ROYAL COMMISSION ON HEALTH SERVICES
ROYAL COMMISSION ON
HEALTH SERVICES

1964 -- VOLUME 1
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1964
TO HIS EXCELLENCY

THE GOVERNOR GENERAL IN COUNCIL,

MAY IT PLEASE YOUR EXCELLENCY,

We, the Commissioners appointed by an Order in Council dated 20th June, 1961, to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians:

BEG TO SUBMIT TO YOUR EXCELLENCY

VOLUME I OF OUR REPORT
Elizabeth the Second

BY THE GRACE OF GOD

OF THE UNITED KINGDOM,

CANADA AND HER OTHER

REALMS AND TERRITORIES

Queen

HEAD OF THE COMMONWEALTH,

DEFENDER OF THE FAITH

[Signature]

ACTING DEPUTY ATTORNEY GENERAL

[Signature]

DEPUTY ADMINISTRATOR
TO ALL TO WHOM THESE PRESENTS SHALL COME OR WHOM THE SAME MAY IN ANYWISE CONCERN,

Greeting:

WHEREAS pursuant to the provisions of Part I of the Inquiries Act, chapter 154 of the Revised Statutes of Canada, 1952, His Excellency the Governor in Council, by Order P.C. 1961-883 of the twentieth day of June, in the year of Our Lord one thousand nine hundred and sixty-one, a copy of which is hereto annexed, has authorized the appointment of Our Commissioners therein and hereinafter named to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians and, in particular, without restricting the generality of the foregoing, to inquire into and report upon

(a) the existing facilities and methods for providing personal health services including prevention, diagnosis, treatment and rehabilitation;

(b) methods of improving such existing health services;

(c) the correlation of any new or improved program with existing services with a view to providing improved health services;

(d) the present and future requirements of personnel to provide health services;

(e) methods of providing adequate personnel with the best possible training and qualifications for such services;

(f) the present physical facilities and the future requirements for the provisions of adequate health services;

(g) the estimated cost of health services now being rendered to Canadians, with projected costs of any changes that may be recommended for the extension of existing programs or for any new programs suggested;

(h) the methods of financing health care services as presently sponsored by management, labour, professional associations, insurance companies or in any other manner;

(i) the methods of financing any new or extended programs which may be recommended;

(j) the relationship of existing and any recommended health care programs with medical research and the means of encouraging a high rate of scientific development in the field of medicine in Canada;
(k) the feasibility and desirability of priorities in the development of health care services; and

(1) such other matters as the Commissioners deem appropriate for the improvement of health services to all Canadians,

and has conferred certain rights, powers and privileges upon Our said Commissioners as will by reference to the said Order more fully appear.

NOW KNOW YE that, by and with the advice of Our Privy Council for Canada, We do by these Presents nominate, constitute and appoint Chief Justice Emmett M. Hall of the City of Regina, in the Province of Saskatchewan, Miss Alice Girard, Registered Nurse, of the City of Montreal, in the Province of Quebec, Doctor David M. Baltzan, of the City of Saskatoon, in the Province of Saskatchewan, Professor O. J. Firestone, of the City of Ottawa, in the Province of Ontario, M. Wallace McCutcheon, Esquire, of the City of Toronto, in the Province of Ontario, Doctor C. L. Strachan, of the City of London, in the Province of Ontario, and Doctor Arthur F. Van Wart of the City of Fredericton, in the Province of New Brunswick, to be Our Commissioners to conduct such enquiry.

TO HAVE, HOLD, EXERCISE AND ENJOY the said office, place and trust unto the said Emmett M. Hall, Alice Girard, David M. Baltzan, O. J. Firestone, M. Wallace McCutcheon, C. L. Strachan, Arthur F. Van Wart, together with the rights, powers, privileges and emoluments unto the said office, place and trust of right and by law appertaining during Our Pleasure.

AND WE DO HEREBY authorize Our said Commissioners to exercise all the powers conferred upon them by section 11 of the Inquiries Act and be assisted to the fullest extent by government departments and agencies.

AND WE DO HEREBY authorize Our said Commissioners to adopt such procedure and methods as they may from time to time deem expedient for the proper conduct of the enquiry and sit at such times and at such places in Canada as they may decide from time to time.

AND WE DO HEREBY authorize Our said Commissioners to engage the services of such counsel, staff and technical advisers as they may require at rates of remuneration and reimbursement to be approved by the Treasury Board.

AND WE DO HEREBY require and direct Our said Commissioners to report their findings to Our Governor in Council, and file with the Dominion Archivist the papers and records of the Commission as soon as reasonably may be after the conclusion of the inquiry.

AND WE FURTHER appoint the said Chief Justice Emmett M. Hall to be Chairman of Our said Commissioners.

74563—21
IN TESTIMONY WHEREOF We have caused these Our Letters to be made Patent and the Great Seal of Canada to be hereunto affixed.


AT OTTAWA, this twenty-fourth day of July in the year of Our Lord one thousand nine hundred and sixty-one and in the tenth year of Our Reign.

By Command,

[Signature]

ACTING UNDER SECRETARY OF STATE
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Order in Council P.C. 1961-883 which set up this Commission charged us to inquire into and report upon the existing facilities and the future need for health services for the people of Canada, the resources required to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians.

The Commission held public hearings in all Provinces and the Yukon. Members of the Commission either singly or in groups studied at first hand the programmes and practices in other countries including the United Kingdom, France, Holland, Sweden, Switzerland, Austria, Italy, the United States, the U.S.S.R., Australia, and New Zealand. In the Canadian hearings we received submissions and heard representatives from 406 organizations or individuals. All major groups interested in health in Canada participated. We commissioned the preparation of 26 research studies by outstanding Canadian scholars working either singly or in teams. These studies are being readied for publication where the information is considered to be of general usefulness and necessary to give a complete background to many of the matters dealt with in the Report.

We were impressed in the course of our inquiry with the deep feeling of conviction and the sense of urgency common to all who appeared before us about the need for careful planning and speedy and wise action to ensure continuing progress and improvement in the health field in Canada. There was no dissent to the view that some form of government action was needed to bring to all Canadians the best possible health care. There were divergent opinions as to how this objective could or should be attained and the extent to which governments should participate.

We were impressed also with the generally expressed views that to date Canadians have, by and large, enjoyed a comparatively high level of health services. We heard frequent references to serious gaps or inadequacies by virtually all who testified including those who spoke for The Canadian

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1 See Appendix D.
2 See Appendix B.
Medical Association and its ten provincial branches; L'Association des Médecins de Langue Française du Canada and its Filiale du Québec; L'Association des Médecins-Chirurgiens en Pratique Générale du District Médical de Montréal; the ten Provincial Colleges or Councils of Physicians and Surgeons including the Collège des Médecins et Chirurgiens de la Province de Québec; L'Association Médicale de la Province de Québec; the Canadian Dental Association, its corporate bodies, and a few other dental associations including La Société Dentaire de Montréal, who were frank in acknowledging that remedial action was essential in many fields.

It became clear as we entered upon our hearings that two factors in particular were going to pose special difficulties. One was the haphazard approach of organizations and governments in the search for solutions to the problem of providing a measure of health care for Canadians. The second was the over-emphasis given to "medicare". This latter factor threatened to overshadow the broad purpose of the inquiry. No one would suggest that the payment of medical bills is not an important item, but it is after all but one item in the full range of health services and in any objective approach it could not be permitted to dominate the whole field.

There are many other areas in the health service field that cry out for improvement: mental illness, retarded children, crippled children, the crippling diseases, paraplegics, the aged and the infirm, dental services, and drug costs. All these and others must have their proper place in the plans for the future if the objectives outlined in the Order in Council are to be achieved. Positive preventive measures must be expanded and, in addition, educational and training facilities for physicians, dentists, nurses, and others must be provided at once to meet the needs of a rapidly expanding population.

During our hearings and while our research studies were underway, and as we deliberated on this Report, three provincial governments introduced legislation with respect to payment for physicians' services. Saskatchewan established an all inclusive plan on a compulsory basis attended by much needless friction with the medical profession of that Province. Two provinces, Alberta and Ontario, introduced legislation, not similar in form, but basically providing for voluntary coverage of certain medical services with subsidies for specified categories of citizens to help with the payment of premiums with such plans administered by private carriers, both profit and non-profit. The initiative shown by the three provinces is based, we believe, on the recognition that government action in the personal health care field is overwhelmingly desired by Canadians. But the different scope of the plans as announced by these three provincial governments, particularly the limitations of the Alberta and Ontario plans and the lack of harmony in Saskatchewan, point to the danger which Canada faces if health planning and health care coverage is left solely to the initiative and financial ability of
individual provinces without regard to adequate standards of health services for Canadians from one end of the country to the other, without adequate provision for the supply of physicians, dentists, nurses, and other health personnel, and health facilities to implement such a programme, and without making the most effective use of Canada's health resources both existing and those that will be forthcoming through integrated and co-operative health planning on a non-political Canada-wide basis.

So, in preparing this Report we have been at all times conscious of the mandate given us to investigate the whole field, and we have tried our best to see that the Report does not give primacy to any one area while at the same time recognizing that health services consist of many interdependent elements with the physician as the central figure. Co-operation of all elements must be of the essence of any properly conceived health service. The programme we visualize is rooted in this concept of close co-operation of all health services personnel with the physician and with the administering agency or agencies. It is a multi-phased approach to health services and to good health embracing (1) the education and training of sufficient personnel, (2) preventive measures, (3) diagnostic and curative procedures and (4) rehabilitative facilities, all integrated to achieve the best possible health care for all Canadians while at the same time fostering research into all elements of disease and good health.

How can this objective be best achieved? Through a haphazard and makeshift approach or by means of a well planned programme founded on basic principles which will allow for flexibility and change, but keep Canadians at all times striving towards the goal of the best possible health care for all. To us the answer is clear: we need a set of principles and we need to apply them with vigour and imagination and without hesitancy.

We present in Chapter 1 the basic considerations and general philosophy to be embodied in a Health Charter for Canadians. In Chapter 2 we present recommendations for a comprehensive health care programme which, if implemented, will contribute significantly to the improvement of the health of Canadians of this and succeeding generations. The principles and our recommendations are based on a thorough analysis in Chapters 3 to 12 of the health of the Canadian people, and the health services available to them, and on an extensive examination in Chapters 13 to 21 of health requirements and problems faced, and on an assessment of the costs of a health care programme over the next 30 years projecting present trends and allowing for changes such as we recommend.

We have excluded as beyond our Terms of Reference what are described as borderline areas relating to health,¹ such as social aspects of

health,¹ problems of ageing, non-prescribed drugs, environmental aspects of health,² and income maintenance during periods of ill health.

This is Volume I of our Report.³ It contains our major analyses and recommendations.⁴ It will be followed by Volume II which deals with other matters relating to our Terms of Reference including pharmacists, paramedical personnel, other personnel such as chiropractors, osteopaths, and naturopaths, the place of voluntary organizations in the provision of health services, the organization of health research, the role of health planning, the evaluation of existing programmes in the health services complex, and present and future problems in the patterns of organizing community health services and facilities.

The Commission as originally constituted named seven members. However, one of our number, The Honourable M. Wallace McCutcheon, Q.C., resigned from the Commission on August 8, 1962, on being appointed to the Senate of Canada and a member of the Government. Senator McCutcheon participated throughout the public hearings and in our deliberations prior to his resignation. His penetrating analysis of the problems before us and his co-operation in the search for solutions was of great assistance.

In preparing this Report we have had the assistance of a very competent research and administrative staff, and invaluable help from a large number of individual experts in the health professions, in governments, in universities, and other institutions. We acknowledge this help gratefully with details given in Appendix A.

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¹ For example, training and employment of handicapped persons.
² For example, air and water pollution.
³ Because the quoted material contained in this Volume is taken from preliminary drafts of the studies set out in Appendix B, it may differ in form, but not in substance, from the corresponding material contained in the final version of these studies.
⁴ We have made allowances in our cost estimates presented in Volume I for expenditures relating to the recommendations included in Volume II. Any additional expenditures that may result from the recommendations in Volume II would be minor so that for practical purposes the cost figures as presented in this Volume can be taken as the cost of the over-all programme.
PART I

PRINCIPLES AND RECOMMENDATIONS
Basic Concepts

Throughout the course of our hearings, the Commission was greatly impressed by the public response to our inquiry. Interested parties have presented an amazing variety of recommendations; of things to be done, or not to be done, as well as suggestions indicating who should or who should not do them. As we sifted through and analysed these recommendations we were impressed by the wide areas of agreement among Canadian citizens as to our most pressing health needs, on the present stage of our health services development, and on the necessity to extend the advantages of prepayment to all Canadians. Outstanding among our impressions was the constructive work of many voluntary agencies and the number of individuals contributing their services to them.

There was disagreement, on the part of some, as to the respective roles of individuals, of voluntary associations, of commercial enterprises, and of governments in health services. In a democracy such divergent views are to be expected.

Faced with these conflicting representations and charged by our Terms of Reference to make recommendations respecting the improvement of health services in Canada, it seemed essential for our purposes to resolve in so far as possible these various points of view by answering the fundamental question: What is society's interest in the health of its individual members? If we can answer that question satisfactorily we may then be in a position to better determine what legislative measures and programmes may be required to discharge society's obligations to the individual. We begin with and adhere to the view that the public interest, whatever its extent, is clearly supportive of the individual's interest in his own health. What, then, is the individual's responsibility?

INDIVIDUAL RESPONSIBILITY FOR HEALTH

The Commission believes that the individual's responsibility for his personal health and that of the members of his or her family is paramount to the extent of the individual's capacities. Briefs from the health professions and other experts, and studies by our research staff emphasize the wide scope that the individual has for the determination of his own health and well-being. With the near-disappearance of most communicable diseases, that
range of self-determination has increased. Personal hygiene, cleanliness in the home, balanced diets, precautions against accidents, regular exercise, wise use of time for leisure and recreation; in short, temperate living—all of these are not only of first importance in the maintenance of health but are largely under the control of the individual, and in our opinion, are clearly his responsibility.

However, in this day of advanced medical knowledge and skill, these are not enough. The individual must assume responsibility for wise and prudent use of health services, for periodic health examinations, including regular dental examinations, for assuring that the mother receives complete pre- and post-natal care, for seeing that children are properly immunized, and at the first sign of symptoms for consulting a physician or dentist. The wise use of available health services cannot be over-stressed. Much serious illness and unhappiness would be avoided if this were done. It goes without saying that since all such resources are scarce, it is the duty of the individual, as well as of the practitioner prescribing them, to see that the services are used with prudence and economy.

There are other obligations. These services cost money; therefore the individual must also be prepared to assign a reasonable part of his income by taxes, premiums or both to meet the costs of health services which will be faced by every person during the course of his lifetime.

In addition, the individual must assume responsibility as a member of organized society for meeting a fair share of the costs of providing health resources for the nation including those which give him protection through environmental controls, the educational institutions that produce our supply of health workers, and the research institutions that advance our knowledge of life and disease processes and new methods of therapy.

These obligations and responsibilities we believe to be wholly compatible with the democratic concept of the individual in a free, self-governing society.

PUBLIC INTEREST IN INDIVIDUAL HEALTH

The public interest in health has been typically manifested by community action to deal with health problems that the individual was incapable of managing himself. In the past this meant community measures to prevent and control communicable diseases. Organized health activities in Canada originated in community efforts to stem the epidemics of the last century.

In recent decades, a number of factors have enlarged the scope of the public interest and given it new force and cogency.

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1 Health services provided to accident victims cost an estimated $74,000,000 in 1961, see Chapter 5, Table 5-18. In the same year, over 11,000 people died in Canada from accidents, poisoning, and other acts of violence.
The first is a deepening of our humanitarian concern for our fellows. We recognize that the well-being and happiness of the society is simply the sum total of the well-being and happiness of its individual members. It is clear that the well-being of a proportion of the population at any given time is seriously curtailed because of mental or physical disease or impairment that, strictly by the laws of chance, could strike any one of us.

We seem, in a sense, to have become "insurance minded" in that we now believe that an individual family should not have to bear alone the full cost of risks that could happen to any one of us. Accordingly, if the resources of the whole can be used to strengthen the ability of families and individuals to manage and plan for themselves, then they should be so used.

The depression of the nineteen thirties with its mass unemployment, requiring massive national, provincial and municipal expenditures to help individuals regain their independence and self-sufficiency, probably did more to translate into action what is basically a Judeo-Christian philosophical concept than any other event of our era. Just as we have accepted that the costs of industrial accidents should be a charge upon the whole productive economy and not be borne by the injured workman and his family, so are we now accepting that society as a whole must help to bear the costs of accidents and disease that we know will strike the total population in predictable numbers, although we cannot foretell which of its members will be stricken. The almost immediate response of governments in the thalidomide tragedy is the most recent dramatic example, but everywhere throughout the land—as innumerable briefs to the Commission attest—there is an awakened conscience and a growing consciousness of the need for more organized assistance for those families carrying the unpredictable burdens of children with severe mental deficiency, children deformed or injured at birth or maimed in infancy, of members who are mentally ill, of members injured in accidents, of members who are aged and infirm. There is a growing consensus that since we do not know which of us may be afflicted, all should make a contribution to a common fund to assist those who are.

There is yet another major reason for an expanding public interest in health. It is the growing awareness of the cost to society as a whole of failure to be concerned and to act on behalf of its members. The most dramatic evidence was the rejection rates of armed services recruits in World War II. With the nation in peril, dependent upon its healthy man- and woman-power for survival, the price we were paying for our past lack of adequate health resources and services was glaringly apparent. The second most revealing piece of evidence was the Sickness Survey of 1951. It showed the appalling social and economic cost to Canada of ill-health, proving that the family and the nation pay heavily in terms of lost production for failure to make available to all Canadian citizens the standard of health service we
know how to provide. Nor is it only in loss of production\(^1\) that we pay. Many of our so-called “welfare” expenditures are the end result of illness, disability, and premature death. Not all of these expenditures are avoidable, of course, but clearly many of them are.

To the extent, then, that health expenditures prevent or shorten periods of sickness, reduce the extent of disability, postpone death, and contribute to the productivity of citizens, then to that degree health expenditures are investments in our human resources, with the prospect of rich dividends.

There are also undoubtedly external forces causing us to explore new ways in which a democratic society can co-operate to enable its members and those of other societies to achieve a fuller life. One of these is the threat of totalitarian regimes with their professed greater concern for people. If a democracy fails to meet the legitimate aspirations of its people there can be few who doubt that alien philosophies will win the right to try. Another is Canada’s membership in such special agencies of the United Nations as the World Health Organization, the International Children’s Fund, the Food and Agricultural Organization, the International Labour Office, all in some measure related to health. Apart from being bound by the various international agreements it has ratified, it should be remembered that this country, by signing the Constitution of the World Health Organization, has subscribed to the following principles announced in the preamble to its Charter:

>“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

>“The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.”\(^2\)

Thus, humanitarian considerations are at the source of Canada’s concern with this situation as much as her self-interest and formal international obligations.

The Commission is convinced that, quite apart from humanitarian considerations, the health of Canadians is a matter of concern to us as a nation, and that no enlightened government can ignore that the economic capacity of its citizens to be productive depends upon their health and vigour as much as upon their educational attainment.

We accept the statement of Sir Arthur Newsholme:

>“Civilised communities have arrived at two conclusions, from which there will be no retreat, though their full realisation in experience has nowhere been completely achieved.

\(^1\) In 1961, an estimated total of 52,700,000 man-days was lost through sickness in the labour force.

“In the first place, THE HEALTH OF EVERY INDIVIDUAL IS A SOCIAL CONCERN AND RESPONSIBILITY; and secondly, as following from this, MEDICAL CARE IN ITS WIDEST SENSE FOR EVERY INDIVIDUAL IS AN ESSENTIAL CONDITION OF MAXIMUM EFFICIENCY AND HAPPINESS IN A CIVILISED COMMUNITY”.

Let us now examine the areas we consider to come within public and group responsibility.

PUBLIC AND GROUP RESPONSIBILITY

Responsibility for Environmental Health Services

Nearly a century of success with public health measures has removed all argument from the proposition that assuring a healthful environment is a public responsibility. Sewerage systems, pest control, assurance of pure water supply, pasteurization of milk, meat and food inspection, sanitary inspection of public eating establishments, public conveyances, and the like; all of these have made their contribution to lower morbidity and mortality.

