7.63, or 16.87 days. 16.87×$3.50=$59.04, divided into $2,422,846=41,037 persons, or 10.92 per cent.

166. It becomes, therefore, important to note that the percentage of days' attendance at hospital is subject to the average morbidity of the particular groups served, and will vary according to the variation in group morbidity.

OPERATION.

167. Closely allied with the question of costs is the method by which the machinery of a health-insurance scheme should be operated. Diversity in the operation of different schemes will be accounted for by local conditions. It may, however, be pointed out generally that in most instances the administration is carried on with the assistance of mutual-aid or other societies. There are many advantages to be gained by adopting this procedure, but we are of opinion that the disadvantages greatly outweigh the advantages. For one thing, administration by societies is apt to lead to abuses which would have the effect of destroying the real aim of health-insurance work. This may perhaps be best exemplified by the following from the pen of Mr. R. W. Harris, in the article previously referred to:—

> From the outset the Insurance Medical Service has suffered from the lack of those aids to a general practitioner service which ought to form part of any national scheme for providing medical treatment. The need for laboratory facilities, providing centres for team-work, for consultation between medical men, for second opinions, and for specialist services has time and again been insisted upon; the doctors themselves have been as insistent for these improvements as anybody. These things became practicable of attainment when the Royal Commission reported in 1926 and pointed out not only the ways of, but the means existing for providing them, but a certain lukewarmness on the part of some of those Approved Societies into whose surplus funds a considerable hole would have been made commenced the process of failing vitality, which the new proposals began to evince almost before they were born, and the cold clutch of Economy did the rest.

168. This criticism of approved societies, which is the latest word before us upon this administration aspect of the British scheme, bears out what emanated from the Geneva office referred to in paragraph 29 above.

169. Additional objections as disclosed in the Kingsgate Commission may be thus briefly summarized: The inequalities of benefit under the approved-society plan have been the cause of great discontent. The members of a society which has built up a large surplus are placed in the position of receiving additional benefits which the members of a poorer society will be denied. And it is pointed out, with justice, we think, that such inequalities are indefensible in a State scheme of insurance based on compulsory contributions at a uniform flat rate for all.

170. The Kingsgate Commission coincided with the view that the fact that societies are "not organized on a geographic basis adds undoubtedly to the labour involved in the administration of medical benefit, which must necessarily be conducted on a territorial basis."

171. Friendly societies were adopted at the outset in England because they existed in almost every part of the country and were in a position to immediately take care of the millions expected to join the scheme. There are some 15,000,000 insured persons in the Great Britain scheme. None of these considerations, however, are applicable here, and there are so many outlying points where no societies exist that it seems impracticable to use them as in England. To have societies in this place and none in that would result in confusion. The central authority could not escape the necessity of setting up local committees in many places, and the argument for the utilization of societies—which was important in Great Britain —has no basis in British Columbia.

172. Finally, it is important to note that, although the Kingsgate Commission was pressed to advocate the elimination of approved societies, and although the Minority Report so recommended, the Majority Report retained them only from a sense of justice, pointing out that they are in the field by action of Parliament and, having developed their organization by virtue of these rights, their abolition from the health-insurance scheme would have the effect of compelling their dissolution. The Commission did, however, recommend the pooling of surpluses.

173. The above conditions do not, however, obtain here, and we feel that mutual-aid or fraternal societies do not constitute the desideratum to be aimed at for management in British Columbia. Our recommendation in this connection is that administration be carried out through a Central Board aided by the creation of regional committees in various areas throughout the Province, such committees to be composed of representatives from the insured, the employers, the medical profession, and local Government or community bodies. The residents within each region would thus acquire an autonomous jurisdiction somewhat similar to that of the British Insurance Committees;* these committees to serve without remuneration and to be subject to the central authority, in which would be placed the governing responsibility. In the conclusions we have come to in this connection, we are fortified by the views expressed by both Messrs. J. H. McVety and E. S. H. Winn, K.C., that the insurance fund should be administered by a Central Board. The remarks of these gentlemen to us are as follows:—

Mr. McVety: As to the suggestion of whether a State Health Insurance Act in British Columbia might be administered through approved societies, as in England, I think there is only one way to administer such a law—through a Board. I do not think the majority of the societies are actuarially sound. Experience under the Dominion "Insurance Act" proved conclusively in Ontario some years ago that they were actuarially unsound from an insurance standpoint. (Appendix H, Volume 2.)