With advancing knowledge of health measures that can be taken on a mass basis, the definition of public health is necessarily broadened. It ceases to be simply the traditional functions of public health departments— communicable disease control, sanitary inspection, maternal and child health, mental hospitals, health education, and statistics—and becomes any health problem that involves a sufficient number of individuals to become a public problem, and for the adequate solution of which public action is necessary or desirable. Hence, health services for indigents, cancer diagnostic and treatment clinics, mental health clinics, facilities for crippled children and for retarded children, tuberculosis sanatoria, rehabilitation centres, and the like, become accepted public health activities because it is now recognized that it is clearly in the public interest to undertake them. In our open society, with voluntary action serving as the mainspring for most progress, it has been typical for new areas of need to be first explored, the problem defined, and the solutions discovered or organized by voluntary agencies. Frequently, the volume of need thus revealed has been beyond the capacity of voluntary action to finance. At that point public demand for action results in government action, and the voluntary leaders turn their attention to other unmet needs that their experience has revealed. In this way, progress continues towards an ever-advancing goal of higher standards by reducing the universal hazards to mankind. We believe that this process of interaction of voluntary and public action and, hence, this progress, will continue.

Education of Personnel

The creation and operation of the educational institutions to provide society's increasing requirements for health workers, together with the subsidy required to ensure an adequate supply of qualified graduates, is clearly a public responsibility.

If it is accepted, as we accept, that the investment in health pays cash dividends as well as dividends in human well-being, then it is a public responsibility to ensure that the supply of health workers is expanded to meet essential needs. In some areas, a crash programme of expansion of facilities as well as of recruiting will be required. Dentistry and nursing are outstanding examples. Moreover, the public interest is not concerned simply with the production of numbers of health personnel; it is deeply concerned with the quality of education. For it is on the quality of their training that the quality of performance of their skills largely depends. We have much to say on this subject as well as on the need for continuing education in all the health professions.

One other aspect of the education of health professions demands comment. It is the anomaly that the training of our most essential health workers—the front-line medical practitioner—has depended upon there being a low-income or indigent group in our society to provide the essential clinical experience in "public wards" and "out-patient" clinics. We have not yet abolished poverty or indigency, but the training of society's essential professions can no longer rest on this limited, indigent base. It is now a public responsibility in the sense that every member of the public must accept the obligation, when hospitalized in teaching hospitals, to serve in the education process.

 Provision of Facilities

Over $133 million spent by the Federal Government on hospital construction since 1948,1 and an even greater amount by the provinces in the same period, plus millions of dollars contributed by municipal governments and hospital taxing districts testify to the acceptance of the provision of health facilities as an area of the public interest. 2

But it is an interest that has been acknowledged in a variety of ways and in a variety of degrees.

In the provision of hospital facilities, however, the history is a long and varied mixture. Private philanthropy and religious endeavour—these two (with the occasional military establishment being the exception)

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2 Facilities for the most vital function of all, that of the practising physician and dentist, have been left almost wholly as a private responsibility of the practitioner. "Setting up a practice" is still one more economic hurdle for the medical and dental graduate.
provided our first facilities for organized care, and they continue to this day. But in the western provinces, where a new society had the needs but not the philanthropic resources, recourse to the municipal tax base was unavoidable to supplement the efforts of the pioneer religious groups.

In the last few years, three factors seem to have altered the pattern: the rising costs of hospital construction, the effect of income taxes on philanthropic resources, and the transfer to the public sector of the financing of hospital operations. With this combination of factors (and there are undoubtedly others) hospital financing became increasingly a responsibility of governments although the proportion of costs assumed by government has varied markedly from province to province.

Hospitals for the mentally ill are for the most part a public (provincial) responsibility and hospitals for Veterans, Indians and Eskimos, largely a federal responsibility.

Despite the continuing importance of voluntary contributions, the provision of the facilities that Canadians require will obviously become primarily a public responsibility and we believe that steps should be taken to rationalize the system and equalize the burden.

**Distribution of Personnel and Other Resources**

Although we have been ever mindful of the present constitutional provisions respecting jurisdiction over health matters, we cannot ignore the unequal distribution of resources, particularly of personnel, to meet our health needs. And, as we have indicated, if there ever was a time when Canadians in one section of our country could be oblivious to lower health standards elsewhere in Canada, that time is not now. There is clearly an overriding national interest in the health of Canadians wherever they reside. We are a mobile people and illness knows no provincial boundaries nor other differences.

We are convinced that, however much we prefer voluntary to public action, nothing but public action and support at every level of government can correct the imbalance.

It is necessary, therefore, to view the distribution of health resources—personnel and facilities—as a primary concern of the public interest. Specific recommendations to achieve adequate national standards are presented in Chapter 2.

**Prepayment for Health Services**

This century has witnessed tremendous strides in the science and art of medical care in its widest sense. But as medical knowledge, skill and techniques have advanced, so have the costs of their application. Were it not for the device of prepayment, only a few at the top of the income scale in Canada could emerge from serious illness or injury without being finan-
cially crippled. The rationale of health insurance is now so well known and accepted that it scarcely needs restating. What Winston Churchill once described as “the application of averages for the relief of millions” is, in our opinion, absolutely essential for all but a small minority of wealthy Canadians. Many Canadians have availed themselves of the insurance mechanism, principally those who can afford the protection or those who are in employment where coverage is provided or subsidized as part of their working conditions. However large this group may be it is not large enough. The national interest requires that the risk must be spread over the whole productive population to cover everybody and not only those who choose to insure voluntarily. And the device must be used ultimately to finance the whole spectrum of health services, not merely hospital and physicians’ services. To make certain that all our citizens have access to the necessary health services is now clearly a matter for the public interest. That less than half of our population has some degree of reasonably adequate health insurance coverage for medical services is a matter of grave national concern, and of greater concern is the fact that few organized insurance programmes worth mentioning exist in equally important areas such as mental illness, dental, and optical care, drug requirements, retarded and crippled children.

These are the areas—environmental controls, education, facilities, personnel, and universal availability and access to services—that now clearly constitute the public interest in health care and call for public action.

OBJECTIVE

As we examined the hundreds of briefs with their thousands of recommendations we were impressed with the fact that the field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of men, on the other.

What the Commission recommends is that in Canada this gap be closed. That as a nation we now take the necessary legislative, organizational and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind. All our recommendations are directed toward this objective.

There can be no greater challenge to a free society of free men.

The Commission believes that this goal should be incorporated in a declaration of purpose, and recommends that the following Health Charter be accepted as an objective of national policy for Canada.
HEALTH CHARTER FOR CANADIANS

The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian people, IMPLEMENTED in accordance with Canada's evolving constitutional arrangements;

BASED upon freedom of choice, and upon free and self-governing professions and institutions;

FINANCED through prepayment arrangements;

ACCOMPLISHED through the full co-operation of the general public, the health professions, voluntary agencies, all political parties, and governments, federal, provincial and municipal;

DIRECTED towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being.

1. "Comprehensive" includes all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide.

2. "Universal" means that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors.

3. "Health Services Programme" consists of legislative enactments and administrative arrangements to organize comprehensive universal health care including prepayment arrangements for financing personal health services introduced in stages. Such a programme will provide complete health care with due regard to human factors and the spiritual, social, economic and regional forces intrinsic in the Canadian way of life.

4. "Canada's evolving constitutional arrangements" take into account the primary jurisdiction of provincial governments with respect to health matters including staging, scope and administration of health services, as well as the necessity for federal financial assistance to enable each of the provinces to implement a comprehensive, universal Health Services Programme.

5. "Freedom of choice" means the right of a patient to select his physician or dentist and the right of the practitioner to accept or not to accept a patient except in emergency or on humanitarian grounds.
6. "Free and self-governing professions" means the right of members of health professions to practise within the law, to free choice of location and type of practice, and to professional self-government. With respect to "institutions" it means academic freedom for medical, dental and other professional schools, and for hospitals, freedom from political control or domination and encouragement of administration at the local level.

7. "Prepayment arrangements" means (a) financing within a province by means of premiums, subsidized premiums, sales or other taxes, supplements from provincial general revenues and (b) by federal grants taking into account provincial fiscal need.

8. "Full co-operation" means
   
   (a) the responsibility of the individual to observe good health practices and to use available health services prudently;
   
   (b) the responsibility of the individual to allocate a reasonable share of his income (by way of taxes or premiums or both) for health purposes;
   
   (c) the methods of remuneration of health personnel—fee-for-service, salary or other arrangements—and the rates thereof should be as agreed upon by the professional associations and the administrative agencies and not by arbitrary decision, with an appeal procedure in the event of inability to agree;
   
   (d) the maintenance of the close relationship between those who provide and those who receive health services, safeguarding the confidential nature of that relationship;
   
   (e) the provision of educational facilities of the highest standards and the removal of financial barriers to education and training to enable all those capable and desirous of so doing to pursue health service careers;
   
   (f) the adequate support of health research and its application;
   
   (g) the necessity of retaining and developing further the indispensable work of voluntary agencies in the health care field;
   
   (h) the efforts to improve the quality and availability of health services must be supplemented by a wide range of other measures concerned with such matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism and drug addiction;
   
   (i) the development of representative health planning agencies at all levels of government, federal, provincial, regional and municipal, and integration of health planning.
COURSE OF ACTION

This is what Canada and the provinces working together should do. It is not an idealist's dream but a practical programme within Canada's ability, financially and practically, as subsequent chapters will show. It is what Canadians ought to strive for and expect through their governments. They should not be content with less.\(^1\) A nation that in 1962 spent $756 million on cigarettes and tobacco and $973 million on alcoholic beverages\(^2\) can afford the programme we recommend which would involve an additional $466 million in 1971.\(^3\)

The Health Services Programme which we have set forth is a distinctive Canadian development in harmony with our constitutional division of legislative powers. The federal and provincial governments must each play their part, and in so doing promote the national well-being. Such a programme, we believe, will be a major contribution to equalizing the opportunities for our citizens wherever they live.

We urge Canadians not to become involved in a battle of semantics. In recommending the programme we have proposed, we have steered clear of the views of those on the extreme right or extreme left. We are opposed to state medicine, a system in which all providers of health services are functionaries under the control of the state. We recommend a course of action based upon social principles and the co-operation and participation of society as a whole\(^4\) in order to achieve the best possible health care for all Canadians, an aim that Canadians by their individual efforts cannot attain.

Such action, we insist, is based upon freedom of choice on the part of the citizen, and on services provided by free and self-governing professions. By safeguarding these elements, so vital to a free society, we believe we have avoided the difficulties inherent in a programme which attempts to nationalize the services which one group provides for others.

We must reiterate, however, that the comprehensive universal Health Services Programme we recommend requires careful planning, wise use of the resources at our disposal, and acceptance of the principle of prepayment whereby all Canadians can be provided with health services.

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\(^1\) The United Church of Canada has taken the stand that "a Medical Insurance Plan should be universal (including all citizens within its provisions); comprehensive (including various medical and related needs in co-operation with the medical, nursing, dental, pharmaceutical and other related professions); and national (with the various provincial plans co-ordinated in a nation-wide plan)". The United Church of Canada, brief presented to the Medical Services Insurance Enquiry, Toronto, January 1964, p. 2.


\(^3\) See Chapter 2 and Chapter 20. This amount is in addition to that which will likely be spent in 1971 with existing programmes.

We recognize, of course, that this whole programme cannot be put into effect immediately or simultaneously in all provinces. We do not foresee the programme coming forth full-grown but rather as an orderly and well-planned series of steps which taken together will in a period of years accomplish our objective.

The first requirement is sufficient trained personnel. This demands crash programmes\(^1\) to expand the educational and training facilities. These must be undertaken at once because it takes a period of years to qualify physicians, dentists, nurses, and others, and we must be ready to provide services to the expanding population of Canada which we estimate will be 22,600,000 in 1971, 28,250,000 in 1981, and 35,100,000 in 1991.\(^2\) We cannot wait until we are overwhelmed before acting.

Quick action too should be taken in the field of mental illness and we have specific recommendations in this long neglected field.

Retarded children and crippled children should be given high priority.\(^3\) Their parents must have the support of society as a whole.

A programme to help the aged and the infirm can be put into operation as we move forward in other fields.

The unsatisfactory dental health of the nation and particularly of its children must be attended to as soon as personnel can be trained in one of these crash programmes.

The burden of drug costs must be faced and redistributed.

Research facilities must be provided and personnel trained and research fostered.

While we are aware that shortages of physicians, dentists, nurses, and other paramedical personnel will make it difficult to establish the full Health Services Programme the Charter envisages, none the less the fact that there are shortages must not be used as an excuse to delay initiating programmes and plans. The various provinces should act promptly to co-operate with the Federal Government in planning and putting into operation the new medical schools, dental schools, nursing schools, and training institutes which are needed to overcome these shortages.

All of these matters will require careful planning and the fullest co-operation at all levels of government and with the health professions. It follows that the advisory and planning councils we recommend in Chapter 2 should be agreed upon and chosen following a Federal-Provincial Health Conference which we urge should be called within six months by the Federal Government. The responsibility for leadership must be accepted by the

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\(^1\) Our success with crash programmes during World War II shows that much can be accomplished when the will to do so exists.

\(^2\) See Chapter 4.

\(^3\) See Chapter 2, Recommendation 200(c).
Federal Government and plans made so as to ensure that every phase of the development of the programme is consistent with its over-all objective. The unity of the programme and its application to all Canadians must be safeguarded.

We do not suggest that the various provincial programmes be required to conform to any rigid pattern, but to qualify for federal support they need to provide, in whatever manner may be chosen, universal coverage in the province regardless of age or condition, or ability to pay, upon uniform terms and conditions, and to adhere to the basic inclusive features of each of the programmes recommended.
Recommendations

Our Terms of Reference required us in general "to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians".

In applying the principles which we have set forth in the Health Charter in Chapter 1, and after considering carefully the evidence presented to us, we have formulated a Health Services Programme as set out in Recommendation No. 1 on page 19. The details and methods of developing this Programme are set out in the Recommendations Nos. 2 to 200 under the following headings:

I. Health Services
   1. Health Services Programme: Principles and Policies (No. 1)
   2. Mental Health, Alcoholism, and Drug Addiction (Nos. 2-28)
   3. Medical Services (Nos. 29-38)
   4. Dental Services (Nos. 39-57)
   5. Prescription Drug Services (Nos. 58-82)
   6. Optical Services (Nos. 83-94)
   7. Hospital Services (The Hospital Insurance and Diagnostic Services Act) (Nos. 95-112)
   8. Prosthetic Services and Appliances (Nos. 113-115)
   9. Home Care Services (Nos. 116-123)

II. Health Personnel, Facilities and Research
   10. Nurse Education and Recruitment (Nos. 124-139)
   11. Medical Education and Recruitment (Nos. 140-154)
   12. Dental Education and Recruitment (Nos. 155-173)
   13. Health Professions University Grant (No. 174)
   14. Health Facilities Development Fund (Nos. 175-176)
   15. Health Sciences Research Council (Nos. 177-185)
   16. Health Statistics (Nos. 186-189)
III. Financing and Priorities

17. Over-all Financing (Nos. 190-195)
18. National Health Grants (Nos. 196-198)

We conclude this chapter with a brief quantitative assessment of the health personnel, health capital, and health expenditures involved in undertaking the Health Services Programme which we envisage for Canadians for the period 1961 to 1991.

I. HEALTH SERVICES

1. Health Services Programme: Principles and Policies

We have given careful consideration to the question of health services costs, and, as we see it, the problem facing the Canadian people is not solely the financing of physician services, but the full range of essential services—mental, medical, dental, hospital, pharmaceutical, nursing, prosthetic, home care, and optical. On the basis of the evidence before us, we believe that government action is imperative, and that the nation’s resources should be mustered to establish universal, comprehensive health services programmes in the ten provinces, the Yukon, and the Northwest Territories.

However, we have had to recognize that it would be impossible to introduce immediately universal programmes for dental and optical services due to the shortage of personnel. We have, therefore, limited our recommendations in these two fields primarily, but not solely, to children’s programmes.

To meet the objectives stated, joint Federal-Provincial action on a broad health front is imperative. The case for such action is overwhelming when we consider how far we are from where we might be. As indicated in Chapter 1, there is probably no other area of basic human need where our organizational and financial arrangements have fallen so far short in making available to all our people what science has discovered and professions know how to do.

The course of action is clear. It is to extend the very successful pattern of joint Federal-Provincial co-operation in hospital services to bring all personal health services to the entire population. The comprehensive programme should be based on similar principles. It should be universal; it will require Federal financial assistance; health funds should be used not only to pay for services, but also to provide more resources and to improve
the quality of care given; wherever possible emphasis must be on prevent-
ion; and we must also give higher priorities to rehabilitation services so
that individuals become self-supporting and families are restored to inde-
pendence. Although we have come to the conclusion that Federal and
Provincial governments must take the lead, it is essential that all the
resources of voluntary agencies be co-ordinated in achieving the objective
of "the best possible health care for all Canadians".

The Commission recommends:

1. That the Federal Government enter into agreements with the prov-
inces to provide grants on a fiscal need formula to assist the prov-
inces to introduce and operate comprehensive, universal, provincial
programmes of personal health services, with similar arrangements
for the Yukon and the Northwest Territories. The programmes
should consist of the following services, with the provinces exercising
the right to determine the order of priority of each service and the
timing of its introduction:

Medical Services
Dental Services, for children, expectant mothers, and public
assistance recipients
Prescription Drug Services
Optical Services, for children and public assistance recipients
Prosthetic Services
Home Care Services

In addition we propose a complete reorganization and reorientation
of the mental health services and important changes in the Hospital
Insurance Programme.

Although nursing services are not dealt with as a separate service,
it is obvious that they constitute an important element in hospital
and home care programmes. We believe it essential for the effective
coordination of health resources that nursing be administered as
an integral element of each of these services.

In implementing these programmes, the Commission believes that the
following principles and policies, consistent with the concepts and objectives
set out in Chapter 1, should obtain:

(1) The grants should be based, as in the case of the Hospital Insurance
Programme, on actual costs of services, with incentives for economy,
and there should be, as well, adjustment grants to take account of
provincial fiscal need.
(2) The grants should also be designed to help bring the ratio of health personnel to population in all provinces up to an acceptable standard.

(3) Coverage of health services should be continuous with portability of benefits assured to individuals moving from province to province, and wherever the services are rendered.\(^1\)

(4) The finances for the Programme must be sufficient to provide a high level of remuneration to health personnel, for the health professions must attract and retain a larger proportion of young people in the future than they have in the past.

(5) All administrative organization and procedures must be directed to maintaining and enhancing free, independent, and self-governing professions.

(6) As in the hospital insurance programmes, all personal health services should be universally available on uniform terms and conditions for all residents.

(7) Administration at the provincial level should be a Commission representative of the public, the health professions, and Government, and reporting to the Minister of Health, and it should also assume administration of the hospital insurance plan in the province. In a province where a voluntary prepayment agency operates, we recommend that such an agency may be used as the administrative vehicle augmented by additional representation of the public, the health professions and Government.\(^2\) The Deputy Minister of Health should be, “ex-officio”, a member of the Commission and because of the inter-relation of health and welfare, the Deputy Minister of Welfare should also be a member, “ex-officio”. There should be committees representative of the various professions to advise on professional matters and the members of these committees as well as the professional members of the Commission should be appointed only after consultation with the respective professions.

(8) The Federal Government should share in the administrative costs of the Health Services Programme to a maximum not to exceed five percent of its total contribution.

(9) There must be carefully designed statistical reporting on all services so that the programmes can be evaluated, their short-comings revealed, and new directions planned.

\(^1\) Federal and provincial authorities should study the question of coverage for Canadians serving abroad by Federal-Provincial agreement.

\(^2\) The Government of Manitoba, brief submitted to the Royal Commission on Health Services, Winnipeg, 1962, p. 11.
(10) Provision must be made at local, regional, provincial, and federal levels for representative Health Planning Councils to ensure democratic participation in the setting of goals and objectives and the meeting of human needs.

(11) The administration of health services for Indians and Eskimos should be entrusted to the provinces, and health services provided for them in the same manner and of the same quality as those enjoyed by other Canadians.

2. Mental Health, Alcoholism, and Drug Addiction

MENTAL HEALTH

Of all the problems presented before the Commission, that which reflects the greatest public concern, apart from the financing of health services generally, is mental illness—case finding, diagnosis, treatment and rehabilitation.

From the briefs and testimony presented to the Commission, two major conclusions can be reached. The first is that in the past general ignorance on the part of society of the nature of mental illness has led to a "ghetto attitude" towards those affected. Treatment of the mentally ill has been for too long characterized by callousness and neglect. The second conclusion is that we are in the midst of a great period of transition, perhaps just at the beginning of that period, in which not only are public attitudes rapidly changing, but that very change is making positive action possible and the outlook for treatment results hopeful if not actually optimistic.

The public interest manifested to the Commission was extraordinary. The concern of volunteers and professionals in such organizations as the Canadian Mental Health Association, the Canadian Association for Retarded Children and others was both admirable and encouraging.

But despite all this evidence of positive change in public attitudes, it is not enough. The rate of change must be accelerated. There must be an immediate end to the distinction that some still make in attitudes towards those who are mentally ill and those who are physically ill. There must be developed an increasing awareness of the possibilities in improved treatment. There must be more wide-spread understanding of the tremendous cost to the economy and to society resulting from the lack of contribution of the mentally ill and the length of their treatment.¹

¹ It is estimated that some ten per cent of the population, or about 1.9 million persons, may be suffering from psychiatric and emotional disorders of varying degrees, with an average daily number of patients in institutions of about 69,000. See Chapter 5.
Only with strong public support that comes from such understanding will we be able to make the gains that now appear possible. We believe that, fortunately, the Canadian people are now ready and that the necessary public support will be forthcoming.

The problem of mental disorder may be divided into two major categories: (a) mental retardation or deficiency and (b) psychiatric illness.

Unfortunately in many institutions insufficient effort has been made to separate what are essentially educational services for the mentally retarded on the one hand and health services for the mentally ill on the other. Nor has there been an adequate range of services available to either group.

** Personnel **

From an examination of the personnel resources for actively treating mental illness as distinct from our present pattern of providing largely custodial care, it is evident that there are serious shortages of psychiatrists, neurologists, clinical psychologists, psychiatric nurses, and psychiatric social workers. Since, in the treatment of mental illness, personnel are far more important than buildings and equipment, an all-out attack must be made on these shortages.

The Commission recommends:

2. That as part of a seven year crash programme, Professional Training Grants of $5,000 per year be made to medical graduates preparing for their specialist certificates in psychiatry, neuro-psychiatry, paediatric psychiatry, and neuro-surgery.

3. That as part of the same crash programme, Professional Training Grants of $3,000 per year be made available to university graduates specializing in clinical psychology and psychiatric social work, and to registered nurses specializing in psychiatric nursing.

4. That as part of the same crash programme, Professional Training Grants of $3,000 per year be made available to qualified university graduates in education for post-graduate work in psychology, especially in abnormal psychology, and for special work in teaching the mentally handicapped child.

5. That medical schools be granted funds to conduct special courses in psychiatry for general practitioners and that the Provincial Colleges of Physicians and Surgeons and the College of General Practice give high priority to such courses in their programmes of continuing education.
RECOMMENDATIONS

Research

But it is not only in personnel that mental health services are lacking. The major deficiency in dealing with mental disorder is in research. Although important work is going forward in a number of centres, much more needs to be done. Moreover, the Commission is convinced that not only do we need more research into the basic causes of mental illness; we need more critical evaluation of the effectiveness of the treatment programmes we now pursue.

The Commission recommends:

6. That increased public funds be made available through the Health Sciences Research Council and increased private funds be contributed to assist official and voluntary agencies and the universities to expand co-ordinated programmes of research into the causes of mental illness and mental retardation as well as to evaluate community programmes and present treatment services in these fields.

The Mentally Retarded

The mentally retarded can be grouped, roughly, in three categories:

(1) the mildly retarded, with I.Q.'s ranging from 50 to 75,
(2) the moderately retarded, with I.Q.'s ranging from 25 to 49,
(3) the low grade mental defective, with I.Q.'s ranging below 25.\(^1\)

It is important to distinguish the emotionally disturbed intelligent child from the mentally retarded. Unfortunately, there is evidence that through lack of early or accurate diagnosis, the emotionally disturbed child and the child with defective vision or hearing are too often categorized as mentally retarded. It is imperative that community resources be increased to obtain early diagnosis because lack of proper treatment impairs the chances for rehabilitation. These resources include community mental health clinics, consulting psychologists in the school system, and psychiatric units in large paediatric hospitals or units.

For too long mentally defective children have been segregated in large institutions, sometimes even housed with the adult psychotically ill. We believe that a more positive approach must be taken, following along the lines advocated by the Canadian Association for Retarded Children.

\(^1\) Canadian Association for Retarded Children, brief submitted to the Royal Commission on Health Services, Toronto, May 1962, pp. 7 and 8. Other classifications of the mentally retarded are discussed in Chapter 8.
The Commission recommends:

7. That in view of the extreme importance of early diagnosis of mental illness and especially mental retardation in children, e.g., as in the case of phenylketonuria, all children be examined shortly after birth.¹

8. That consulting clinical psychologists be appointed to all large urban school units and that health regions appoint clinical psychologists who will be available as consultants to schools in small towns and rural areas.

9. That the majority of mentally retarded children, i.e., the mildly retarded, not be segregated in institutions but remain at home, in the community, and be educated in special classes in the regular school programme.

10. That communities provide sheltered workshops where the mentally retarded may find employment after the school-leaving age.

11. That the moderately retarded be trained in special nursery-type day schools, and at the young adult age be given employment, when possible, in sheltered workshops.

12. That the wholly-dependent or low grade group be cared for at home if practicable and if the necessary home care services can be made available as a community service so that the parents or guardian may be assisted in providing constant care for the child. This should include separate nursery-type day care centres to which these children should be transported at public expense. If and when care at home becomes impracticable, the child should be transferred to a small hospital unit of not more than about 100 beds, located in the same general area, and cared for as part of the mental health programme.

The Mentally Ill

Treatment services for mental illness comprise a broad spectrum ranging from the family physician, clinical psychologist, psychiatrists, to community mental health clinics, psychiatric wards or wings in general hospitals, and the mental hospital.

For our purposes it is important to note that some but not all medical care insurance plans pay for services by private psychiatrists, and that the national Hospital Insurance and Diagnostic Services programme shares

¹The implementation of this recommendation in the case of phenylketonuria would bring substantial savings in treatment costs of from 80 to 90 per cent. Further, about 100 children annually would be saved from life-long suffering from mental retardation (see Transcript of evidence, Hearings, Vol. 5, November 1, 1961, pp. 1236 and 1237).
RECOMMENDATIONS

in the costs of hospitalizing patients in psychiatric units in general hospitals, but not in mental hospitals which, by and large, are financed wholly by provincial governments.

The Commission has received numerous representations urging that the exclusion of "hospitals for the mentally ill" in the Hospital Insurance and Diagnostic Services Act be removed. Most provincial governments have urged this amendment since the first draft of the legislation appeared.

This request, the Commission believes, touches the very core of mental illness treatment. The Commission takes the view that the financial provisions of the national Hospital Insurance and Diagnostic Services programme should be used in such a way as to improve this treatment. We believe that adequate treatment of mentally ill patients cannot be properly achieved in large, isolated, segregated, undifferentiated mental "asylums". We believe that most mental illness requiring hospitalization at all should be treated in general hospitals, in special wings of them, or in small regional psychiatric hospitals of up to 300 beds adjoining a general hospital. We also believe that the costs of all such treatment for mental illness should be recognized as a shareable cost by the Federal Government.

We believe that provinces should move with all due speed to remove all patients receiving or capable of receiving active care from mental hospitals and transfer them to general hospitals.

But this will obviously require time. We believe it can be accomplished by 1973 if we begin immediately to build additional psychiatric wings or units in most large general hospitals at the rate of approximately 1,300 beds per year, to reach a total by 1973 of about 14,000 such beds.

With the accomplishment of this objective by 1973, we can expect that a much larger number of patients will be treated in a given number of beds because of the shorter length of stay. However, there will remain a large number of custodial patients, now in mental hospitals, who will not be transferred to active treatment, psychiatric hospitals or units. If possible, these patients should be moved to other appropriate facilities, some of which are available and others we recommend to be established. The Commission has noted with great admiration the work of many voluntary agencies in providing homes for the aged and believes that this is one of the most important projects that voluntary organizations might undertake.

The Commission recommends:

13. That the Hospital Construction Grant regulations under the Health Facilities Development Fund be amended immediately to provide one-half the cost of construction of psychiatric wards or wings in all general hospitals over 100 beds in size, or of small regional psychiatric hospitals with up to 300 beds, adjacent to general hospitals,
including the requisite out-patient facilities, and the small units for the mentally retarded.

14. That federal and provincial authorities designate those wards of existing mental hospitals in which patients are clearly receiving active or convalescent care as a "hospital" or "facility" under the Hospital Insurance and Diagnostic Services Act, commencing January 1, 1965, so that these costs will be shared.

15. That the number of beds in the said ward or wards of each existing mental hospital so recognized be "reduced" by at least one-fourth, effective January 1, 1969, by at least one-half, effective January 1, 1971, and by at least three-fourths, effective January 1, 1973, and that all such recognition be removed by December 31, 1974.

16. That no grants be available for any new hospital for the mentally ill that is larger than 300 beds.

17. That salaries or sessional fees for psychiatrists directing these hospital wards or regional hospitals be accepted as a shareable cost under the Hospital Insurance and Diagnostic Services Act.

18. That the psychiatric units, wings, or regional hospitals have organized out-patient departments, in-patient treatment and consultative service, twenty-four hour emergency service, and "day" and "night" care programmes.

19. That each such unit develop a rehabilitative services properly staffed with psychiatric social workers and psychiatric nurses, and that this service be fully co-ordinated with other community health and welfare services.

20. That the development of homes for the aged and domiciliary services and foster home services be accelerated and that these be co-ordinated with other geriatric services in the community.

ALCOHOLISM

The serious and growing problem of alcoholism requires special consideration. Although it is estimated that 2,000 out of every 100,000 Canadians manifest an alcoholic problem, only a small percentage make use of the few, overly taxed facilities available. The Commission is greatly impressed by the work of voluntary organizations, and especially that of Alcoholics Anonymous.

However, the problem of treatment, like mental illness itself, is exacerbated by our lack of knowledge of the causes of the disease and methods of prevention, as well as of the efficacy of present treatment methods.
RECOMMENDATIONS

Clearly, in addition to expansion of services there is urgent need for more fundamental research as well as evaluation. Since both the Federal and Provincial Governments derive substantial revenues from taxes on sales of alcoholic beverages, a much higher proportion of these revenues than is now allocated should be expended on research and evaluation.

The Commission recommends:

21. That provincial governments increase their grants to foundations of alcoholism research and treatment agencies and universities and that the Federal Government match their grants. Research should be expanded at all levels: biochemical, neuro-physiological, psychological, and social.

22. That professional personnel be given Professional Training Grants for advanced study at various alcoholism institutes.

23. That special facilities be made available in general hospitals for handling the acute stages of patients' specific episodes and for psychiatric evaluation of the underlying causes.

24. That specialized after-care services be developed and full advantage taken of other community services.

DRUG ADDICTION

Drug addiction is a symptom of an underlying personality disorder combined with the influences of the social environment.

Because of the complex psycho-social background of the symptoms, treatment of drug addiction must proceed in a variety of ways.

The Commission recommends:

25. That psychiatric services in prisons and penitentiaries be improved to deal adequately with the problem of addiction and other psychiatric disorders.

26. That at least one general hospital in the larger centres should have a non-penal unit for the withdrawal and treatment of addicts, and to which addicts may go voluntarily for help while withdrawing from their addiction. Some experimentation in the registration of addicts and in providing them with narcotics under strict medical and narcotic control supervision might be undertaken. This would remove the profit incentive from drug peddling. It is this profit motive which encourages the vicious drug trafficker to recruit new addicts even among the high school population to maintain and expand his market.
He creates customers who must steal or turn to prostitution for the money needed to pay the exorbitant prices which prevail in the underworld. This social status forced on most drug addicts creates a secondary problem making withdrawal and reformation virtually impossible.

27. That there be established a community after-care programme in those centres where such is needed and where they do not now exist.

28. That substantial grants for research into the epidemiological and psycho-social aspects of addiction be made by the Health Sciences Research Council.

3. Medical Services

With almost the total population becoming entitled to prepaid hospital services, the next essential service to be organized is care provided by physicians and surgeons and some ancillary services all of which we refer to as "medical services".

It was evident in our hearings that by and large Canadians believe that they have been well served by their physicians and other health personnel. We heard the virtues of other programmes praised and we were asked to recommend for Canada systems and programmes which have worked well in other lands. We think we should state at the outset that it is our conclusion that the quality of medical services available to Canadians compares favourably with the standards prevailing in other advanced industrialized nations. It does not follow from this that there are no deficiencies. There are grave deficiencies; gaps that challenge the imagination, creative capacity and skills of a people emerging as an industrial leader among the nations of the free world.

Although we agree with those who urged us to take cognizance of successful experience elsewhere in the world, which we have done, we do not believe that our deficiencies can be remedied by trying to transplant to Canada an entire programme or system, however well it may have worked elsewhere. Rather, we must develop here an indigenous programme that builds upon the resources we have and that accords with our traditions and the historical development of health services in Canada. This is fundamental in all our proposals. The capitation system of paying physicians in England, strongly recommended to us, is a case in point. After examining that system, we have concluded that it would be unworkable in Canada because it depends upon the historical division between general practitioners and specialists. Canada has not had the separation of general practice in the doctor's "surgery" or home and the hospital-based specialist practice that prevails in England.
In Canada both the general practitioner and the specialist have always had a close hospital connection. The specialist has not been, as a rule, on hospital salary. Some practise both as specialists and general practitioners. This travelling of divergent paths for upwards of half a century has solidified customs and practices so different in Canada from those in England that it is now neither practical nor desirable to try to impose a capitation system on Canadian medicine. It works well in England. The profession there as a whole is satisfied and wants no major change. It will be remembered that capitation already in use in England in the last century through the Friendly Societies was extended by Lloyd George’s Act of 1911 to cover the small wage earner, then a substantial segment of the population, became much broader in 1931, and universal for the payment of general practitioners in 1948. It was a logical development in line with established custom and practice.

The capitation system as practised in England is used in Holland but not in West Germany or Sweden, both of which use a basic fee-for-service plan. Capitation was used in Denmark until it was abolished in 1961 in favour of the fee-for-service system. Norway, Sweden, Switzerland, France and Australia are among the countries that operate principally on what is called the reimbursement system. With the exception of Norway, it appears to be a feature of most reimbursement systems of paying for medical services that no schedule of maximum fees is agreed with the profession. We do not believe that the reimbursement system could be transplanted into Canada any more successfully than the capitation system. Historically the fee-for-service system has become the method generally used in Canada. In recommending the use of the fee-for-service method in a health service for Canada, we wish to stress that it must be based on a schedule of maximum fees agreed to with the profession in each province and that medical services be paid for on such agreed schedules and not on any arbitrary percentage of the schedules. Extra billing would not be permitted.

We believe that the procedures for the provision of medical services in Canada established by those medical care prepayment plans operating on a “service contract” basis have demonstrated their effectiveness and the possibility of low cost administration. Their experience has enabled these plans to develop not only effective organization and efficient administration but also to evolve other features essential in the operation of a programme of this sort. Thus they have efficient systems for enrolling both groups and

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1 Another example of the different patterns of service is the fact that in England 37 per cent of all deliveries occur outside the hospital compared with 2 per cent in Canada in 1962 (communication from Department of National Health and Welfare).

individuals, for processing and paying accounts, for record keeping, and for techniques to control over-utilization and over-servicing. However, deficiencies have become apparent in this type of contract in that many millions are excluded because of age, pre-existing physical or mental conditions or inability to pay the premiums. Then too, contracts are terminable at the option of the carrier and some provide for extra billing. Until the recent introduction of the extended health benefit plans as an alternative to the limited traditional coverage, these plans covered physicians' services only.

What we seek is a method that will provide everybody in Canada with comprehensive coverage regardless of age or state of health or ability to pay, upon uniform terms and conditions. We recommend that the medical services benefits come into effect only when provinces with approximately half of Canada's population are ready to implement them, a condition similar to that prevailing at the introduction of the Hospital Insurance and Diagnostic Services Act.

We do not believe, however, that all final answers have been found, and provision must be made for continuing experimentation and the introduction of new methods. There is a strong case for organization of medical (and hospital) services on a regional basis (e.g., the Swift Current Health Region) in order to facilitate such experimentation and variety. For example, although we have assumed that the basic method of payment for physicians and surgeons will be "fee-for-service", other methods and combinations of methods should be tried, and adopted where they appear desirable.\(^1\)

Again, the basic pattern for provision of medical (and dental) services will likely rest for some time on solo practitioners. Nevertheless we believe that the advantages of group practice so far outweigh the disadvantages that the programme should offer such inducements that a larger proportion of physicians and surgeons provide their services through group practice clinics.

It may be argued that how medical personnel provide their personal services is strictly their own affair, but there are cogent reasons why this matter is also of interest to consumers and society as a whole. The first is the matter of quality, for it has been demonstrated beyond reasonable doubt that the team practice of medicine where there is continuing professional contact by a physician with his confrères does tend to improve quality. Moreover, the group practice of medicine brings together physicians, often of diverse and highly developed skills, and the necessary supporting auxiliary workers and technical equipment necessary for the modern practice

\(^1\) As in frontier or "under-doctored" areas.
of medicine. The concentration of the equipment and auxiliary workers results in their more efficient use. This, together with the fact that physicians can assume responsibility for more patients than in solo practice, results in lower unit costs for higher quality care. The consumer has, therefore, an interest in economy because it is he who foots the bill. The society has an interest because group practice raises productivity.

We believe that long-term loans at reasonable rates should be made available for the development of group practice facilities, and that provision might be made for accelerated depreciation of capital expenditures for income tax purposes. We believe also that subsidies should be available for small group practice clinics in rural areas so that health personnel (and their patients) may obtain some of the advantages available or becoming available to urban residents. Subsidies may be of different kinds: basic salary, office accommodation, residence, transportation, or others.

One further problem requires some comment. We have affirmed our belief in free self-governing professions. Certain licensing and disciplinary functions are exercised by Provincial Colleges of Physicians and Surgeons. These provincial colleges derive their authority from provincial legislatures and act as an arm of government in the spheres of activity allotted to them. In some provinces the functions of the Provincial Colleges of Physicians and Surgeons are not clearly separated from those of the provincial division of the Canadian Medical Association, the voluntary body concerned with the common interests of its members and such matters as public relations. We believe that the provincial colleges should be clearly separated from the voluntary association or associations, and we also believe that the disciplinary powers of the provincial colleges ought to be extended so that they may have the authority to ensure that all medical and surgical practice is of high quality.

The Commission recommends:

29. That henceforth all discrimination in the distinction between physical and mental illness in the organization and provision of services for their treatment, and the attitudes upon which these discriminations are based be disavowed for all time as unworthy and unscientific.¹

¹ Acceptance of this key principle apparently continues to elude the insurance industry as is indicated in the submission of spokesmen for the Canadian Health Insurance Association to the Medical Services Insurance Enquiry of the Province of Ontario, given at Toronto, January 29, 1964 (Proceedings, pages 1141 and 1142), adhering to the position taken by the Association before us at Toronto on May 16, 1962 (Proceedings, Volume 54, pages 10264-10269).
30. That the medical services benefit include the services of general practitioners and specialists, provided in the office, hospital, patient's home, and group practice clinic.

The medical services benefit should incorporate the following insured services:

(a) medical services—the diagnosis and treatment of all physical and psychiatric conditions including mental retardation;

(b) surgical services—diagnosis, pre-operative care and treatment, surgical procedures and post-operative care rendered to a person requiring or receiving a surgical operation or procedure, including the services of a surgical assistant where required by the nature of the procedure;

(c) maternity services—obstetrical care, including pre-natal and post-natal care and attendance at confinement;

(d) new-born care—routine care of the new-born;

(e) specialist services—all services provided by a physician who is a specialist, and psychodiagnostic and psychotherapeutic services rendered by a properly qualified psychologist with special training in these areas;

(f) anaesthesia—the administration of anaesthetics including:
   (i) anaesthesia for diagnostic, surgical and other procedures;
   (ii) obstetrical anaesthesia;
   (iii) dental anaesthesia in hospital;
   (iv) dental anaesthesia in dental surgeries where rendered by a physician;

(g) X-ray, laboratory and other diagnostic procedures, including interpretations;

(h) preventive medical services:
   (i) inoculations and vaccinations where those services are not provided through a government agency;
   (ii) periodic physical examinations, but not including examinations for the purpose of marriage, insurance or employment, or at the request of a third party;

(i) blood transfusions as required;\(^1\)

\(^1\) See discussion of Red Cross Blood Transfusion Service in Chapter 8.
RECOMMENDATIONS

(j) dental services where provided by a dentist in conjunction with maxillo-facial surgery;¹

(k) prosthetic and orthotic devices, appliances, or aids when prescribed;²

(l) physiotherapy where provided by a physical therapist upon the order of a physician;

(m) podiatric and chiropractic treatment when prescribed by a physician;

(n) ambulance services and similar forms of transportation of patients, except as may be designated as part of any other health service benefit;

(o) any other services specified by a Federal-Provincial agreement.