Mr. Winn: The Act should be administered by a Central Board or Commission with wide powers of distribution of its powers and functions to subsidiary and subordinate local or regional committees. (Appendix H, Volume 3.)

174. If this procedure be adopted, the cost of administration will be economical, and surpluses and interest on accumulated surpluses will occupy a central fund for the additional benefit of all, and not for some few in a particular region.

COLLECTION OF REVENUE.

(5.) To suggest methods by which the annual cost might be collected from the employers, prospective beneficiaries, and general taxpayers respectively.

175. There should be little difficulty in collecting the required compulsory contributions. The system universally adopted for the collection of contributions is that of deduction from wages at their source, whereby the employer is required to pay the whole of the joint contribution (his own and the employee's) and is authorized to deduct the share payable by the insured person from such person's wages. Under such a system the onus is upon the employer, who is liable if an employee is not insured. This method of collection is simple, inexpensive, and easily administered, the contributions of employers and employed persons being collected in most cases by means of insurance stamps, such stamps being affixed by the

* *See* p. 167, Kingsgate Report, No. 63, Appendix B, for details as to the work of these committees.

employer to a contribution card issued by the insurance office to each employed contributor. The normal time for affixing stamps is when wages are paid.* The due payment of contributions is supervised by inspectors appointed for the purpose. At the end of each half-year the insured person obtains the stamped card from his employer, forwards it to the insurance office, and is supplied with a new card.

176. In the case of contributions from volunteers, regard should be had to some such safety provisions as are illustrated in paragraphs 31 to 34, inclusive.

MISCELLANEOUS OBSERVATIONS.

(6.) Generally to inquire into any and all matters affecting the said subjects respectively.

177. Incidental to the effective organization and operation of a health-insurance and maternity-benefit scheme in British Columbia are a number of important considerations with which we propose to deal briefly for the benefit of the scheme which we have outlined, as well as of those who may pursue the subject-matter of our inquiry at the point where we leave it.

DENTAL BENEFIT.

178. First in importance, in our view, comes the consideration of establishing dental service, and our omission to include dental treatment in any of the financial plans submitted is distinctly not because we undervalue the benefit to be derived from such an important service, but because the question of figuring costs has presented difficulties which we have been unable to surmount. For one thing, we have no means of accurately ascertaining the number of persons who might apply for treatment. We know, from the evidence given before the Kingsgate Commission, that the proportion of insured persons requiring dental service is estimated at from 60 to 80 per cent. of the total insured population. A similar proportion would likely be found in British Columbia. This figure, however, is of little value, as there is no means of knowing the number of persons who would be likely to employ the service. We are of the view, for the reasons which follow, that any health-insurance institution to be inaugurated in the Province should make one of its first duties the ascertainment of statistics for the purpose of establishing a dental benefit.

179. We are advised by the Kingsgate Commission that the dental condition of the industrial classes is deplorable, and we think the same comment would be equally applicable to any other class. It was pointed out to that Commission that the benefit to general health consequent upon the establishment of dental service by some of the approved societies had produced many beneficial reactions upon the medical benefit funds—a matter to be borne in mind when considering the cost of establishing dental benefit. Furthermore, until definite local statistics could be made available, it would be possible to inaugurate a system of half or mixed dental benefits. For instance, to include extractions and fillings, but not dentures, or vice versa; also, to allow at first only a proportion of the cost. That dental benefit is a very popular service is apparent from the evidence of some of the British approved societies. The Hearts of Oak Benefit Society, for example, found it necessary to diminish additional cash benefits in order to meet the demands of

* For details of the card and stamp system *see* p. 74 of Kingsgate Report and sec. 2 of the 1930 French "Social Insurance Act."

members for dental service. That such a service is a necessary and very valuable one may be gauged from the evidence submitted to the Kingsgate Commission, in respect of which we refer to pp. 41 and 42 of their Report, and from which it would appear that "the value to health of timely, continued, and effective dental treatment emphasizes the need for making the benefit generally available on uniform lines."

FREE CHOICE OF DOCTOR.

180. There is now no recognized valid argument, in the purview of modern sickness-insurance systems, against permitting the widest possible selection by the insured of his medical adviser. Locally, this view has been well expressed by Dr. E. L. Garner, of Vancouver:—

> The main principles are that the patient should have free choice of doctor; that is a distinct right of the individual patient. It brings the doctor well up in his harness, keeps him up to his work; he must be constantly in competition, which is good for him. Then, too, the fees are regulated by the Act, which is an essential thing. (Appendix H, Volume 2.)

181. To what extent, however, this freedom of choice may be available will depend upon the flexibility of conditions pertaining to any given area, plus what the medical profession may be able, or prepared, to offer. Freedom of choice of doctor rests largely upon an answer to the question whether remuneration to the doctor will be on a flat capita basis or on an attendance basis. Different views are held by different members of the profession. Dr. Garner, for instance, says:—

> Another principle is that the doctor should be paid for the work he does and not for what he does not do. If he is paid a lump sum monthly, some of us are so frightfully human I am afraid he is going to lag behind. (Appendix H, Volume 2.)

182. On the other hand, Mr. Winn, of the Workmen's Compensation Board, favours the panel system. He says:—

> The panel system for medical men has been established as the most economical and generally satisfactory for all parties concerned. It should unquestionably be adopted. . . . If people knew they could call for medical service for trivial complaints the doctors could be deluged with calls for imaginary or inconsequential ills, charges per call bankrupting and destroying the scheme and its usefulness being destroyed. (Appendix H, Volume 3.)

183. If the finances of the scheme in any given area would permit only payment on the panel system, and only one doctor in that area would go upon the panel, then obviously there would be no freedom of choice for that particular location. However, these are matters which cannot be foreseen at this juncture, and the soundest recommendation which we feel can be made is that the administrative body be empowered to effect such working arrangements with the medical profession as may be best suited to the welfare of the insurance institution, being confined to neither system, if any individual locality requires the alternative. For a detailed consideration of these matters we refer to the Kingsgate Report under caption "The Insurance Practitioners' Contract," commencing at p. 181; and also caption "Private and Insurance Service," p. 36; also section 4 of the 1930 French "Social Insurance Act."

RESIDENTIAL QUALIFICATIONS.

184. An important consideration was raised before us by Dr. Moore, of Chilliwack, in connection with the invitation which an isolated Provincial health-insured area would offer to the medically unfit to migrate from other parts of Canada or from elsewhere in the world. He said:—

If you have State health insurance here, and it is not adopted in the other Provinces, we are going to be swamped with costs and our hospital losses will increase. If there were such an inducement for diseased persons to come in, they would come to us in even larger numbers. (Appendix H, Volume 2.)

185. We are impressed with the soundness of this suggestion, and believe the situation can be properly taken care of by requiring that all persons of less than one year's residence in the Province shall pass a satisfactory medical examination before admittance into the insurance institution.

186. Section 19 of the British "National Health Insurance Act" provides that no benefits shall be payable to an insured while resident, either temporarily or permanently, outside the United Kingdom, excepting in cases where the insured has received the consent of the insurance institution to be temporarily absent, when he may receive sickness or disablement benefit providing the incapacity commenced prior to his becoming temporarily resident outside the Kingdom. The obvious reason for this restriction is to ensure that the beneficiary will be under the supervision and control of the insurance institution, as otherwise there would be no means of checking up the right to obtain grant of benefits, nor the equally important matter of determining when those benefits should cease. We recommend similar restrictions.

DOMINION GOVERNMENT GRANT.