The following services should not be included as insured services:

(a) services received by a beneficiary under provincial Workmen’s Compensation legislation;

(b) services received by a beneficiary under other provincial legislation;

(c) services received by a beneficiary under other federal legislation;

(d) services rendered by a physician pursuant to an arrangement for rendering services to the employees of an employer or to members of an association;

¹ We have noted the submission made by the Royal College of Dental Surgeons of Ontario and The Ontario Dental Association to the Medical Services Insurance Enquiry in connection with Bill 163, An Act Respecting Medical Services Insurance, that “there are many services residing within the legal and academic competence of dentists which are frequently rendered by physicians”. The point was made that a plan which would entitle the beneficiaries to such “services when they are performed by a physician, but would deny entitlement for the same services when they are performed by a dentist”, would be “both unjust and discriminatory”. (Brief reprinted, The Ontario Dental Association Journal, Toronto: January 1964, Vol. 41, p. 7.)

There are two reasons for limiting our recommendations above to include in the first instance only dental services where provided by a dentist in conjunction with maxillo-facial surgery. The first is the extremely limited supply of dental specialists trained in oral surgery and the high priority we attach to the children’s dental programme which is likely to make substantial demands on the comparatively small number of dental oral surgeons practising in Canada.

The second reason is the difficulty of defining for administrative purposes dental oral surgery without opening the way to claims for all tooth extractions and similar work done by dental oral surgeons. Overcoming the shortage of dental oral surgeons and the administrative problems involved will take time and effort. This is an area where further exploratory work should be undertaken on a co-operative basis between governments, the dental profession and other interested groups with a view to resolving the problems encountered in this specialized field. Payments to dental oral surgeons could then be made for specified services as may be provided under Federal-Provincial agreements. (See Recommendation 30 (o) above.)

² These would include all forms of bracing, including corrective splints and boots made specially on prescription for persons for whom standard footwear is inadequate. (See also Recommendation 113.)
(e) travelling by a physician except under circumstances specified by a Federal-Provincial agreement.

31. That the basic method of paying for medical services provided by physicians in private practice be fee-for-service, and that other methods and combinations of methods be experimented with and adopted where they are agreed upon as being more suitable.

32. That the schedule of maximum fees or other payments should be negotiated between the medical association and the respective provincial administrative agency without extra billing. Provincial legislation should provide for an appeal procedure in the event of disagreement.

33. That subsidies chargeable to the Health Services Programme be used to attract physicians to rural areas.

34. That loans be made available under the National Housing Act for financing facilities for "group practice clinics" on the basis of terms as provided for new houses.

35. That the capital cost allowance provisions governing the construction and equipping of group practice clinics be amended to permit capital costs to be written off at twice the rate permitted under present regulations.

36. That in order to provide the best possible health care under the circumstances to residents of isolated, northern and other regions, special services be made available including air ambulance, two-way radio communication, additional nursing stations and medicine depots.¹

37. That the medical services benefits shall not come into effect until two or more provinces containing approximately one-half the population of Canada have entered into an agreement to provide the medical service benefits and the provincial law in relation thereto is in force.

38. That in all provinces the College of Physicians and Surgeons be separately organized from the provincial division of the Canadian Medical Association and that the power of all provincial medical licensing agencies be extended to give them sufficient authority to ensure that medical and surgical practice is of high quality.

¹We are greatly concerned with the need for providing health services, the best possible under the circumstances, to the people in the sparsely settled rural and remote areas of this country, particularly the northern regions. Impressive progress has been made by federal, provincial, religious and other voluntary agencies against the hazards of a forbidding geography and climate, but much more remains to be done. In these areas we have to take into account the rapidly changing technology of travel and communications. At present we envisage that two-way radio communications accessible to residents of these areas would enable them and the public health nurse to consult or call a physician at a base point. (See Chapter 13.)
4. Dental Services

As the evidence in Chapter 13 indicates, the shortage of dentists in Canada is so acute that, however desirable and necessary it may be, it is impossible to think at the present time in terms of a programme of dental services for the entire population. In fact, so serious is the shortage that we recognize that the proposals we are about to make will be difficult to achieve. Nevertheless, we believe it imperative to make a beginning and that beginning should start with the new generation.

**ORGANIZED PROGRAMME FOR CHILDREN**

There should be introduced as quickly as organization and recruitment can be accomplished a dental programme for children using the services of dentists and dental auxiliaries. In the first year, say, 1968, all children aged five and six would be entitled to dental examination and restorative services, including, where necessary, referral to orthodontic and other specialists. In the second year, 1969, all children aged four, five, six and seven would be entitled to services, and in the third year, 1970, all children from three to eight. In each of the following years a succeeding single year age group should be added.\(^1\) By 1980, all children up to the age of 18 would be entitled to services and all children then 18 would have had regular dental care throughout their formative years.\(^2\) We should like to see the children's programme introduced in all provinces simultaneously so that children moving from one province to another do not lose continuity of service. In addition, any province that has the resources should be encouraged to accelerate the programme.

We have no illusions about the difficulties and problems that this decision will create. Financial resources must be made available to attract dental personnel into this programme on a large scale.

Furthermore, we are aware of the problems created by the necessity to exclude from the programme older children in the same family in which a younger child is entitled to services under the programme. For this reason we believe that the programme must be financed solely from Federal and Provincial general funds. That means there must be no specific "premium" for this programme. We also believe this programme to be so important that it cannot await Federal Government and Provincial Government decisions on the comprehensive health programme as a whole and of which this benefit might be considered a part. This programme must have one of the highest priorities among all our proposals.

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\(^1\) This phasing is similar to the suggestion of the Canadian Dental Association in their brief submitted to the Royal Commission on Health Services, Ottawa, 1962, pp. 42-44.

\(^2\) See Chapter 13 for a discussion of utilization of this service.
If the dental resources of the nation have been expanded as we recommend, it may be possible to consider in the nineteen eighties a general dental programme for the adult population based on appropriate arrangements with all dentists in private practice.

The Commission recommends:

39. That the National Health Grants Programme be expanded to include a Children's Dental Health Grant to provinces to provide for dental services for children aged five and six years, in the first year, children aged four to seven in the second year, children aged three to eight in the third year, with the succeeding one-year age group to be added each subsequent year; the grant to be large enough to make provision each year for at least two examinations and the evident necessary care for each child.

40. That a Dental Construction and Equipment Grant be established under the Health Facilities Development Fund to provide funds for dental clinic facilities in hospitals, public health centres, schools, or other health facilities, for the purpose of the recommended programme and, where necessary, equipment for travelling dental clinics, the Federal share to be 75 per cent of the cost to 1969, and 50 per cent thereafter.

41. That the Federal Government provide matching funds under the National Health Grants Programme to meet the costs of the programme, including the employment of dentists on either a full-time or sessional basis to direct the work of the clinics and provide continuing supervision of the dental auxiliaries, the employment of dental auxiliaries, the costs of referrals to specialists, and the operating costs of clinics, including transportation of personnel and equipment to outlying centres. In areas where none of the above-mentioned arrangements is feasible, special arrangements should be made with dentists in private practice. The remuneration for dentists in this programme as in all other programmes employing dentists should be competitive with incomes in private practice.

42. That dental public health educational programmes be organized and actively promoted in all health regions or units in the nation.

43. That the Health Sciences Research Council establish, as part of a continuing system of health statistics in Canada, a dental health survey including the maintenance of the dental health index established by the Canadian Dental Association.
44. That special consideration be given to the dental requirements of children suffering from physical or mental handicaps and the frequent need to admit them to hospital in order to provide essential dental treatment.

**FLUORIDATION**

As recommended above, a dental programme for children must proceed with all due speed. But, as we have indicated, dental personnel are in such short supply that we will not in our generation have sufficient dental resources to meet our total needs. The only possible effective solution is to reduce our needs, as well as to enhance our resources. Fortunately, the now proven method of fluoridation by the use of a controlled quantity of fluoride in community water resources goes beyond a remedy; it does more by preventing a high proportion of dental caries ever appearing at all. We have heard the evidence of the dental profession, and we have examined other evidence including the thorough and factual report of the Ontario Committee on Fluoridation.¹ The evidence, now garnered over 30 years is that the technique of fluoridation properly controlled is effective, inexpensive and safe. Wherever it has been adopted² the savings in dental costs have been impressive; and the reduction of human suffering equally great.

*The Commission recommends:*

45. That every community water system in Canada be immediately equipped to provide, and does provide, the approved level of fluoride.

46. That the Federal Government provide under the Health Facilities Development Fund a grant to the provinces of 75 per cent of the cost of equipment and installation for fluoridating community water supplies.

47. That the Health Sciences Research Council provide for research and evaluation studies for the purpose of assessing the efficacy of fluoridation and the Children’s Dental Programme.

48. That the Federal Government immediately provide for fluoridation of all water supplies in areas or institutions under its jurisdiction, viz., the territories, the armed forces establishments where children are located, and the like.

² In Canada, in 1963, about 3,800,000 persons or 20 per cent of the population had mechanically fluoridated water (see House of Commons Debates, Ottawa, March 23, 1964, p. 1333).
49. That in rural areas where community water systems are non-existent the public health authorities adopt means for meeting fluoride needs.¹

MATERNAL DENTAL HEALTH PROGRAMME

There is a third area in which we believe there is an over-riding public interest. It is the dental health of expectant mothers. The high incidence of dental defects among expectant mothers is well known. The Commission believes that as soon as dental manpower resources have been increased by the establishment of additional dental schools, this group in the population should receive special consideration.

The Commission recommends:

50. That a programme of dental services for expectant mothers, with services provided by dentists in private practice, be introduced as a benefit of the Health Services Programme in 1971, or as soon thereafter as it is deemed that dental manpower resources are adequate to meet the needs.

DISTRIBUTION OF DENTISTS

Apart from the general shortage of dentists in Canada, the most serious problems arise from the acute shortage in small towns, villages and rural areas. It is essential that provincial health departments and health regions combine resources to offer special subsidies to attract dentists to these areas. Subsidies may be of different kinds: basic salary, office accommodation, travelling clinic equipment, residence, transportation, or others.

The Commission recommends:

51. That subsidies chargeable to the Children’s Dental Health Programme Grant be used to attract dentists to rural areas, and that in areas with populations too scattered to warrant resident dentists, arrangements be made for travelling dental clinics, and that special inducements be offered to attract dental specialists to medium sized centres.

DENTAL SERVICES FOR WELFARE RECIPIENTS

A number of provinces have met the problem of dental need for welfare recipients by introducing a dental welfare services programme. The recipient is entitled to services (including, where necessary, the provision of dentures) from a hospital out-patient department or public health dental clinic or a dentist in private practice at either no cost or only part of the

¹The Commission recognizes that presently known alternative means are both more expensive and less effective than fluoridating the community water supply.
normal fee. We believe that such programmes should be introduced by all provinces and that federal subsidy of 50 per cent, as with other forms of public assistance, should be granted, provided that the provinces take appropriate safeguards to assure the standards of service provided.

The Commission recommends:

52. That all provinces introduce programmes of adequate dental services for all recipients of public assistance and their dependants.

53. That the Federal Government contribute one-half the cost of such programmes under the Health Services Programme.

HOSPITAL DENTAL DEPARTMENTS

Experience in certain hospitals in Canada and in other countries makes evident the important advantages to certain patients if their dental requirements can be met in hospital. Among these are patients requiring multiple extractions under general anaesthesia, the treatment of severe infections of the mouth and jaws, the management of complicated fractures, as well as patients who are physically and mentally handicapped. There are important advances to be made through a team approach of an oral surgeon, orthodontist, and medical and/or dental specialists and paramedical personnel. The Commission is convinced that all major hospitals not having yet done so should now establish Departments of Dentistry.

The Commission recommends:

54. That all major general hospitals proceed as soon as possible to establish and equip a Department of Dentistry, providing both in-patient and out-patient services.

55. That a Chief of the Dental Service be appointed in such hospitals.

56. That qualified dentists be appointed to the hospital staff.

57. That centres for treatment of cleft palate cases be established in children’s hospitals and in general hospitals where adequate paediatric and associated services are available.¹

5. Prescription Drug Services

In view of the high costs of many of the new life-saving, life-sustaining, pain-killing, and disease-preventing drugs, the Commission has concluded that prescribed drugs² should be introduced as a benefit of the Health Services

¹ See Canadian Dental Association, op. cit., p. 59.
² Drugs prescribed by licensed medical practitioners.
Programme. Again, the decisions respecting the scope and priority of this benefit would be made by the provinces, but its authorization should be an early objective of the Canadian Parliament.

Few aspects of health services have generated so much public interest and concern as that now directed toward drugs and the drug manufacturing and distributing industries. In view of the official investigations undertaken and being launched, the Commission has not itself conducted a detailed examination of the industry. It has had available to it, however, a large number of important studies, and legislative hearings, as well as extensive submissions. All of these underscore both the complexity of the problem and the necessity for solutions that enable essential drugs to be readily available and at reasonable cost. It is no accident that the public interest has increased in direct relationship to the efficacy of drug therapy and the high cost of many of the most effective drugs. Expenditures on all drugs are equivalent to 95 per cent of the outlay on physicians’ services with prescribed drugs representing about 43 per cent of medical expenditures.

Although we accept that the manufacture and distribution of drugs in this country is a private enterprise venture, we have no hesitation in stating that the public interest is dominant. When we speak of the availability of a large number of specific drugs, we are talking in terms of lives and the health of people.

Either the industry will itself make these drugs available at the lowest possible cost, or it will be necessary for agencies and devices of government to do so. We must not confuse the distribution of essential drugs with the distribution of cosmetics and sundries.

1 Director of Investigation and Research Combines Investigation Act, Material Collected for Submission to the Restrictive Trade Practices Commission in the Course of an Inquiry under Section 42 of the Combines Investigation Act, Relating to The Manufacture, Distribution and Sale of Drugs, Ottawa: Department of Justice, 1961.


Ontario Legislature, Select Committee to Inquire into Matters Pertaining to the Cost of Drugs, Proceedings of Hearings of Select Committee on Drugs, Toronto, June 1960.


House of Commons, Special Committee on Food and Drugs, Proceedings No. 1; Minutes of Proceedings and Evidence, Nos. 2-4, Dec. 1962-Feb. 1963, Ottawa: Queen's Printer, 1963.


2 Data relate to 1961, see Chapter 9.
Both the Federal and the Provincial Governments will undoubtedly have to make a multi-pronged approach in reducing costs of distribution, and some of these steps need not await the introduction of drugs as a benefit under the Health Services Programme.

In the administration of the programme it will be necessary for Health Services Commissions and the respective provincial pharmaceutical associations to agree upon a standard price and fee schedule for all prescriptions. Further, the Commission considers it highly desirable that a contributory payment should be made by the purchaser for each prescription, and suggests that the amount should be $1.00 per prescription. If the retailer wishes to reduce the standard price of the prescription, with the purchaser’s contribution being reduced by that amount, he should be free to do so.

Our recommendations with respect to drugs also include some suggestions that need not await the introduction of the drug benefit for their implementation and consequent effect.¹

**The Commission recommends:**

58. That the Federal Government contribute grants to the provinces (50 per cent of the cost of the programme) for the purpose of introducing a Prescription Drug Benefit within the Health Services Programme.

59. That in the provision of the drug benefit, there should be required a $1.00 contributory payment by the purchaser for each prescription, subject to such discount as the retailer may offer. This charge should not be applied to drugs required for long-term therapy.

60. That the programme should cover such quantities of drugs for each prescription as are required by good medical practice taking into account the need for flexibility to assure an adequate but not wasteful supply. Further, prescribing practices should be reviewed periodically to ascertain whether and to what extent any over-prescribing of pharmaceuticals takes place, followed by appropriate changes in the regulations covering quantities of drugs paid for under the programme.

61. That the functions of the Drug Advisory Committee which is responsible for advising the Department of National Health and Welfare be expanded, and its membership enlarged to include representatives of the Canadian Medical Association, l’Association des médecins de langue française du Canada, the Canadian Pharmaceutical Association, the Canadian Hospital Association, the provincial Schools of Pharmacy, the provincial Colleges of Pharmacists, and the provincial Departments of Health.

¹The evidence on which our recommendations are based is reviewed in Chapters 9, 16 and 17.
62. That the Food and Drug Directorate, with the assistance of the Advisory Committee, prepare and issue a National Drug Formulary which would be maintained on a current basis. This Formulary would include only those drugs which meet the specifications of the Directorate, and would be identified as such, and therefore eligible for inclusion in the Prescription Drug Benefit, one of the objects being to minimize the cost of prescribed drugs. There should be established an appeals procedure for dealing with rejected applications, and an Information Service which would issue periodic bulletins providing the latest information on drugs and drug therapy to physicians, pharmacists, and hospitals.

63. That the budget of the Food and Drug Directorate of the Department of National Health and Welfare be increased to enable it to recruit and train the personnel necessary to fulfil the additional functions and responsibilities that it is essential for it to assume.

64. That in the application of the provisions of the Corporation Income Tax Act to manufacturers, importers, and distributors of drugs, consideration should be given to establishing a maximum of 15 per cent of total sales as the allowable deductible expense for advertising, sales promotion, "detail men", and other similar items.

65. That the federal sales tax be removed from all drugs listed in the Formulary.

66. That Section 19 of the Patent Act extending the right of the Crown in the name of the Government of Canada to use patented inventions "paying to the patentee such sum as the Commissioner reports to be a reasonable compensation for the use thereof" be expanded to include provincial governments and their agencies.

67. That Section 41(3) of the Patent Act be amended to extend compulsory licensing to include the licensing of imports. The quality of such imported drugs should be assured by:

(a) requiring examination to ensure that they meet the specifications of the Food and Drug Directorate, and

(b) continuous checks of quantities imported.

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1 See Chapter 16.
2 This recommendation differs from that of the Restrictive Trade Practices Commission for two reasons:

(1) The drug industry is different from other industries in that its products are essential for health and, indeed, life.

(2) The great bulk of production of drugs for Canadian consumption is produced by non-Canadian companies.
68. That the Federal Government consider delaying for five years a decision to implement the recommendation of the Restrictive Trade Practices Commission that patents on drugs be abolished, in order to ascertain whether the alternatives recommended above achieve the same results.

69. That provisions and administration of procedures with respect to granting of compulsory licences by the Commissioner of Patents be revised to remove unnecessary delays with respect to a decision to grant.\(^1\) Provision should be made to establish a standard royalty payment comprising a fixed fee on application and a percentage of sales over the period of the licence to speed up proceedings and to encourage responsible applicants.\(^2\)

70. That the Trade-marks Act should be amended (Section 20) to make clear that no infringement can be claimed where imported drugs are manufactured by a "related" company.

71. That the Canadian Tariff Board be requested to review tariffs on drugs with a view to establishing which tariff should be reduced or abolished covering imported drugs included in the National Formulary.

72. That in the administration of "anti-dumping" regulations in respect to drugs, the Minister of National Revenue be given discretion to establish "market value" at lower levels\(^3\) than that resulting from present practice to contribute to a reduction of drug prices.

73. That the Government of Canada, assisted by the Drug Advisory Committee, sponsor jointly with the drug industry and such provincial governments as wish to participate, a study of the feasibility of a voluntary drug price restraint programme for Canada, for implementation on a trial basis for a period of five years.

74. That provincial governments consider legislation enabling pharmacists in the dispensing of prescriptions to use a drug or drug combination

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\(^1\) This is an endorsement of a recommendation of the Royal Commission on Patents, Copyright and Industrial Designs, and of the Restrictive Trade Practices Commission.

\(^2\) A recent order of the Federal Trade Commission in the United States removing unlawful restraints on trade in the formulation and sale of tetracycline provides for compulsory licensing of all domestic applicants under the patents in question whereby all applicants may be required to pay $2,500 upon being issued a licence, which amount is to be applied against future royalties which are not to exceed 2½ per cent of licencees' net sales of tetracycline. Commerce Clearing House, Inc., Trade Regulation Reporter, Washington, D.C., 1964, p. 21,600.

\(^3\) The Restrictive Trade Practices Commission reported "...that, with respect to ethical drugs and more especially antibiotics and tranquillizers, the dumping duty rules may sometimes operate to increase the costs of some Canadian importers without giving any substantial protection to Canadian manufacturers." Restrictive Trade Practices Commission, op. cit., p. 507.
that is the non-proprietary name equivalent of that named in the prescription unless the physician specifically indicates otherwise.¹

75. That educational programmes be conducted by the Food and Drug Directorate, the medical and pharmaceutical professions, and the provincial health service agencies to create greater understanding and co-operation between practitioners and pharmacists concerning the cost of drugs, and their prescription by proper names whenever possible.

76. That universities through their faculties of medicine and pharmacy strengthen their courses in pharmacology taken by medical students, by providing instruction in the economics of prescribing, including examination of comparative costs of drugs with similar therapeutic quality and efficacy; by short refresher courses dealing with pharmacology for physicians; and by extension work with medical practitioners in such fields as evaluation and therapeutics.

77. That the Federal Government centralize all its drug purchases in one agency.

78. That provinces be encouraged to adopt bulk-purchasing of drugs for all hospitals and public agencies, and that all tenders for drugs should be based, whenever possible, on specifications of the ingredients of the pharmaceutical.

79. That hospital pharmacies under the direction of a licensed pharmacist be permitted to provide narcotics and control drugs on prescription under the Food and Drug Act and the Narcotics Control Act.

80. That the Federal Government expand considerably research grants by the Health Sciences Research Council to universities and non-professional institutions to encourage the development of new drugs and/or improvement of existing drugs in Canada. In case of patentable discoveries these should be vested in the Crown.

81. That the Research and Statistics Division of the Department of National Health and Welfare undertake continuing cost-price analyses of drugs and periodically publish the results. Such studies would:
   (a) assist in the compulsory licensing under the Patent Act of drugs to be manufactured in Canada,
   (b) assist in the compulsory licensing of drugs to be imported into Canada,
   (c) assist in the review of tariff items on drugs, undertaken by the Canadian Tariff Board,

¹ Similar to legislation presently in effect in Alberta, Chapter 16.
RECOMMENDATIONS

(d) assist the Director of Investigation and Research under the Com- bines Act,
(e) assist public agencies at the federal and provincial level in calling for tenders for drugs,
(f) assist the Federal and Provincial Governments in formulating fiscal and procurement policies concerning drugs,
(g) assist drug manufacturers and drug distributors in examining their relative cost position and facilitate increasing competition where appropriate,
(h) assist the general public in acquiring an understanding of the various factors entering into drug costs and drug prices.

82. That the Research and Statistics Division of the Department of National Health and Welfare and the Dominion Bureau of Statistics co-operate in developing more comprehensive and up-to-date statistics relating to the supply costs of, and expenditures on, drugs covering both prescribed and non-prescribed pharmaceuticals.

6. Optical Services

The problem of visual deficiency is one of our most prevalent health defects. It is most serious among the aged, but failure to recognize and to correct visual deficiency early in children can adversely affect the course of their lives.

A decision to introduce an extensive public programme of eye care services at a specific point in time must take account of the stage of development of the technology (i.e., the body of scientific knowledge and the instruments) and of the resources and qualifications of professional personnel for diagnosis and treatment.

In the historical development of eye services the determination of the presence of refractive errors and their correction by the use of glasses can be said to represent a first stage. In fact, self-service in the provision of glasses still exists since they can be bought in retail stores even now and the itinerant peddler of glasses is within the memory of many.

The technique of refraction by a trained "refractionist" which permits a scientific measurement of refractive error and therefore the prescription of accurately correcting lenses represents a more advanced stage. And for the majority of people needing glasses this limited procedure may be satisfactory because the eye is healthy.

The third stage of technology is that of diagnosis of pathological conditions and other abnormalities that may or may not be related to
refractive error or which may, in fact, actually reveal pathological conditions elsewhere than in the eye to be treated by medical and surgical procedures.

It is in this third stage that the greatest advances have been recently made, both in diagnosis and in treatment, and it can be assumed that with continuing research and experimentation this body of knowledge and range of skills will become even greater. The essential point here is that the gap between the technology of stage two and of stage three will become increasingly larger in the future.

The significance of this widening gap is that each of these two last stages of technology is represented by a separate group of practitioners.

(1) The ophthalmologists, who are medical specialists, qualified not only to diagnose disorders of vision by means of refraction and prescribe spectacles but, more important, qualified also to diagnose and treat medically and surgically diseases and other defects of the eye.

The medically qualified group in Canada totals approximately 600 and includes three categories:

(a) ophthalmologists, who specialize in eye care, and whose training requires 10 to 11 years;

(b) a group of ophthalmologists who are also qualified as rhinolaryngologists (ear, nose and throat specialists);

(c) a number of general practitioners who practice ophthalmology.

(2) The optometrists, whose capabilities are in the main limited to those disorders of vision that can be determined by refraction and corrected by the prescribing of spectacles with their corrective lenses.

The optometrists, of whom there are approximately 1,500 in Canada, are trained in a four-year course following senior matriculation, and the nature of their training and skill is underscored by their own designation of themselves as "refractionists".

It is estimated by the professional societies of both groups that there is a shortage of personnel and, in fact, despite increased populations, there were in all but two provinces fewer optometrists in 1960 than in 1955.

(3) The third group involved in eye services are the dispensing opticians who prepare the lenses and sell spectacles on prescription.

The Commission is convinced that optical services must have a high priority as a benefit in a comprehensive health programme, especially for children. But because of the conflicting representations made before it, the Commission has had to consider the respective roles of the ophthalmologists and the optometrists.

It should be noted that while all the medical sponsored prepayment plans now operating do provide for payment for medical and surgical services
performed by ophthalmologists, the policy with respect to payment for refractions performed by ophthalmologists varies from plan to plan. Two of the largest plans do pay; most of the others do not. None pay optometrists.

Under the recommended general medical services benefits, medical and surgical services provided by ophthalmologists would be automatically included.

It is obvious that there are not enough ophthalmologists to provide complete services including refractions for the entire population. Accordingly, a decision must be made with respect to the role, if any, of optometrists in the programme.

The fact that a patient visits an optometrist is *prima facie* evidence that he has some symptom or symptoms that he feels are related to his eyes. In the majority of cases, the eyes will be healthy although glasses to correct abnormal vision may be necessary.

With these cases there is no cause for concern. The question at issue arises out of our concern for those patients whose symptoms are the result of pathological conditions of the eye or other systemic disease and which may not be sufficiently evident to be detected even by the most experienced optometrist.

The optometrist is not medically qualified. He is not trained in pharmacology, and is prohibited by law from the use of drugs and cannot, therefore, use a cycloplegic (a drug that dilates the pupil) in order to make an eye examination complete enough to detect with certainty the presence of many pathological conditions. This requirement of the cycloplegic is even more essential in the examination of children than of adults. The present courses in the two schools of optometry in Canada now provide good training in optics and the technique of refraction. They also give some basic training in anatomy, physiology and pathology. The question before the Commission is whether this latter training is adequate.

Although we have been impressed by the emphasis placed in the optometrists’ brief to the Commission stressing their responsibility for referral of those conditions which they detect as being beyond their ability to treat, we have also been impressed by the fact that the experience of ophthalmologists indicates a higher proportion of conditions requiring medical diagnosis and treatment than the average referred by optometrists.

The optometrists’ report that on the average, 4.4 per cent of their patients are referred to ophthalmologists or other physicians, but available data indicate the incidence of eye diseases, or diseases as manifested in the eyes, is around 5 per cent of the total population. Obviously, those individuals seeking eye care from the optometrist are a self-selected group in which the incidence will be much higher than 5 per cent. The ophthalmologists’ experi-
ence is that of those patients who come for refractions only, almost half had an associated eye disease and 13 per cent had a general disease affecting the eyes.¹

Whether the discrepancy is as large as sample surveys reveal, it is one which cannot be ignored. And more serious, as we have said, the continuing discoveries of new and improved methods of diagnosis will automatically result in an increasing proportion of serious conditions of or manifested in the eye being missed by optometrists that could be detected by ophthalmologists.

No doubt, in actual practice some optometrists do detect the presence of a pathological condition that a medical practitioner may overlook. Human experience being what it is, such cases are bound to occur. But the Commission is concerned that the very conditions most likely to be missed by an optometrist are among those having the most serious effects. Since the consequence of loss of sight is so serious we believe that every effort should be made to eliminate all elements of risk.

In seeking a solution to this dilemma, certain factors need to be considered:

(1) The shortage of ophthalmologists and the long period of their training makes any proposal for restricting all prepaid eye care in the Health Services Programme to that profession wholly unrealistic. Optometrists must be used and their qualifications upgraded.

(2) Since we believe that the schools of optometry do not provide adequate training in recognition of pathological eye conditions, there are two solutions:

(a) the need for provision in the present curriculum for increased training in anatomy, physiology, pathology, and in the use of


cycloplegics. This instruction should be provided by qualified instructors in the medical school faculties. This will solve the problem, however, only for those optometrists graduating after the implementation of our recommendation for upgrading, say, 1968.

(b) the need for provision of courses in anatomy, physiology, pathology, and in the use of cycloplegics for optometrists now in practice through programmes of continuing education in the medical schools or in the Schools of Optometry provided by qualified instructors from medical school faculties. Co-operation from the medical profession to provide this instruction is essential and no refusal by the medical profession, or the medical school faculties, to assist in upgrading the optometrist can be tolerated. The objective should be a properly qualified optometrical profession practising their profession as such, and not relying on the sale of frames and other merchandise as their principal source of income.

(3) There is a strong case, we believe, for optometrists to be employed, as they are now employed in the Canadian Forces Medical Service, under the general direction of ophthalmologists in “eye clinics” or group practice clinics. This arrangement of practice would remove our concern about the completeness of the diagnostic examination and seems to us to represent a most effective co-ordination of skills.

(4) In the development of a programme benefit of optical services, one of the important considerations is the cost of the eye-glasses that will be required. It can be argued, and we believe convincingly, that the cost of the glasses is a relatively modest amount, that it is not a cost that recurs frequently, and is certainly one for which patients, except those receiving public assistance, can budget, either in advance or by instalment payments. On the other hand, so important is eyesight to the developing child that we do not believe that these arguments apply in the case of children. We believe that the optical services benefit for children should be complete. At some later date, consideration can be given to extending the provision of spectacles to all adults. In the meantime, provision of spectacles should be limited to children and recipients of public assistance.

The Commission recommends:

83. That the Health Services Programme provide optical services (but not spectacles) to all insured persons.
84. That diagnostic services be provided, as now, by medically licensed practitioners.

85. That refractions be provided by ophthalmologists, other qualified physicians, and by optometrists who graduate in or after 1968, and by optometrists who by the year 1967 have taken the recommended additional training in anatomy, physiology, pathology, and in the use of cycloplegics.

86. That the schools of optometry be affiliated with the universities in the cities in which they are located, and the respective Medical School Departments should assume responsibility for the courses in anatomy, physiology, and pathology, and in the use of cycloplegics. Special courses should be provided in these subjects for optometrists now in practice, so that all who wish to do so may qualify to participate in the programme. The tuition fees, travelling and living expenses incurred by optometrists in taking such courses should be regarded as deductible expenses for income tax purposes.

87. That glasses of a standard quality of frame, lens, and price (although not necessarily of standard style) be provided to children (including young persons up to the age of 18) at no cost, but a part payment of one-third of the cost should be charged for a subsequent set required by reason of loss or damage.

88. That a charge of one-third of the cost also be made for any set provided to an adult recipient of public assistance.

89. That special inducements should be provided to attract more ophthalmologists to smaller population centres.

90. That specialized diagnostic clinics for serious eye disorders be established in all large population centres.

91. That in order to augment our scarce resources in the field of vision care, consideration be given by both ophthalmologists and optometrists to uniting their special skills and their efforts in various forms of group practice.

92. That the provincial health services agency make special arrangements for the bulk purchase, on tender, of spectacle frames and lenses.

93. That the Health Sciences Research Council give high priority to research grants in all aspects of ophthalmology.

94. That as part of a seven year crash programme special Professional Training Grants of $5,000 per year be allocated to physicians undertaking post-graduate study in ophthalmology.
7. Hospital Services

(The Hospital Insurance and Diagnostic Services Act)

As we discuss in Chapter 10, the Hospital Insurance and Diagnostic Services Act of 1957 had its origin in the recommendations of the 1943-44 House of Commons Select Committee on Social Security, which included hospital services and diagnostic services as two of the benefits in a comprehensive health services programme.

The 1957 Act was passed as a result of a general consensus between most of the provinces and the Federal Government arrived at during the 1955 Federal-Provincial Conference and subsequent meetings of Provincial and Federal Ministers of Health and Finance. The records show that the greatest degree of agreement was reached on the necessity to introduce out-patient services either in advance of, or simultaneously with, the in-patient hospital services benefit. We find, from our investigations and from the evidence presented to us, that the wisdom of that approach was, and is, incontrovertible.

The other major principles upon which provisions of the Hospital Insurance and Diagnostic Services Act were based are also considered in Chapter 10. These major provisions relate to universal coverage; terms and conditions on which benefits are to be available; definition of hospitals; quality of care; shareable costs; authorized charges; and the formula for federal sharing of costs.

On the basis of five years' experience, together with the representations made to us and the results of our own investigations, and in the light of needs for the comprehensive Health Services Programme we have recommended, each of the major provisions of the Act needs re-examination.

UNIVERSAL COVERAGE

We believe that the provisions for universal coverage as intended in the term “universally available” were sound, and that the flexibility provided in the negotiations of agreements with those provinces using the premium method of financing was most desirable. To have insisted upon compulsory coverage of the entire population from the first day of introduction of a provincial plan would have been administratively unrealistic. However, we now believe it essential that in those provinces not yet having one hundred per cent coverage of all residents, further steps should be taken to see that all are insured.

QUALITY OF CARE

We are aware that many agencies and many people are concerned with the quality of health care and are striving mightily to improve it; we are not convinced that all their efforts are yet adequate.

The major forces for upgrading are the medical profession itself, the nursing profession, and the Hospital Accreditation Council. The first exercises its efforts in a variety of ways including refresher courses in medical schools, lectures and classes at medical society meetings, but chiefly, we believe, through the medical staff organization in hospitals. The Hospital Accreditation Council exercises its role through inspections of hospitals. It is noteworthy, and highly to be commended, that the Hospital Accreditation Council is financed, in part, by contributions from the Canadian Medical Association, and l'Association des médecins de langue française du Canada from fees collected from its members.

A third type of agency concerned with quality is that typically referred to as the Hospitals Division in each of the provincial governments. Most provinces had such an agency before the programme was introduced, but all were required to have one under the terms of the agreements of the Hospital Insurance and Diagnostic Services Act. The agency may be part of the health department or a separate hospital insurance agency.

We find a number of gaps in these various approaches. A substantial volume of care in Canada is given by physicians who practise alone and have no hospital connection. Obviously, few of the organized efforts mentioned can reach them. A great many physicians practise in small hospitals where the number of physicians is so small that medical staff organization (and therefore organized general supervision of quality) is non-existent. In other places, private hospitals of varying size and of dubious quality also appear to be outside the scope of continuing inspection. Another weakness is that most, if not all, of the provincial hospitals divisions are under-staffed to provide the requisite degree of inspection and consultation. An equally serious shortcoming, in our view, is that the Hospital Accreditation Council is inadequately financed, and, therefore, under-staffed.

There is a further element in regard to the quality of care, namely hospital privileges. As we observed on page 29, physicians in Canada, both general practitioners and specialists, have historically had a close hospital connection. This does not mean, nor can it mean, that every licensed physician is automatically entitled to all hospital privileges he or she may ask for. The physician's right to hospital privileges is directly linked with the quality of care in the hospital. Many factors must be taken into consideration, including the number of beds available, the size of the medical staff needed, the training and experience of the physician—all directed to assuring the highest quality of patient care which must be the ultimate goal.

We should like to reiterate as a general principle that the quality of care in hospital is a matter of public interest. At its lowest point, it borders simply on protection of the patient against unsanitary conditions and malpractice and does not differ, therefore, from other protective measures.
undertaken on behalf of the public such as restaurant inspection, meat-processing inspection and drug inspection.

At its highest, it is manifested in all the educational work undertaken by the professions in the upgrading of their performance.

We must state it as one of our fundamental beliefs that for the vast majority of members of the health professions, as for most hospitals, the greatest advances are to be made by the organized efforts that they themselves take through education, and self-regulation. It is for this reason that we strongly endorse the activities of the voluntary Hospital Accreditation Council. But, again, it must not be forgotten that all of these efforts are undertaken in the public interest and that, if by default, or because of inadequate support, the requirements are inadequately met, then public agencies must act on behalf of the public. The recommendations made elsewhere with respect to assistance towards both basic and continuing education are consistent with this general statement. These, however, are not enough; they must be supplemented by effective safeguards of a high standard of hospital service.

Specific recommendations regarding hospital services will also be found under the following headings:

- Mental Health, Alcoholism, and Drug Addiction (Recommendations 14, 15 and 17)
- Dental Services (Recommendations 54-57)
- Home Care Services (Recommendations 120-121)
- Nurse Education and Recruitment (Recommendation 129)
- Medical Education and Recruitment (Recommendation 143)

The Commission recommends:

95. That grants to Hospital Accreditation Council be substantially increased; that the Council increase the number of surveyors and provide for more frequent inspections of hospitals of all sizes.

96. That provincial hospital insurance agencies, the Canadian Hospital Association, the Canadian Medical Association, and l'Association des médecins de langue française du Canada expand their efforts to encourage professional activities studies, and that all hospitals having 25 beds or more and at least three physicians on the staff participate in this programme of professional self-assessment, the costs of the programme to be accepted as a shareable cost under the Hospital Insurance and Diagnostic Services Act.

97. That the provincial Colleges of Physicians and Surgeons have greater authority for the quality of care and the volume of surgery, especially

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1 See Recommendations 140-155 and 175.
2 Similar to those of the Hospital Medical Records Institute in Toronto.

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of that performed in small hospitals without adequate equipment or sufficient qualified personnel.

98. That the Hospital Accreditation Council formulate in co-operation with the Canadian Hospital Association and the Catholic Hospital Association, rules and regulations relating to the granting of hospital privileges to physicians.

99. That statistics on complications and surgical operations in hospital, and on length of stay in hospital by diagnoses be supplied by the hospital insurance agencies to joint committees of the Colleges of Physicians and Surgeons and the Hospital Associations in each province for analysis and review.

100. That hospital insurance agencies provide adequate funds to hospitals to provide for care of patients by registered nurses on all shifts, and that all necessary nursing service authorized by the attending physician and approved by the chief of the relevant service be provided by the hospital as authorized in the Hospital Insurance and Diagnostic Services Act.

101. That student nurses be not solely responsible for patient care especially on the night shift.

102. That the staffs of the provincial hospitals agency be increased (this can be done through the National Health Grants) to make such arrangements as are necessary to ensure that adequate standards are maintained in hospitals, including the supervision, licensing and inspection thereof; with special attention to small hospitals (under 100 beds), all private hospitals, and all nursing homes.

103. That all provincial hospital insurance agencies be aware that their decision with respect to staffing and equipping hospitals must constantly take into account the rapidly developing knowledge and technology in health care. It is highly desirable that they avail themselves of qualified experts in assessing requests by hospitals for additional personnel and new equipment.

104. That the Health Planning Councils\(^1\) make every effort to ensure that hospitals avoid unnecessary duplication of specialized equipment and personnel in their joint efforts to meet community needs.

OUT-PATIENT SERVICES

As indicated above, it was the consensus of provincial and federal representatives at the 1955 Conference that, regardless of the decision with respect to the hospital insurance benefit, hospital out-patient services should

\(^1\) See Recommendation 1(10).
receive the highest priority. The evidence presented to this Commission indicates that in those provinces that have not introduced a complete outpatient benefit, the volume of care unnecessarily provided to in-patients that could equally well be provided to them at a lower cost as out-patients, is large indeed. This represents the needless expenditure of millions of dollars of federal and provincial tax funds. There is no justification for this waste of scarce tax dollars. The eastern provinces have shown that the administration of the benefit presents no serious obstacle. We are recommending a federal contribution to the financing of the construction of new, and the extension of existing outpatient facilities.

The Commission recommends:

105. That the Act be amended to require the outpatient services benefit as a condition of any further payment in respect of in-patient benefits, and that the Minister thereupon give notice to those provinces not providing the full range of outpatient services that the Agreements are to be renegotiated. In the meantime, citizens concerned with hospital insurance costs might impress upon their governments the need for immediate action.

106. That in providing the outpatient service, the diagnostic facilities in recognized clinics and in specialists' offices with facilities related to their specialty, their place of work be designated as a "facility" under the meaning of the Act, to provide such of the outpatient services as they are qualified to do, under the terms and conditions of the Act, prior to the introduction of a Medical Services Programme.

107. That the limitations on availability of outpatient services as an insured service to periods of 24 or 48 hours following an accident be eliminated.

MENTAL HOSPITAL CARE

Under the present conditions of the Act, payment for care of mentally ill patients is excluded if it is provided in mental hospitals, but is included if it is provided in general hospitals. We believe that this policy of excluding the bulk of treatment for mental illness is not in the public interest. The whole issue is of such magnitude and importance that it is treated as a separate section of this Report.  