187. Inasmuch as State health plans in all countries now operating same are established as a Federal measure, it becomes of importance to realize that, in the view of the Department of Justice for Canada, the Dominion Government cannot constitutionally undertake such a project, and that, if State health insurance is to be established in any part of Canada, it must be upon the initiative of individual Provinces.

188. It follows, however, that the Dominion, having the power to appropriate part of the Consolidated Revenue Fund of Canada towards the maintenance of such a scheme, there is a strong moral obligation upon that Government to do so. We have already covered the legal aspect of this phase at page 11 of our Progress Report, to which reference is directed, and we recommend that the Dominion Government be urged to assist in the establishment and maintenance of whatever scheme of State health insurance be inaugurated in British Columbia.

CAPITAL FUND.

189. In order to have sufficient funds on hand in a State health-insurance institution wherewith to make benefit disbursements before the arrival of the period at which contributions will be sufficiently available for such purpose, a fund can be created by an advance from the public treasury. In a scheme, however, such as we recommend, having as an object in view a saving to the State rather than an additional expense, this preliminary fund can be obtained by the simple expedient of imposing, during the first few months of operation, a fixed waiting period before the expiration of which no benefits will be payable. To take Plan A as an illustration: $2,075,953 will be required and collected for the year's disbursements, or $172,996 per month. Some months, however, will necessarily elapse in organization process before the machinery for collection of contributions will be properly functioning. This may be placed at three months, on the assumption that any well-managed institution will have its organization reasonably perfected as to details

before benefit expenses become a liability. A fourth month should be added to allow for the receipt of contributions from monthly-paid employees; and a fifth month should be allowed to employers for reasonable delays in remitting payments. At the expiration of five months the majority portion of $172,996 should be collected. And if another month, or six months in all, be established as the preliminary fund-creating period, the institution should be able to commence functioning from its own initiative, with a sum in hand of not less than $200,000, which will be sufficient inception capitalization.

190. We recommend that the medical fund now collected and operated by the Workmen's Compensation Board be transferred to the State health-insurance fund, in the computations for the formation of which sickness by accident has also been included. This will relieve the workmen from contributing the extra 1 cent per day, and will, in some plans, effect a very significant saving to the employer.

OTHER ADMINISTRATIVE DETAILS.

191. In an inquiry covering investigation as to the desirability of introducing a system of such complex variety as State health insurance, the line of demarcation between a general exposition of findings and recommendations on the one hand, and administrative details on the other, must finally be drawn. It will be obvious that we cannot undertake in our Report to furnish a complete exposition of the voluminous and intricate details surrounding the inauguration of the social system we have investigated, and we feel that we have now approached the stage where we have at length exhausted the area of investigation lying within the ambit of our Commission. To go further would be to unduly trespass upon the field of those who may be required to place in operation a system founded upon our recommendations. To them, therefore, must be left the consideration of various matters of detail, such as, to mention but a few, the affording of benefits to remote and inaccessible regions of the Province; continuance of cash benefits by disablement allowance; specialist medical service; complaints, disputes, and appeals; health propaganda; notice of illness and linking up illnesses; medical certification; definition of employment; exemptions; repayment of benefits improperly paid; disposal of sums arising from benefits forming part of estate of deceased persons; married women and benefits alternate upon marriage; offences and penalties; institution of proceedings; protection against distress and execution; persons of unsound mind, etc.

192. For the elucidation of practice covering all such matters and many others ancillary to the administrative management of a State health-insurance system, we refer to the material covering the world practice which we have collected and which may be found in the Provincial Library and in the Department of Labour, where we have deposited all matter catalogued under Appendix B. Particular reference is directed to the new French law and the proposed Belgian laws upon the subject. We had intended to draft a model Bill for an Act of Parliament, embodying all necessary features leading to the establishment in British Columbia of a State health-insurance and maternity-benefit plan, and for this purpose had collected a variety of data bearing upon the subject. Our anxiety, however, to comply with the terms of our Commission before the advent of another session of the Legislature, coupled with the conclusion that the suggestion is likely *dehors* our jurisdiction, has led us to abandon the idea.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

(The numbers of the relative paragraphs of the Report are given for convenience of reference.)