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1 One hospital estimates that "outpatient services and adequate facilities for chronic care would relieve our hospital of . . . 11.1% of our bed total". (The Regina Grey Nuns' Hospital, brief submitted to the Royal Commission on Health Services, Regina, 1962, p. 7). Nova Scotia with one of the most extensive outpatient service as insured service finds this service relieves "very substantially the pressure on much needed hospital beds". (Annual Report of the Nova Scotia Hospital Insurance Commission for the year ended March 31, 1962, Halifax: Queen's Printer, 1962, p. 9).

2 See Recommendation 176.

3 See Chapters 8 and 14.
HOME CARE PROGRAMME

The fact that home care services, even if provided by a hospital-based plan and under the auspices of the hospital, are not covered by the Act, severely hampers the development of such plans. In dealing with home care programmes, we therefore recommend that care provided by hospital-based home care programmes be brought under the provisions of the Act.

SPECIALIZED FUNCTIONS OF TEACHING HOSPITALS

Teaching hospitals do have certain special costs which justifiably can be interpreted as "shareable costs" under the Act because they relate to hospital services as well as to the teaching function. This applies also to part of the salary of faculty staff. We therefore recommend the coverage of such costs under the Act.

TUBERCULOSIS SANATORIA

The question of payment for the care of tuberculosis patients, also excluded from the Act, is, fortunately, not as serious as that of care for mentally-ill patients. Nevertheless the Commission also finds no rationale for this exclusion.

The Commission recommends:

108. That the exclusion of tuberculosis hospitals and sanatoria be removed from the Act and that wards of such hospitals providing treatment be designated as a "hospital" or "facility" under the terms of the Act.

SHAREABLE COSTS

Interest and Depreciation

The national hospital insurance programme accomplished much, but like all projects of human progress, it has revealed new problems to be solved. In effect, our society has said that no Canadian should be barred, for economic reasons, from needed hospital care.

What the Canadian people have not quite resolved, however, is the question how, in a democracy governed by three levels of government, the hospital facilities required to provide that care should be financed.

The Federal Government provides through the Hospital Construction Grant approximately 15 per cent of the cost of hospital facilities and, through the hospital plan, half the cost of equipment. This has left

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1 See Recommendations 120 and 121.
2 See Recommendation 143.
to the provinces, local authorities, and voluntary groups, the responsibility for the major share of the problem of financing construction. And, again, although the general principle may be sound, it is the unequal ability among the provinces to assume the provincial share that creates the main problem. This unequal capacity is reflected in the variety of provisions the provinces have adopted, as shown below:

**FEDERAL AND PROVINCIAL CONTRIBUTIONS TO ACTIVE TREATMENT HOSPITAL CONSTRUCTION FINANCING, DEC. 31, 1963**

<table>
<thead>
<tr>
<th>Province</th>
<th>Federal Grant</th>
<th>Provincial Grant</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Plus 50 per cent of balance of approved cost</td>
</tr>
<tr>
<td>Alberta</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Pays balance of cost by meeting debenture and interest payments as due</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>$2,000</td>
<td></td>
<td>70 per cent of balance in Base Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60 per cent of balance in Regional Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40 per cent of balance in Community Hospitals</td>
</tr>
<tr>
<td>Manitoba</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Plus 80 per cent of balance by meeting debenture and interest payments as due</td>
</tr>
<tr>
<td>Ontario</td>
<td>$2,000</td>
<td>$3,200</td>
<td>Plus discretionary grants</td>
</tr>
<tr>
<td>Quebec</td>
<td>$2,000</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>New Brunswick</td>
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<tr>
<td>Nova Scotia</td>
<td>$2,000</td>
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<td>Plus $1,000</td>
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<tr>
<td>Prince Edward Island</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Plus capital and interest to maximum half of balance</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>$2,000</td>
<td>$2,000</td>
<td>Plus unspecified assistance.</td>
</tr>
</tbody>
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The Commission recommends:

**109.** That depreciation allowances on the value of buildings and fixed equipment, less the amount paid by federal and provincial grants, be recognized as a shareable cost.

**Authorized Charges**

"Authorized charges" is the term applied in the Act to what are known as "co-insurance" or "deterrent fees" or "utilization fees". The provisions of the Act penalize any province that adopts such charges by refusing to match the revenues from authorized charges as it does revenues channelled directly
from provincial funds. The Commission is concerned, as it has said elsewhere, with the mounting cost of the hospital plan and believes, therefore, that the efforts of a province to introduce a greater degree of prudence in the use of these services, which are both reasonable and compatible with the spirit of the Act, should not be penalized.

*The Commission recommends:*

110. That Section 4(a) (ii) of the Act be amended to remove the penalty now imposed upon a province that requires a reasonable per diem patient payment.

**Authorized Charges for Hospitalized Welfare Recipients**

In British Columbia and Alberta, the authorized charges (patient payment) for hospitalized welfare recipients are paid by the respective welfare departments. For these patients, therefore, the situation is precisely the same as it is for all insured patients in the other provinces where there are no co-insurance charges. Nevertheless, the Federal Government does not share in that part of the cost represented by the co-insurance payment which is borne in full by the provincial governments. This seems to us an injustice based on a too legalistic interpretation of the Act.

*The Commission recommends:*

111. That this discrimination be removed with respect to hospitalized welfare patients.

**Net Income from Gift Shops, and Other Ancillary Operations**

The Commission believes that the regulations concerning earnings from these types of ancillary operations are too narrowly restrictive, and should be broadened to leave to hospitals the full net proceeds from such activities.

*The Commission recommends:*

112. That the regulations concerning earnings from gift shops and other ancillary operations should be made less restrictive.

**8. Prosthetic Services and Appliances**

In Chapter 5 we discuss the various health hazards and their social impact. In particular we stress the fact that prolonged illness and impairment have an effect quite different from that of a corresponding number of shorter illnesses. This applies especially to the permanent disabilities and
impairments. A number of short illnesses, even if accompanied by inability to carry on one's usual activity, need not interfere seriously with one's pursuit in life, be it going to school, working, or any other activity. Many employees are, in fact, assured not only of retaining their job but also their income during illness of a specified duration each year by the provision of paid sick leave or sickness benefit insurance.

Long-term illness and disability, however, do create serious social and economic problems for the patient and his dependents or other members of the household. It is chronic illness which more and more saps the strength of our population in a twofold way: first by reducing the well-being and social function of the stricken individual, and next by the demand he creates for services and assistance from his family and the community.

For this reason we were particularly impressed by the evidence before us regarding the progress of rehabilitation services. The many forms of rehabilitation services have in common that the care of the patient does not stop with the halting or slowing-down of the disease process but continues in an all-out attempt to restore the patient as nearly as possible to his normal social role. Any degree of independence thus gained or regained not only contributes to the individual's happiness and economic security but also relieves, correspondingly, the community of a potential burden.

For those whose disability results from the absence, loss, impairment or deformity of limbs or organs, rehabilitation cannot be achieved without adequate prosthetic devices, appliances or aids, which therefore form an integral part of health care. The lifetime cost of such devices, appliances, or aids may range up to several thousand dollars in the case of children whose prostheses have to be renewed periodically as they grow.

The problem is greatest among the babies and children with congenital deformities. The thalidomide story has focussed public attention on the plight of these children and their parents. While the deformities resulting from this drug are particularly severe, similar cases of congenital deformities have occurred before and will continue to occur. These infants are as deserving as the victims of thalidomide. Observing these very young children, we have been deeply moved by their distressing situation and the strain they place on their parents, but also we have been struck with the amazing benefits these children can derive from the ingenuity of modern prosthetic techniques.

These children will depend on their prosthesis for a whole lifetime. The aid of an artificial limb or other device or aid can also make the difference to an older person between many years of complete dependency on others on the one hand and self-reliance on the other hand. In all cases it is

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1 See Chapter 15.
important that the device be so designed as to equip the patient to function as normally as possible.

The cost of these and other devices, appliances or aids should, therefore, not be left to the individual, or his parents, nor should the handicapped person have to rely on charity or the generosity of service clubs for this essential service as is now the case. It is the magnificent work of the voluntary agencies that has brought to public attention the seriousness and magnitude of this problem and the consequent need for government action. This benefit forms part of the Medical Services outlined in Recommendation No. 30.

The Commission recommends:

113. That prosthetic devices, appliances, or aids be supplied as a medical services benefit under the plan, as prescribed by a committee consisting of the patient's physician and a prosthetist, and where possible also of an occupational therapist or physio-therapist.

114. That such prosthetic devices or appliances be repaired or renewed as a benefit under the plan, on the recommendation of a committee as described above.

115. That funds be made available through the Health Sciences Research Council for research and experimentation into the creation and distribution of prosthetic devices, the development of effective techniques; and by Professional Training Grants for the training of the necessary technical personnel.

9. Home Care Services

During our investigations into facilities and services for patient care we have been struck by the general lack of development of one of the most promising types of services for providing quality care at relatively low cost. This is the programme of organized home care, in which experiments have repeatedly demonstrated that some patients are better satisfied, and costs are lower. Home care programmes have been conducted over a period of at least fifteen years in Canada, the United States, and Europe, and can now be said to have successfully passed beyond the experimental stage.

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1 Such as the sponsorship by Rotary Clubs across Canada of the Crippled Children's Easter Seal Fund.
2 See Chapter 15.
3 Visiting nursing, an essential component of home care, has existed in Canada on an organized basis since the inauguration of the Victorian Order of Nurses for Canada in 1897. It is now provided by this Order, the Saint Elizabeth Visiting Nurses Association, and the Société des Infirmières Visiteuses.
The hospital-sponsored Blue Cross Plan of New York has this to say about home care programmes:

"They have demonstrated that care in the home can be excellent care for the well-selected patient. Use of Home Care also increases the availability of hospital beds for patients who require in-hospital care. At the same time, the costs of care are reduced because maintenance of the patient in his own home is less expensive than in-hospital care".¹

We believe that in the interests of patients and of costs, full-scale programmes of home care should now be launched in every urban centre of, say, 10,000 population and over, and in smaller centres as resources can be mobilized.

These programmes should be either hospital- or community-based, the first probably oriented to earlier discharge of hospitalized patients and the second primarily to patients not requiring admission to hospital. The first can readily be financed under the present terms of the Hospital Insurance and Diagnostic Services Act, and both federal and provincial authorities should take the lead in assisting hospitals to establish and finance such programmes. In fact a full-scale hospital based home care programme should be required before any request for hospital bed expansion is considered by the provincial hospital planning authority for communities of 10,000 population or more.

Although the most important reason for making use of home care is the patients' interest, we cannot afford not to take advantage of the lower cost that home care makes possible.

We recognize that there are problems in getting home care programmes under way, and that, to be fully successful, they require the full co-operation of medical staff, hospital administration, and voluntary agencies.

One of the chief results of home care programmes is the convenience to the physician who finds readily available to him an organization that puts at his disposal and that of his patients an array of services not hitherto utilized by him or of which he may have been unaware.

The Commission recommends:

116. That every hospital in Canada of 100 beds or more introduce either independently, or in association with other hospitals in the same centre, other community organizations, the local health department, or any combination of these, a home care programme.

117. That local medical societies establish a liaison committee to expedite the development and use of home care services.

118. That hospital medical review committees stress the early discharge of patients who can be suitably cared for at home with the services of such a programme.

119. That pamphlets describing the programme and its services be prepared and distributed to patients considered possible candidates for early discharge under the programme.

120. That the Hospital Insurance and Diagnostic Services Act regulations be interpreted to cover costs of patient care provided by hospital-based home care programmes.

121. That the Hospital Insurance and Diagnostic Services Act regulations be interpreted to include as shareable costs payments made to community-based home care programmes for care provided to hospital patients returned to their homes but retained on the hospital register.

122. That the Public Health Grant be used to assist in financing community-based home care programmes.

123. That public health departments and voluntary agencies be encouraged by such grant assistance to undertake home care programmes either as community-based programmes or in co-operation with hospitals.

II. HEALTH PERSONNEL, FACILITIES AND RESEARCH

10. Nurse Education and Recruitment

The representations made before the Commission, and the studies prepared for it, together with the voluminous literature now available on the subject of nursing, all point to the pressing need for a clearer delineation of nursing responsibilities and, simultaneously, a restructuring of nursing education.¹

A number of factors underscore the need for reform.

(1) There is a serious shortage of qualified instructors to staff the hospital schools and university schools of nursing. Our studies show that 75 per cent of the instructors in the hospital schools and 56 per cent in the university schools do not have even minimum² qualifications.

¹ See Chapter 13 for a discussion of the various types of nurses.
² A B.Sc. degree for instructors in hospital schools of nursing, and at least a Master's degree in university schools.
RECOMMENDATIONS

fications. The graduates of a school can be no better than the quality of their educational experience.

(2) In the light of our knowledge of and established practice in the education of all other professions, the apprenticeship-type system by which the majority of nurses are now solely trained clearly requires re-examination.

(3) Our study of nursing utilization reveals that many nurses are performing duties for which they are over-qualified, duties for which they are not qualified, and duties that should be assigned to other occupations. The apprenticeship system of education helps to perpetuate this lack of a clear division of responsibility.

(4) The period of training is unnecessarily long. A three-year programme, in which two-thirds of all formal instruction is given in the first year, is obviously oriented to some purpose other than education. The recent reorganization of some courses, in which the trainee is classified for two years as a student and for the third year as an "intern" on part salary, is tacit recognition of the large element of "service" by which the nursing student pays for her education.¹

On the basis of present knowledge and experience, two categories of nurses are required, both to be prepared through the post-high school educational system:

(1) The graduate of a four- or five-year integrated basic university programme or of a shorter programme for university graduates. It is estimated that about 25 per cent of positions for nurses require this type and range of preparation. These are the instructors, supervisors, administrators and nurses in other leading positions.

(2) The graduate of a new type of two-year diploma programme who would function as a clinical or bedside nurse.

Each of these two categories of nurses requires a specially designed programme of instruction, but nurses in each category should remain Registered Nurses.

In addition to these two categories of nurses, nursing assistants will still be required in order to promote the more effective use of nurses. These aides may be recruited from among those who do not have the academic standing required to enter schools of nursing.

With the recommendations we have made respecting the need to integrate the psychiatric and general health services (particularly the care of psychiatric patients in general hospitals), we believe that the need for the

¹ See Chapter 13.
separate programme for psychiatric nurses in the four western provinces will disappear. Special programmes should be set up and financial assistance provided to enable qualified psychiatric nurses (R.P.N.) to qualify for and obtain the Registered Nurse (R.N.) licence.

THE HOSPITAL SCHOOL OF NURSING

Much of the evidence presented to the Commission indicates major changes are under way in nursing education in the hospital schools and, in general, the Commission believes that these changes are highly appropriate and should be accelerated. As in most professions, the preparation of nurses began as a system of apprenticeship. As the scientific knowledge component in nursing practice increased, it became necessary to expand the time spent in classroom instruction.

In order to meet the service needs of the hospital as well as the training needs of the students, the students have typically spent more time in caring for patients than was necessary for their training. In return for this service, the hospital has provided living accommodation and free tuition. In recent years, however, new approaches have concentrated the instruction and clinical experience in two years, and thereby reduced the "service" component. In these schools, the education and training of nurses is following the pattern of other professions that are reducing or eliminating the apprenticeship aspects of their preparation.

The Commission believes this to be the right approach. The educational system for nursing should be organized and financed like other forms of professional education. An additional reason for the change in nursing education is not only that we shall obtain equally, if not better, qualified personnel in shorter time, but that a substantial part of hospitalized patient care will no longer depend, as it does now, upon apprentices.

We recognize that there is divergent opinion on this subject of control of nursing education. We are aware, as our studies indicate, that most nursing service directors make heroic efforts to assure that the time spent by students "on the wards" is limited to that necessary for adequate clinical experience. That most of them fail in this objective is due to the system, and to the pressures upon the nursing service (of which the students are considered to be part) to give priority to the immediate needs of patients rather than to the educational needs of students. The staffing policies pursued by several of the provincial hospital insurance authorities make the use of students as part of the nursing service inescapable, and we consider this restriction on the employment of qualified nurses as undesirable, and, indeed, dangerous. This represents an unwarranted restriction on effective management of hospitals.
It will be necessary to separate as completely as possible the functions of nursing education from the hospital nursing service, and place control of the education programme completely under the Director of the School of Nursing.

It will take time to accomplish this major and long overdue reform in nursing education, and there will be many difficulties to overcome. But it is a reform that we believe to be both desirable and inevitable, and the longer it is delayed, the greater will the obstacles become. We recognize that the changes must be introduced in stages so as not to disrupt the nursing services unduly, and, further, that some hospital schools will be able to make a more complete change than others. But we are convinced that the time to start is now.

The steps that will need to be taken to accomplish this objective are as follows:

1. The establishment in each province of a Nursing Education Planning Committee, advisory to the Minister of Health with representatives from the Provincial Nurses’ Association, the Hospital Associations, the Hospital Insurance authority, the University(ies) and the Provincial Department of Education to select annually the number of schools in which the programme will be initiated, and thereby assure its gradual and orderly development.

2. The separation of the budget of the school of nursing from that of the hospital to make sure that the nursing school budget be used for educational purposes only. The separation of educational and nursing service functions can obviously be reached in stages and in a variety of ways. In some hospitals the Director of the School of Nursing may be responsible to the Board through a Nursing Education Advisory Committee of the Board; in others, this objective may be reached satisfactorily by having her directly responsible to the Board.

3. An arrangement between the school administration and the hospital administration for the use of the hospital’s educational and clinical facilities that approximates the arrangement that now exists in many hospitals for students in medical schools and university schools of nursing.

4. The establishment of a new educational curriculum in nursing leading to a diploma in two years.¹

5. An annual reduction in the percentage of time the student spends in nursing service which will require the recruitment by the hospitals

¹ See Chapter 13 for a discussion of the urgency and feasibility of this programme.
of additional qualified nurses and nursing aides to perform the services now provided by the students, and authorization by the hospital insurance agencies for the establishment of these positions. Concurrently an equivalent reduction must be made in the numbers of student nurses counted in the complement of nursing service personnel authorized by the hospital insurance agencies.

(6) Experimentation with other agencies to conduct an educational programme for nurses. These could be such post-high school institutions as Junior Colleges or Institutes of Technology. Although, in our view, the Hospital School of Nursing will remain the major training institution for this profession, there is no inherent reason for the hospital to be the only agency to be conducting a school for nurses at this level, although all schools will need to use hospitals for clinical experience.¹

(7) Financial assistance should be provided to students who cannot pay their own fees and/or maintenance. It is recognized that by changing the present system under which the student pays for her own education by her contribution of service to the hospital, a substantial number of those coming from families with moderate incomes will need assistance to enrol. Accordingly, bursaries must be available to enable these candidates to continue to select nursing as a career. Federal and provincial funds must continue to be made available to meet the operating costs of the schools. The principle for both these forms of assistance is now embodied in the Hospital Insurance and Diagnostic Services Act, under which other health workers (e.g., radiological and laboratory technicians) are subsidized while taking their training.

(8) With all of the foregoing accomplished, there will remain one factor on which the success of the new programme will depend: an all-out effort to prepare more highly qualified instructors. This shortage is the most serious obstacle to any improvement in nursing education and, therefore, of any improvement in nursing service. For the preparation of these instructors we must look to the University Schools of Nursing.

THE UNIVERSITY SCHOOL OF NURSING

Six of the fourteen University Schools of Nursing offer a basic four- or five-year integrated programme and control all of the student's experience during this period as do other university professional schools. The clinical

¹ Such as the Quo Vadis Project initiated by the Catholic Hospital Conference in Ontario in 1962, to encourage women between the ages of 30 and 50 to take up nursing as a career.
experience is obtained in hospitals affiliated with the school but under the supervision of university clinical instructors. The other eight schools grant a baccalaureate degree for a combination of two years of work in the university and three years of work in a hospital school of nursing, where the student is under the control of the hospital school and subject to the same service requirements as the non-university students. We believe the integrated programme is the only educationally sound one and should be adopted by the remaining University Schools of Nursing.

It is of the utmost importance that these schools be rapidly expanded in number to enable them to prepare approximately one-fourth of the total recruits to the nursing force. It is from this pool that the instructors, supervisors, administrators and other leaders in the profession must come.

The Commission recommends:

124. That there be established in each province a Nursing Education Planning Committee, advisory to the Minister of Health, to plan and direct the gradual and orderly development of nursing education. The Committee should be representative of the Provincial Nurses Association, the Hospital Associations, University(ies), the Hospital Insurance agency, and the Department of Education.

125. That the budgets of the Schools of Nursing operated by hospitals be separated from that of the Nursing Service of the hospital to the end that the Schools of Nursing become wholly educational in their function.

126. That hospitals make their educational and clinical facilities available for the instruction and clinical experience of students, without claim on the student for service.