193. That compulsory health insurance has proven to be an important and invaluable factor in the promotion of health, by reason not only of enabling the poorer people to meet the costs of sickness, but also because of the development of a system of illness-prevention, which is a natural offshoot of a progressively organized health-insurance scheme. (Paragraphs 48 to 63, inclusive; 75.)

194. That the wish of the people of British Columbia as submitted in evidence to us has been overwhelmingly in favour of a compulsory health-insurance and maternity-benefit scheme for British Columbia. (Paragraphs 64 to 71, inclusive.)

195. That the public interest requires the introduction of a compulsory health-insurance and maternity-benefit plan in British Columbia, for the following reasons:—

(*a*.) Many people are unable to provide for the costs consequent upon sickness, as a result of which they are shackled with a burden of discouraging proportions which, if a subsequent illness follows, tends to make life itself a hopeless burden. (Paragraph 72.)

(*b*.) The inability to meet these costs deters many from seeking medical advice and treatment, with consequent serious jeopardy to recovery and often to life, both for themselves and others who come in contact with them; added to which a system of sickness-prevention would obviate much illness. (Paragraphs 72, 74 to 79, inclusive.)

(*c*.) The adoption of a scheme of compulsory health insurance with hospitalization benefit would greatly, if not wholly, relieve the hospitals in the Province of the present financial embarrassment. (Paragraphs 81 to 83, inclusive; 152 to 158, inclusive.)

196. That no evidence of any weight, and scarcely any evidence of any kind, has been presented to us against the principle of compulsory health insurance, aside from those who object to any kind of medical treatment. (Paragraph 68.)

197. That a system of compulsory health-insurance and maternity-benefit scheme be established at an early date in British Columbia, with first provision for: (*a*) General medical and surgical treatment, including the necessary pharmaceutical supplies and surgical appliances; (*b*) hospitalization; and (*c*) maternity benefit. (Paragraphs 111, 114.)

198. That benefits (*a*) and (*b*) be furnished to all insured persons, where considered necessary in the opinion of a doctor attached to the system, such benefits not to exceed a maximum period of 26 weeks; and that benefit (*c*) be granted to the wife of any insured person or to an insured woman, upon confinement, either by providing medical and hospitalization service, or by payment of a cash benefit, to be not less than $12.50 and not more than $25. (Paragraphs 112, 113, 137, 138.)

199. That if benefits (*a*) and (*b*) be not made available also for the dependents of insured persons at the outset, the same be made available at the earliest possible date consistent with the financial resources of the fund to the insured's wife and the insured's dependents up to 16 years of age (paragraphs 21, 99, 115, 116, 133, 134); and that similarly a cash benefit during each day's incapacity through sick-

ness be paid to an insured person so soon as the same may be economically possible, such benefit to be not less than $1 and not more than $1.50. (Paragraph 111.)

200. That the parties to be included compulsorily in the system be all employed persons in the Province between the ages of 16 and 70, who shall be in receipt of not more than $2,400 per year, together with such persons who shall choose to join the scheme voluntarily. (Paragraphs 90 to 94, inclusive; 98.)

201. That restrictions be imposed for the purpose of preventing malingering and undue granting or prolongation of benefits. (Paragraph 111.)

202. That requisite waiting periods, especially in the granting of time-loss cash benefits, be established in accordance with the approved practice of similar institutions. (Paragraphs 30 to 34, inclusive.)

203. That adequate safeguards be imposed to prevent the scheme from being charged with the treatment of venereal diseases, alcoholic ailments, or other maladies brought on by wilful fault. (Paragraph 30.)

204. That consideration be given to the granting of needful health benefits to persons in receipt of old-age pensions who, at the time of receipt of such pensions, are members of the insurance institution: this to be based upon similar practice under the British "National Health Insurance Act" (paragraph 37); and that similar consideration be given to the cases of insured persons unable to qualify for old-age pension, and who may, by reason of poverty, be unable to continue contributions to the insurance institution. The object in this connection being to absorb the care of destitute sick now provided for by the State.