127. That these Schools of Nursing reorganize their curricula to provide for graduation with a diploma in two years, and that, where necessary, provincial legislation be amended to provide for licensing of the graduate as a registered nurse on the successful completion of examinations following the two-year course.

128. That to encourage suitable personnel to enter and remain in the nursing profession, salaries commensurate with the training and responsibilities of nurses and comparable with those in similar fields be paid by federal and provincial agencies and by hospitals.

129. That financial assistance be provided to student nurses in hospital schools in the same amounts and under the same conditions as those for students in other fields in the hospital.
130. That consideration be given to supporting only those schools of a sufficiently large size that will permit the most effective utilization of qualified teaching personnel and financial resources.

131. That all University Schools of Nursing develop an integrated degree programme and direct all phases of this programme. At least one University School in each of Canada's four main regions should also develop a Master's degree programme in nursing, one of which should be a French language school.

132. That the existing University Schools of Nursing be expanded to their optimum capacity and that federal capital grants from the Health Facilities Development Fund and federal operating grants from the Health Professions Education Grant be available to them.

133. That there be established as quickly as qualified personnel can be recruited at least ten more university schools to expand the annual output of university graduate nurses, and that funds be allocated from the Health Facilities Development Fund to provide one-half the cost of establishing these schools. We believe these ten schools can be established in about five years. Among the universities where these might be provided as additional faculties are: University of Victoria, University of Alberta (Calgary), University of Saskatchewan (Regina), Laurentian University, York University, Carleton University, Université Laval, Université de Sherbrooke, Université de Moncton, Memorial University. Given time for them to become fully established, (say, 1971) the 24 schools then operating could, with an average enrolment of 225,¹ produce approximately 1,200 graduates annually.

134. That as part of a seven year crash programme, Professional Training Grant bursaries of $3,500 be made available so that more graduate nurses having the baccalaureate degree be enabled to obtain the Master's degree in nursing to qualify them for appointment as university instructors.

135. That as part of the same seven-year crash programme, Professional Training Grant bursaries to the amount of $2,000 be made available immediately to Registered Nurses wishing to enrol for a Bachelor's degree in nursing in university schools of nursing.

136. That the present Professional Training Grant bursaries be expanded in number to enable more diploma nurses to obtain certification in public health nursing.

¹This allows for an attrition rate of approximately 20 per cent during the four-year period.
137. That when the diploma course is shortened to two years, the training period of the nursing assistant be shortened correspondingly. Meanwhile, a study should be made of the feasibility of training the nursing assistants on the job.

138. That in view of the need for male nurses in the health field, more efforts be made to attract men to the nursing profession.

139. That in order to provide a continuous uninterrupted supply of qualified operating room technicians, a new classification of this type of work be established with adequate salaries so that men may make a career of this occupation.

11. Medical Education and Recruitment

The Commission's chief concern with medical education is the capacity of the medical schools in Canada to graduate a sufficient supply of well-qualified physicians to meet the expanding demands resulting from an increasing population and a doubling of the number of persons who will have their health services prepaid through extension of prepayment to the entire population, as well as to meet Canada's increasing international obligations to train professional health personnel for the developing nations.

We are also concerned, of course, with the resources of buildings for teaching and research and with the personnel qualified as professors and research workers in the medical school faculties. The financing of these resources for medical education, both now and in the future, looms as a matter of major proportions.

In considering this question of education of physicians two important points must be borne in mind:

(1) Education of physicians, like that of dentists, is a matter of national concern. As our manpower studies reveal, physicians are highly mobile and a large proportion of physicians in every province have been trained in some other province. A few schools trained physicians for the entire nation for many years. There is a strong case, therefore, for national financial assistance to provinces carrying this responsibility.

(2) Migration also plays a major role. The average annual immigration of doctors to Canada over the past five years has been equal to the combined graduating classes of our three largest medical schools. At the same time, our losses through emigration have been equal to the graduating classes of two of these schools. Any marked change in either of these inward and outward movements would obviously have
profound effects on our supply. As we have indicated elsewhere, it is our belief that the situation will become more serious. We expect European immigration to decline and, with the increasing shortage of physicians in the United States, the danger exists of an increasing southward drain on our resources.

Because of the length of time (a minimum of seven years) required for the educational preparation of a physician, there can be no substantial increase in our graduating classes before 1970, since the students graduating up to that year are already in university. To meet our needs in the nineteen seventies, it will be necessary both to expand several of our existing schools to their optimum size and to establish at least five new schools to come into operation during the late nineteen sixties and early nineteen seventies. Planning for one new school, Sherbrooke, is already under way and it is scheduled for opening in 1967. A second one, McMaster, is now under discussion and it should open in 1968. Planning should begin for others as follows: Toronto area, 1969; Calgary, 1971; Victoria, 1973. In the mid nineteen seventies, a French language medical school should be established at Moncton. Some of these may begin earlier as two-year pre-clinical courses, and this could also be true, later, at other universities. Failure to meet these dates as scheduled will result in serious deficiencies commencing in the mid nineteen seventies.

A study should be made by the Health Sciences Research Council of the feasibility of organizing one additional medical school probably at Memorial University in St. John's to graduate physicians specially trained in the exigencies of frontier medicine. Such a medical school could help to fulfil Canada's obligation to the emerging nations now short of professional personnel specifically qualified to meet local needs.

Fundamental to the functioning of our medical schools is an adequate supply of qualified faculty members. We are losing an increasing number of these to the United States annually and, unless their remuneration is increased, we will lose more.

In examining the financial problems of medical education, the Commission has had impressed upon it the serious consequences for the medical schools of the lack of specific reference to the teaching hospitals associated with medical schools in the Hospital Insurance and Diagnostic Services Act. These hospitals do have special costs that are related to the teaching function but which are, in our opinion, quite properly definable as hospital “shareable

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1 See Chapter 7.
2 In fact, a United States estimate of future supply of physicians in that country assumes an increasing rate of emigration from Canada to the United States. See Chapter 7.
3 See the Report and Recommendations Regarding a Medical School at McMaster University, Hamilton, The University, September 1963.
4 This idea is similar to the concept underlying the programme organized by St. Francis Xavier University at Antigonish, N.S., in the field of co-operatives to which students now come from many parts of the world.
costs” under this Act. These include a considerable portion of the salaries of full-time faculty, and the appropriate fees of part-time faculty, all of whom devote a large proportion of their time to purely hospital functions, as well as to a large proportion of operational research that is also a hospital requirement. We believe that the Department of National Health and Welfare should take the lead in assuring that these costs are met, and if any obstacles, legal or otherwise, are found, the Act and/or regulations should be amended to make certain that they are recognized and paid as shareable costs.

The Commission recommends:

140. That funds be allocated from the Health Facilities Development Fund to provide for one-half the cost of the required expansion and/or renovation of medical schools now operating.

141. That funds be allocated from the Health Facilities Development Fund to provide one-half the cost of construction of new medical schools, including where necessary the basic sciences facilities at the Université de Sherbrooke (for 1967), McMaster University (for 1968), a university in the Toronto area (for 1969),

2 University of Alberta, Calgary (for 1971), University of Victoria (for 1973), Université de Moncton (for the mid 1970's), and at Memorial University if the study we suggest above supports the idea.

142. That the provisions of the Hospital Construction Grant be amended to provide one-half the cost of hospital facilities for new university hospitals or for expansion or renovation of existing university-affiliated teaching hospitals, or teaching units in non-university hospitals, the grants to cover all departments (e.g., Clinical Investigation Units) to a maximum of ten beds per student in the projected graduating class.

143. That the Department of National Health and Welfare and the provincial hospital insurance authorities immediately recognize expenditures on certain specialized functions of teaching hospitals as shareable costs under the Hospital Insurance and Diagnostic Services Act, including that portion of the salaries or fees of full-time and part-time medical school personnel that relates to what are essentially hospital functions, as well as expenditures on operational research related to quality control of care and departmental administration.

144. That to attract more medical personnel, the Professional Training Grant be increased to provide for an annual grant, on application, of

1See Chapter 13.
2In our view, this can be based on Sunnybrook Hospital with proper safeguards for the entitlement of veterans.
$2,000 to each Canadian medical student with satisfactory performance in his third and fourth medical years at a Canadian school of medicine.

145. That in respect of foreign medical students enrolled in Canadian medical schools at the request of federal departments, a grant be made to the university over and above the regular fees, calculated to represent the amount of university subsidy of the student. (The amount should be negotiated between federal officials and the Canadian Universities Foundation).

146. That the remuneration of part-time clinical teachers be increased to realistic levels.

147. That the salaries paid to interns and residents in teaching hospitals approved for internship and resident training be increased to more reasonable levels.

148. That the Health Sciences Research Council be encouraged to increase the number of research associateships at medical schools and, in addition, make provisions for scholarships to recent medical graduates not yet qualified for research associateships.

149. That to train sufficient personnel required for faculties in basic and pre-clinical science departments the present grants to graduate students from the National Research Council be continued and increased to more reasonable levels.

150. That to help ensure that physicians in practice maintain their level of competence, medical schools inaugurate or expand their programmes of continuing medical education, and that fees, travel, and living expenses for attendance at such courses be regarded as deductible expenses for income tax purposes.

151. That to reduce our most serious shortages of specialists in areas in which we are recommending rapid expansion of services, medical schools and teaching hospitals introduce or expand their programmes for post-graduate study in psychiatry, physical medicine, ophthalmology, anaesthesiology, pathology, and radiology.

152. That as part of a seven year crash programme, special Professional Training Grants of $5,000 per year be allocated to medical graduates undertaking post-graduate study in psychiatry, physical medicine, ophthalmology, anaesthesiology, pathology, and radiology.

153. That funds be made available to medical schools to provide adequate remuneration in order to increase the ratio of full-time to part-time staff.
154. That funds be made available to those schools that wish to convert to year-round operations for the purpose of improving the quality of instruction and/or reducing the total length of time required to qualify for graduation or licensure to practise.

12. Dental Education and Recruitment

Our examination of the problem of dental education convinces us that it has two dimensions. The first concerns the needs with respect to training an adequate supply of qualified dentists. The second dimension is the necessity to train dental auxiliary personnel so that the professional capacity of the highly-trained dentist is augmented in even a modest degree as the capacity of the physician is now augmented in great degree by a score or more of different types of auxiliary workers. In comparison with practice successfully demonstrated elsewhere, it has become evident that Canadian dental practice represents a substantial waste of professional talent as dentists continue to perform tasks that can readily be assigned, under their supervision, to lesser-trained workers. We shall consider the question of dentists first.

**DENTISTS**

Although our calculations show that the number of dentists (full-time and part-time) required for the children's programme will be substantial, nevertheless, the population-dentist ratio for the balance of the children and the adult population will change very little. This ratio is completely unsatisfactory now, and it will remain unsatisfactory. As young people lose their coverage under the Children's Dental Programme at age 18, we can expect a far higher proportion to demand a continuing high level of service than obtains dental care now. And second, as our economic studies indicate, an increasingly prosperous society will be able to afford more dental care than it purchases now. Despite the progress we anticipate from the adoption of fluoridation and the Children's Dental Programme, this generation, we believe, will not be able to meet its total dental requirements.

Accordingly, it is necessary to expand our output of dentists to overcome what are even now glaring shortages.

*The Commission recommends:*

155. That funds be allocated from the Health Facilities Development Fund to provide for one-half the cost of the required expansion and renovation of the dental schools now operating at Dalhousie University, University of Manitoba, McGill University, University of Alberta, and the Université de Montréal.¹

¹ See Chapter 13.
156. That funds be allocated from the Health Facilities Development Fund to provide one-half the cost of construction of five new dental schools in the next ten years, two to be located in Ontario, the University of Ottawa and the University of Western Ontario, and one each at the University of British Columbia (now under development), Université Laval and the University of Saskatchewan, Saskatoon.¹

157. That Provincial Departments of Education, in co-operation with the respective provincial dental associations be encouraged to conduct recruiting campaigns, especially among students in small towns and rural areas, and to attract an increasing number of women into the dental profession.

158. That the Professional Training Grant be increased to provide for an annual grant, on application, of $2,000 a year to each Canadian dental student with satisfactory performance in his final two years at a Canadian Dental School.

159. That the Health Sciences Research Council endeavour to expand in Canada the amount of research on dental disease and prevention both by conducting intra-mural research and by increasing its grants to universities.

160. That to help ensure that dentists in practice maintain a high level of competence, dental schools inaugurate or expand programmes of continuing education, and that fees, travel and living expenses for attendance at such courses be regarded as deductible expenses for income tax purposes.

161. That funds be made available to dental schools to provide adequate remuneration in order to increase the ratio of full-time to part-time staff.

162. That funds be made available to those schools that wish to convert to year-round operations for the purpose of improving the quality of instruction and/or reducing the total length of time required to qualify for graduation or licensure to practise.

163. That additional funds be made available to universities to enable dental schools to expand graduate programmes for training specialists and to add these programmes where they do not now exist.

164. That to reduce the serious shortage of dental specialists, as part of a seven year crash programme, Professional Training Grants of $5,000

¹Ibid.
be allocated to dentists undertaking post-graduate study including those taking dental public health and those preparing for university teaching.

165. That the dental schools provide special courses in children's dentistry and that Professional Training Grants of $5,000 be made available as part of a seven year crash programme for dentists entering the service who wish to take advantage of the special courses, and preparation for specialist qualifications.

166. That the Dental Licensing Authority in every province re-examine the general regulations with respect to the time that immigrant dentists are required to study in a Canadian dental school, with a view to increasing the inflow of qualified dentists.

167. That dentists employed by health agencies and particularly in the children's dental programme be paid adequate salaries to attract a sufficient number of well qualified dentists.

DENTAL AUXILIARIES

The increase in dentists resulting from the above recommendations will be of some help, but will not by any means meet our full needs. To meet the major demands that confront us, the Commission is convinced that it is now necessary to introduce a large-scale training programme to train dental auxiliaries who will be employed solely in the Children's Dental Programme and who will work under the direct supervision of a dentist.¹

We recognize that there may be some temporary opposition, both inside and outside the profession, to our proposal, but the evident deplorable state of dental health in this country,² combined with the scarcity of dentists, the scarcity of qualified professors of dentistry, and the time required to develop new dental schools, make emergency action imperative. Furthermore, the measures we propose have been successful in New Zealand, and are being experimented with and studied in Great Britain. We are confident that we can develop a successful programme in Canada and that all those who are concerned with the dental health of our children will support the proposal to the full.

The proposal is to train, as in New Zealand and now in Great Britain, dental auxiliaries who are qualified to prepare cavities and place fillings in the teeth of children, under strict pre-clinical and clinical supervision. They would also be qualified in dental health education and able to give instruction to patients in self care.

¹ For a complete discussion of this proposal, see Chapter 13.
It is essential that they be licensed to practise only under the supervision of a licensed dentist and be limited to practise only in the Children's Dental Programme.

These auxiliaries can be trained in two years, as both the New Zealand and United Kingdom experience indicate. They can be trained in a special programme provided by a dental school in adjacent quarters or in an institute of technology, supervised by a Dental School Faculty, and accredited by the Dental Auxiliary Advisory Committee that we recommend.

On the basis of our estimates, it will be necessary to have available at least 1,000 such qualified auxiliaries by January 1968 if the Children's Dental Programme is to begin in that year on a national basis and to increase the number graduated each year to 1,500 in 1971. Since, in order to graduate these auxiliaries by 1968 it will be necessary to enrol the first class by late 1965, no time must be lost in organizing the educational programme for these auxiliaries.

The Commission recommends:

168. That a Dental Auxiliary Advisory Training Committee be appointed to the Department of National Health and Welfare, consisting, among others, of representatives of the Canadian Dental Association, the Provincial Dental Colleges or Boards, the National Dental Examining Board, Canadian Dental Schools, the Dominion Council of Health, l'Association des médecins de langue française du Canada, the Canadian Medical Association (Paediatric Section) and of Canadian women, together with the Director of the Dental Health Division, Department of National Health and Welfare.

169. That this body, together with the Deans of the dental schools develop a curriculum that will qualify the auxiliaries in a two-year programme.

170. That the dental auxiliaries be qualified to prepare cavities and place fillings in the teeth of children, under strict clinical and pre-clinical supervision, and to undertake dental health education and give instruction to patients in self care.

171. That dental auxiliaries be paid an adequate salary in order to attract a sufficient number of applicants.

172. That the Federal Government provide grants to dental schools and/or technical schools to provide the equipment and installations and provide the professional faculty required to establish the educational programmes beginning in 1966, to train a minimum of 1,000 dental auxiliaries per year. Technical Schools should also be assisted to establish courses for the preparation of dental technicians and dental assistants.
173. That the Professional Training Grant and the Technical and Vocational Training Grant be increased to provide bursaries to registrants to meet the cost of tuition, books, and maintenance.

13. Health Professions University Grant

In order to meet our requirements for health personnel we have recommended that the Professional Training Grant be expanded to provide bursaries for undergraduate and post-graduate study by health professionals. We also recognize, that if the Universities of this country are to meet Canada's need for health professionals they too will require additional financial assistance if they are to staff their professional schools. There is also Canada's moral obligation to help in the training of health personnel from the less developed countries. Universities that participate in such a programme will require appropriate financial assistance.

As the Federal Government now provides grants to universities equal to $2.00 per capita of each province's population, we believe that this arrangement provides a satisfactory technique for allocating funds to universities providing professional education for health personnel. Accordingly we believe that a Health Professions University Grant should be made available to universities through the mechanism of the Federal University Grant. Specific Recommendations regarding the use of the proposed Health Professions University Grant will be found under the following headings:

Nurse Education and Recruitment (Recommendation 132).
Medical Education and Recruitment (Recommendations 153 and 154).
Dental Education and Recruitment (Recommendations 161 and 162).

The Commission recommends:

174. That quite apart from any future adjustments to the Federal University Grant, it be increased by an additional annual Health Professions University Grant of at least 50 cents per capita, subject to revision in the light of future needs and developments. This Grant is to be allocated to universities having or establishing medical, dental, public health, pharmacy, nursing, physiotherapy schools, or two year pre-clinical programmes and that the methods of distributing this special Grant be arranged with the Canadian Universities Foundation.

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Footnote: Canada, because of its French component, is particularly well equipped to assist in the training of French-speaking health personnel from emerging nations.
14. Health Facilities Development Fund

In order to relieve the shortages of health personnel we require not only the necessary teaching staff and number of students but also the facilities where an increasing number and variety of health professions and occupations can be taught. In this respect also Federal assistance on a co-operative basis is essential. To assist the provinces in this regard we recommend the establishment by the Federal Government of a fund to be used for the capital development of service facilities as well as educational institutions. The former purpose can well be served by the present Hospital Construction Grant as a nucleus with the amendments contained in our Recommendations and including in particular also the recommended Dental Construction and Equipment Grant. To this will have to be added the necessary funds for Federal participation in the cost of constructing, expanding, or renovating educational institutions.

Specific Recommendations regarding the use of this new Health Facilities Development Fund will also be found under the following headings:

- Mental Health, Alcoholism, and Drug Addiction (Recommendations 13 and 16).
- Dental Services (Recommendations 40 and 46).
- Nurse Education and Recruitment (Recommendations 132 and 133).
- Medical Education and Recruitment (Recommendations 140 and 142).
- Dental Education and Recruitment (Recommendations 155 and 156).

The Commission recommends:

175. That the Federal Government establish a ten-year capital development budget to assist in the provision of medical, dental, public health, nursing, and other health profession educational facilities, (including medical schools, dental schools, schools of public health, schools of nursing, basic sciences buildings, and equipment). The fund should be called the Health Facilities Development Fund and should incorporate the present Hospital Construction Grant.

176. That the Hospital Construction Grant regulations be amended immediately to provide one-half the cost of construction of new, or the expansion or renovation of existing hospital out-patient departments.

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1 See Recommendation 40.
In the preparation of our Report we have examined the many facets of our health services. In this undertaking one of our major problems was to obtain adequate data. Time and again we have mentioned the lack of some essential data; that we have had to rely on estimates; that further study, observation, and experimentation are necessary; all of which lead to numerous suggestions in our Report for further investigation of specific problems.

Two factors are responsible for this state of affairs: (a) the absence of adequate historical and current data, and (b) the many dynamic forces continuously altering the basic problems facing the health services. As a result, our Report falls short in many instances in establishing the facts, and where it succeeds it can often do no more than establish a bench-mark from which further continuing studies are required in order to observe the constant changes.

In the past, health research was by and large synonymous with medical research, but today we cannot ignore the many problems of a social, economic, administrative and purely technical nature which confront our health services. All these must be evaluated if the health services of the future are to be as effective and efficient as we want them to be. Medical research is and will remain an essential and basic part of any health research programme. But it is no longer the only area of investigation. Modern concepts in the study of the etiology of health defects by the methods of epidemiology and human ecology lead directly into an examination of the social environment. We must ensure that the educational programmes for all health personnel keep abreast of new developments.