205. That, in the case of voluntary contributors, sufficient restrictions be imposed to guard the financial safety of the sickness-insurance institution (paragraphs 95, 96), and that such voluntary contributors be required to pay both the employee's and the employer's contributions.

206. That persons of less than one year's residence in the Province be required to pass a satisfactory medical examination before they be admitted to the insurance institution. (Paragraphs 184, 185.)

207. That benefits be not granted to persons absent from the Province unless absent with the consent of the insurance institution, and then only if incapacity arose while within the Province. (Paragraph 186.)

208. That a fund for the payment of the aforesaid benefits be created by the compulsory payment of monthly cash contributions from employee and employer, supplemented with cash contributions from the State. (Paragraphs 23, 85, 86, 146 to 150, inclusive.)

209. That a flat rate of contributions based upon the proportions outlined in the financial plans submitted, or other convenient proportions, be adopted (paragraphs 101, 126, 130, 132, 135, 139), and that the contributions for insured females be equal to that for insured males.

210. That contributions shall not be payable by State, employer, or employee during any period in which the insured person is in receipt of benefit.

211. That consideration be given to the desirability of fixing a specially reduced contribution rate for insured persons under age 21, in consideration of their subnormal earning-power, such reduced contribution to be offset by corresponding reduction in benefits. (Paragraph 37.)

212. That the rate of contribution for benefits be based upon the actuarially calculated average morbidity pertinent to the group of persons affected in accordance with the scheme or schemes to be adopted (paragraphs 119, 120), together with provision for the accumulation of reasonable reserves for contingencies and administration.

213. That the employee's contribution shall be deducted from wages or salary by the employer, and that, for the collection of employer's and employee's contributions, consideration be given to the British system of insurance stamps to be affixed by the employer to the employee's contribution card. (Paragraph 175.)

214. That funds available for investment be invested in such securities as are by Statute required for the investment of the sinking funds of the Province of British Columbia.

215. That actuarial valuations of the fund be made at regular intervals.

216. That the fund be subjected to regular periodical audit by the Provincial Auditor-General.

217. That, having regard to paragraphs 187 and 188, efforts be made by the Provincial Government towards securing from the Dominion Government an annual contribution to the insurance fund.

218. That accumulated funds or surpluses be invested in the extension of social services for insured persons, such as providing for the inclusion of dental, opthalmic, or other beneficial health measures, including the establishment of clinics, laboratory aids to diagnosis, and periodical health examinations; or otherwise as may be deemed advisable.

219. That the utmost consideration be given to the desirability of providing a dental service as speedily as possible. (Paragraphs 178, 179.)

220. That the management and administration of all business connected with the scheme be under the control of a Central Board or Commission responsible to the Legislature of the Province, and that the Central Board be empowered to set up such local regional committees as may be conducive to the successful district operation of the system with an especial view to autonomously directed funds, but a centralized system of insurance forming only one accounting unit, all contributions to be paid to a central insurance fund. (Paragraphs 28, 29, 167 to 174, inclusive.)

221. That such regional committees shall comprise representatives of insured persons, employers, the medical profession, municipalities, and such other interested organizations as may seem calculated to assist the furtherance of the scheme, but with the right always to the Central Board to refuse or reject any individual representative for good cause. (Paragraph 173.)

222. That such regional committees have discretion, according to the exigencies of each particular case, to determine whether the maternity benefit shall be granted in cash or in kind, or partly one and partly the other.

223. That power be given the Central Board to make arrangements with general medical practitioners for the medical and surgical treatment of insured persons for a capitation or an attendance fee, accordingly as may be best arranged for any particular district; and that reasonable freedom of choice be allowed insured persons in selection of practitioners. (Paragraphs 180 to 183, inclusive.)

224. That in the case of attendance contracts with practitioners a scale of fees be established to prevent "over-attendance" as well as excessive fees.

225. That, in order to build up a benefit disbursement fund, there be established in the first year of operation such waiting period as may be necessary to place the insurance institution in funds of not less than $200,000. (Paragraph 189.)

226. That the cost of medical aid now administered under the Workmen's Compensation Board be borne by the State health-insurance fund, thereby eliminating the present medical-fund levy made upon workmen and employers by that Board. (Paragraphs 127 and 190.)

227. That sums paid as contributions by employer and employee be deducted from the total income of such persons for purpose of taxation on income. (Paragraph 24.)

228. That, in order to ensure no lapse of information as to world sickness-insurance law and practice as from the conclusion of our inquiry, the Department of Labour take over and continue the subscription of our Commission to the International Labour Office's "Legislative Series" and "Industrial and Labour Information." (Paragraph 8.)

CONCLUSION.

229. Finally, we would say that our recommendations for the early establishment in British Columbia of a suitable compulsory health-insurance plan, including maternity benefits, are the result of the members of our Commission having become thoroughly imbued with the momentous and incalculable beneficial effects which kindred schemes in the Old World are producing in alleviating for the poorer classes the dread incubus of sickness costs, and thereby reducing premature mortality and raising the general standard of health among the masses. After entering upon as exhaustive a study of this problem as has been possible in the limited time at our disposal, we finish our labours and emerge from our inquiry with the following conclusions definitely established from the evidence: Without health, and the means of preserving it, the usefulness of human life is seriously impaired, and, apart from the unhappiness morbidity inflicts upon the individual, an indirect, but nevertheless trenchant, economical loss is imposed upon the community the moment earning-power is injured. With the development, side by side with curative measures, of a sickness-preventive service, an ideal system will be set up for the effectual handling of what may be properly described as the greatest benefit to mankind—the maintenance of good health. In this direction also lies the solution in a very large measure of the problem surrounding the present and constantly increasing unsatisfactory condition of hospital finance, which, to say the least, is an appalling spectacle in an institution so vital to the health and well-being of the public.

230. We have been engaged upon our work for two years, nine and one-half months (April 16th, 1929, to January 30th, 1932), during which time we have expended $24,187.14, details of which are set forth in the Schedule below, and which sum we trust will be regarded as having been justifiably expended in the interests of that great mass of the population which, we feel certain, will be extraordinarily benefited by the social service recommended.

In drawing our endeavours to an end, we are desirous of recording our appreciation for the invaluable services rendered us by Mr. John Fisher, the Pro-

vincial Statistician, whose highly trained ability has been of outstanding assistance in the submission of our financial plans. Our thanks are also due to the deputies and other members of the Civil Service generally, who have been unstinting in furnishing us with every possible courtesy and help. It is also our pleasure to record our appreciation and grateful thanks to the International Labour Office of the League of Nations, Geneva, Switzerland, for the valuable information furnished to us in the elucidation of the practices of health-insurance laws throughout the world. Mr. A. Tixier, Chief of the Social Insurance Section, has been unfailing in instantly complying with our requests, often at considerable pains and always without charge. His co-operation has been of immense service in enabling us to properly understand the various complexities of European systems. Indeed, without this valuable aid our compilation of world laws could not have been completed.

All of which we respectfully submit to Your Honour.

C. F. DAVIE, *Chairman.*
GEO. S. PEARSON.
L. E. BORDEN.
J. J. GILLIS, M.D.
W. F. KENNEDY.

Dated at the City of Victoria this 30th day of January, 1932.

THE SCHEDULE ABOVE REFERRED TO.

STATEMENT OF EXPENDITURE FROM APRIL 16TH, 1929, TO JANUARY 31ST, 1932.

Secretary's salary and expenses	$7,147.57
Chairman's and Commissioners' travelling expenses and sustenance allowance	6,406.70
Reporters	2,470.10
Pay-lists, stenographers, translators, statistician, etc...	5,490.30
Advertising	837.18
Publications (subscriptions, etc.)	41.68
Office equipment	564.25
King's Printer	822.97
Telegrams and telephones	128.36
Sundry accounts	278.03
	$24,187.14

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