New methods in the practice of medicine must be applied within the framework of the existing health services which in turn require continuing observation. In view of the complexity and cost of these services it is becoming increasingly important to ensure their optimum efficiency and co-ordination. It is no longer enough to study individual programmes in isolation. The interdependence of programmes is a major factor in their organization and appraisal. Nor does it suffice any longer to study health services alone. Rehabilitation, home care, and general recognition of the social needs of the patient require close integration of health services with other community facilities and organizations. The need for income maintenance provisions during illness and impairment emphasizes the significance of these schemes in the realm of health.

All this means that a host of new disciplines has been added to the traditional health team: the social scientist, the social worker, the architect, the administrator, the statistician, to mention a few, all must participate in the study of health and health services.
Because of the interdisciplinary implications of this development and the need to separate research from the day-to-day operation of health programmes, whether public or private, there is a need for an independent body to undertake this kind of study.

We have noted the recent establishment of the Medical Research Council as an organization parallel to the National Research Council. Rather than setting up an additional body to carry out the kind of health research we have described here, we propose that the functions of the Medical Research Council be broadened to include all health research, with the necessary expansion of its terms of reference and its budget. This new agency could be called the Health Sciences Research Council.

Accordingly we recommend in regard to the National Health Grants that the Public Health Research Grant and the portions of other Health Grants devoted to research be transferred to this Council.

Specific Recommendations regarding the role of the Council will also be found under the following headings:

- Mental Health, Alcoholism, and Drug Addiction (Recommendations 6, 21 and 28)
- Dental Services (Recommendations 43 and 47)
- Prescription Drug Services (Recommendation 80)
- Optical Services (Recommendation 93)
- Prosthetic Services and Appliances (Recommendation 115)
- Medical Education and Recruitment (Recommendation 148)
- Dental Education and Recruitment (Recommendation 159)
- Health Statistics (Recommendations 186, 187 and 189)
- National Health Grants (Recommendation 197(c)).

The Commission recommends:

177. That the Medical Research Council be broadened by appropriate legislation to include all fields of health research and renamed the Health Sciences Research Council; as so reconstituted it be recognized by the Government of Canada as its principal adviser in the planning and support of health research and the allocation of research funds; its services be available to provincial governments, voluntary health associations, and universities; and, further, that in the proposed Act for the expansion of the Council, there be provision for the appointment of additional outstanding persons from the health and other professions. An outstanding “layman”, not connected with any particular health services programme or agency, should be
appointed Chairman. This does in no way imply any criticism of
the structure of the present Medical Research Council or of its
distinguished Chairman but in the expanding role of the Council
recommended here, embracing other health fields, we believe that
a neutral person rather than a member of one of the health profes-
sions would be desirable as Chairman as and when a vacancy occurs.

178. That the operating budget of the Council be progressively increased,
by an annual amount of $2,000,000 over the next five years, and
that the Council be authorized to hold funds from other sources
such as foundations or other agencies.

179. That the Council be encouraged to increase the number of research
associates at medical, dental, pharmacy, and university nursing
schools and, in addition, make provision for scholarships to recent
medical, dental, pharmacy, and nursing graduates not yet qualified
as research associates.

180. That grants be available to teaching hospitals for experimental
research.

181. That the Council conduct and provide grants for research in the
medical, biological, and related sciences, basic drug research, and
any other scientific research including research in the social sciences,
having as its objective the improvement of the health of the Canadian
people.

182. That the Council support research concerning the most effective train-
ing and use of health workers.

183. That it be a continuing responsibility of the Council to conduct or
provide grants for the conduct of studies evaluating the effectiveness,
efficiency, and co-ordination of the various elements of the health
services complex.

184. That the Council provide advice and guidance, and participate in
developing and maintaining a continuing system of health statistics
in Canada as well as in ad hoc studies for the assessment of current
health problems and their trends, including the maintenance of a
dental health index as established by the Canadian Dental
Association.

185. That the Council be authorized to appoint a research director,
medical, non-medical research staff, and technical advisory com-
mittees as required.

1 The Chairman of the Medical Research Council in Britain is one of the three
"lay" members of the Council. See Medical Research in Britain, Reference Division, Central
16. Health Statistics

Throughout this Report we have referred on a number of occasions to inadequacies of basic data relating to the health status of the Canadian people, health expenditures, health manpower, and numerous other aspects. The inadequacies are of three types: (a) there are, on the one hand, major gaps in the field of health statistics, and, on the other, there is some duplication; (b) existing data are frequently not comparable because of a lack of uniformity in concepts, classification and coverage; (c) statistics are published after great delay thus impairing their usefulness for analytical, policy and administrative purposes; for example, the latest comprehensive hospital statistics made available to this Commission as at the beginning of 1964 were those for 1960.1

It has been presented to us that the main gaps in health statistics in Canada centre around three areas: (a) statistics of health care, (b) statistics of general morbidity in the population, and (c) statistics relating to health economics.2

The Dominion Bureau of Statistics, the Government's central statistical agency, has been responsible for the collection of most health statistics. In recent years, in an effort to fill some of the gaps in statistical knowledge in the health field, the Department of National Health and Welfare has undertaken a number of statistical projects and analytical studies. Our Commission has had full access to the health and related statistics produced by the Dominion Bureau of Statistics, and data compiled and analytical studies undertaken by the Department of National Health and Welfare. We found most of the material supplied to us very useful notwithstanding some of the inadequacies noted above and we are particularly indebted to the Department of National Health and Welfare for the studies undertaken3 and research assistance given. But, what impressed us in examining the data and the studies was the lack of co-ordination of the work of these two agencies (and such other agencies which contributed data used by these departments), and the fact that the collection of statistics in many instances were unrelated to the over-all objective of assessing the health needs and health progress of the Canadian people.

We feel that health statistics, just as statistics in other social and economic fields, should not be collected for the sake of statistics or for trivial purposes, but to provide the basic information which contributes to our knowledge of changes taking place in the health status of the Canadian people, or programmes to meet health needs, as well as evaluations of programmes and requirements. Such data, if available on a continuing, comprehensive, com-

1 See Chapter 8, Table 8-2.
2 We deal with these matters further in Volume II.
3 See Appendix B.
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parable, co-ordinated and current basis would aid greatly in the type of health planning such as we recommend be undertaken by the Health Sciences Research Council.

Specific Recommendations regarding health statistics will also be found under the following heading:

Prescribed Drug Services (Recommendation 82).
Health Sciences Research Council (Recommendation 184).

The Commission recommends:

186. That the Dominion Bureau of Statistics and the Department of National Health and Welfare, in consultation with the Health Sciences Research Council, and other appropriate Federal and Provincial Government and non-government agencies present to the Government an outline of a programme of improving health statistics in Canada and that such a programme be adopted.

187. That a more effective division of labour be worked out between the Dominion Bureau of Statistics and Department of National Health and Welfare with the former concentrating on the collection and examination of health and related statistics, and the latter on the interpretative analysis of the data, recognizing that in certain research projects the Department would be the appropriate agency to collect and process the required statistics. These two agencies should cooperate with the Health Sciences Research Council in developing concepts, definitions and methodology relating to health statistics with the latter published without undue delay.

188. That sufficient funds be made available to the Dominion Bureau of Statistics and the Department of National Health and Welfare to undertake a programme of statistical improvement and research.

189. That the statistics and research functions of the Department of National Health and Welfare and the activities of the Dominion Bureau of Statistics in the field of health statistics be dovetailed and co-ordinated with the functions of the Health Sciences Research Council.

III. FINANCING AND PRIORITIES

17. Over-all Financing

We have outlined in the Health Charter a basic approach to financing the Health Services Programme as recommended in this Report by saying that we endorse first the principle of prepayment in the personal health care field such as is now in operation in the hospital field, secondly that a prepaid
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A programme of personal health services should be provincially organized and administered with the staging, timing and scope determined by provincial governments, and thirdly that the Federal Government contribute to the financing of such a programme through federal grants in the following way:

1. a contributory grant of 50 per cent of the actual costs;
2. an administrative grant of 50 per cent of the administration costs of the programme not to exceed five per cent of the actual costs;
3. a fiscal need grant to assist provinces whose fiscal capacities are below the Canadian average to enable these provinces to provide health care services at standards comparable to the rest of Canada taking into account factors of geography, climate, and health resources.

Our studies show that most western nations now devote between 4.5 and 5.5 per cent of Gross National Expenditure to health care, including health services, health capital, research and education of health personnel, with these proportions rising. In 1961, Canada was devoting about 5.4 per cent of Gross National Expenditure when expenditures were measured in current dollars and 5.2 per cent when expenditures were measured in constant (1957) dollars.

Canadians are now spending 5.4 per cent of Gross National Expenditure on health care. If we carry on with the same services as we have now, the proportion of Gross National Expenditure, measured in current dollars, devoted to health care will rise to 5.5 per cent by 1971. If a Health Services Programme such as we recommend is implemented, the proportion of health care expenditures to Gross National Expenditure would be of the order of 6.1 per cent in 1971, or a difference of about one-half a percentage point as between a planned and comprehensive Health Services Programme and our present relatively unplanned and incomplete health care programme.

In terms of constant (1957) dollars, if a Health Services Programme such as we recommend is implemented, the proportion of Gross National Expenditure allocated to health care would be of the order of 6.0 per cent in 1971, an increase of .8 percentage points over the decade, and to 6.4 per cent in 1991, an increase of 1.2 percentage points over the thirty-year period.

These percentages have been calculated on the basis of a projected growth of Gross National Expenditure (Gross National Product) over the period 1961-1991 consistent with an average rate of unemployment of 4 per cent a year and average labour productivity which grows at a rate of 2.75 per cent a year. We have also estimated the proportion of Gross National Expenditure devoted to health care on the basis of a lower rate of growth of Gross National Expenditure that is consistent with an average unemployment rate of 5 per cent a year and average labour productivity that grows at
a rate of 2.25 per cent a year.¹ Using this lower projection, the proportion of Gross National Expenditure allocated to health care would be somewhat higher.

On the basis of programmes as currently constituted, the proportion of this smaller Gross National Expenditure, measured in current dollars, devoted to health care would rise to 5.8 per cent by 1971. If a Health Services Programme such as we recommend is implemented, the proportion of health care expenditures to Gross National Expenditure would be of the order of 6.4 per cent in 1971, or a difference of about one-half of one percentage point.

In terms of constant (1957) dollars, if a Health Services Programme such as we recommend is implemented, the proportion of Gross National Expenditure allocated to health care would be of the order of 6.4 per cent in 1971 and 7.4 per cent in 1991, an increase of 1.2 percentage points over the decade and 2.2 percentage points over the thirty-year period.

The details of these variations are elaborated in Chapter 20 but it is indicated there that with a lower rate of growth of Gross National Expenditure, the proportion spent on health care likely would not exceed 7 per cent over the period 1961-1991.

We believe there should be an appropriate relationship between the resources devoted by the Canadian nation to health services and resources devoted to other purposes. We are convinced that Canada’s expanding economy can afford to devote 6 per cent of the Gross National Expenditure to health services in 1971 and between 6.4 to 7 per cent in 1991, without in any way affecting detrimentally the requirements of the Canadian people for other goods and services to build a stronger economy and to achieve a higher standard of living.

In essence, most of Canada’s expanding health care programme could be paid for out of additional earned income resulting from more efficient use of our resources and continuing growth of the economy. We believe that the expansion of the Canadian economy which we envisage over the next 30 years is fully realizable with competent private and public management of our affairs and the determined pursuit of sensible and practical economic policies. We conclude that Canada’s future economic growth is of such an order, even under conservative assumptions, that this country can readily implement the health care programme recommended in this Report.

Although the implementation of the public Health Services Programme we envisage would not lead to a substantial increase in the proportion of

¹ For a description of the alternative projections of Gross National Expenditure (Gross National Product) see Chapter 19.
Gross National Expenditure allocated to health care, it is evident that an increased amount of revenue will have to be raised by governments. This is the result of a shift of personal health care expenditures from the private sector to the public sector of the economy to the extent that present direct payments or payments through voluntary plans, would be replaced by taxes or premiums for the future public programme. The individual Canadian will have to pay more in taxes or premiums but he will have more spending power from which to pay. Moreover, an expanding Gross National Product will enable the Federal Government and the Provincial Governments to obtain increasing revenues from the tax system even without substantial changes in taxation rates. In view of the fact that there is another Federal Royal Commission examining the whole field of taxation, we are abstaining from specific recommendations in the field of financing health services. However, we wish to make a few general observations.

We wish first to refer to the recognition by numerous groups encompassing people in all walks of life from one end of Canada to the other, that an expanded health care programme would result in increased taxes including premiums and their expressed willingness to accept such additional taxes, appropriately distributed, to pay for the benefits accruing to Canadians from a comprehensive health care programme.¹

We have outlined several methods of prepayment in the Health Charter including financing by means of premiums, subsidized premiums, sales and other taxes, supplemented by funds, as each province may determine, from its general revenues, and by Federal Government grants as outlined above under (1) to (3). To qualify for a Federal Government grant a province would not be required to conform to any rigid pattern provided the health services included under the plan would cover everyone in the province and be available to all regardless of age, state of health, or ability to pay, upon uniform terms and conditions.

Our analysis in Chapter 10 has brought out the point that provinces have chosen a variety of means for paying hospital costs under the present shared programme. In so doing they have chosen what they consider the means most suitable to their economies. We believe that this pattern of provincial methods of financing should also apply to shared programmes in the personal health care sector as recommended in this Report.

There are other areas of fiscal capacities which provinces may explore as possible sources of financing to pay for their share of a personal health care programme. One possibility would be to incorporate the present employer-employee method of medicare prepayment into a general contributory system to finance all health services.

¹ See Chapter 21.
Another possibility is that urged upon us by La Filiale du Québec de L'Association des Médecins de Langue Française du Canada,\(^1\) of provincial lotteries provided the net proceeds are used solely for health purposes. This would involve, of course, an amendment to the Criminal Code. We do not advocate the use of lotteries. But where a province desires to operate a lottery solely to assist in the financing of health services, the Federal Government, when requested by a province to do so, might submit to Parliament appropriate amendments to the Criminal Code.

The Federal Government's revenue to finance its share of the health care programme including hospital services must come from taxes imposed by Parliament. We are aware of the claims that when governments pay for services out of general revenue, the recipient of the services is not sufficiently aware of the costs to him. Accordingly, in the raising of funds required to pay for its share of the costs of the programme as proposed, the Federal Government, although not earmarking revenues, ought to identify in the mind of the taxpayer such additional taxes with the health care services he is getting.

A final point relates to the effectiveness of the Federal Government's contribution to the operation of programmes generally under provincial jurisdiction through a shared grant system. We have examined the effectiveness of this method of Federal Government's financial participation in provincially operated and administered programmes in Chapter 21,\(^2\) and we have concluded that this method is the most effective and practical means of initiating new programmes in the health field to give all Canadians that equality of opportunity essential to Canadian unity and progress as a nation.

However, we can visualize a time when the comprehensive and universal health care programme which we have recommended has been adopted by all provinces and has been in operation for a number of years thus demonstrating its viability and its full endorsement by the people of Canada.

When that stage has been reached, and if a province so requests, consideration could be given to a method of financing whereby the Federal Government would vacate such a portion of tax fields as would yield revenues to a province corresponding to what it was receiving in the form of Federal grants, provided that the province in question would undertake to operate in the future the programme on the broad basis then established, and continue to participate with the Federal Government and other provinces in the planning and integration of health services for all Canadians.

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\(^1\) La Filiale du Québec de L'Association des Médecins de Langue Française du Canada, brief submitted to the Royal Commission on Health Services, Montreal, April 17, 1962, p. 37.

\(^2\) See also Hanson, E. J., *Public Finance Aspects of Health Services*, a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964.
The Commission recommends:

190. That methods of financing the provincial share of the personal health care programme recommended be left entirely to the provinces as is presently the case with the method of financing the provincial share of the hospital insurance programme.

191. That provinces explore additional methods of financing including the possibility of incorporating the present employer-employee method of medicare prepayment into a general contributory system to finance all health services.

192. That the Federal Government, if requested by a province wishing to operate a lottery solely to assist it in the financing of health services, might submit to Parliament for approval the appropriate amendment to the Criminal Code.

193. That the Federal Government finance its share of costs of the health care programme consisting of a 50 per cent contributory grant of the actual costs, an administrative grant of 50 per cent of the administration costs of the programme not to exceed 5 per cent of the actual costs, and a fiscal need grant to financially weaker provinces through an equitable system of taxation.

194. That taxes collected by the Federal Government to pay for the expanded Health Services Programme be identified in such a manner as to make it clear to the taxpayer that the taxes paid cover the health service benefits made available to him.

195. That as and when the comprehensive and universal Health Services Programme recommended has been adopted by all provinces and has been in operation for a number of years, the Federal Government consider, if so requested by a province, to vacate an appropriate portion of tax fields equivalent to the Federal grant payable to that province provided that the province in question undertakes to operate in the future the programme on the broad basis then established, and continue to participate with the Federal Government and other provinces in the planning and integration of health services for all Canadians.

18. National Health Grants

The National Health Grants, as described in Chapter 10, fall into five main categories:

(1) Grants for services in respect of specific diseases or for a specific group:
(a) Mental Health
(b) Tuberculosis Control
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(c) Cancer Control
(d) Medical Rehabilitation and Crippled Children
(e) Child and Maternal Health

(2) A grant for general public health activities and services (General Public Health Grant).

(3) A grant for research related to public health (Public Health Research Grant).

(4) A grant for training of professional health workers (Professional Training Grant).

(5) A matching grant for the provision of health facilities (Hospital Construction Grant).

The five disease-oriented grants and grants for specific groups, specifically Mental Health, Tuberculosis Control, Cancer, Medical Rehabilitation and Crippled Children, and Child and Maternal Health, have been used for a variety of purposes including treatment, research, personnel training, and other functions that are traditionally termed "public health". As our Health Services Programme recommendations are adopted by the Federal Government and implemented by the provinces, there should be a "phasing out" of these five grants, although they should be retained for those provinces that do not immediately implement the Health Services Programme. This is especially important in the case of the grant for Medical Rehabilitation and Crippled Children which will probably have to be increased for the interim financing of services to crippled children.

With the implementation of the Health Services Programme there still will remain a number of functions, specifically "public health" and research, now associated with the five grants for specific diseases and specific groups. Thus "public health" functions have been financed by funds from the Mental Health, Tuberculosis, and other Grants, while sizeable sums have been allocated from these specific grants to the Public Health Research Grant. This is evident from the fact that in the recent years total spending on research exceeded the amount specifically allocated to the Public Health Research Grant by over 100 per cent.

The existing Public Health Grant and Public Health Research Grant must necessarily be expanded by allocating to them a certain portion of the five categorical grants as these are discontinued.

One other grant should be retained and augmented. This is the grant for professional training which has also been supplemented by allocations for educational purposes from the other grants, bringing the total spent on professional training to more than double the amount of the Profes-
sional Training Grant. References to the future role of this Grant will be found under the following headings in this chapter:

- Mental Health, Alcoholism, and Drug Addiction (Recommendations 2, 3, 4 and 22)
- Optical Services (Recommendation 94)
- Prosthetic Services and Appliances (Recommendation 115)
- Nurse Education and Recruitment (Recommendations 134-136)
- Medical Education and Recruitment (Recommendations 144 and 152)
- Dental Education and Recruitment (Recommendations 158, 164, 165 and 173)

In addition, as recommended elsewhere, a new grant should be introduced immediately to provide for the children's dental health programme. The Hospital Construction Grant is to be transferred to the Health Facilities Development Fund.

Specific Recommendations regarding the National Health Grants Programme apart from the Professional Training Grant will also be found under the following headings:

- Dental Services (Recommendations 39, 41 and 51)
- Hospital Services (Recommendation 102)
- Home Care Services (Recommendations 122 and 123)
- Health Facilities Development Fund (Recommendation 176)

The Commission recommends:

196. That provision be made for terminating the present pattern of health grants to provinces for specific disease categories and client groups as each province begins to receive its Medical Services Grant, but that the grants be continued in their present form for the remaining provinces until all are in receipt of the Medical Services Grant. The one exception should be the grant for Medical Rehabilitation and Crippled Children, which should be extended as an interim measure in order to implement our Recommendation 200(c) that services to crippled children be given priority.

197. That for those provinces receiving the Medical Services Grant, the following grants be continued; with these modifications:

(a) The General Public Health Grant should be increased to $1.00 per capita.

(b) The Professional Training Grant should be increased in accordance with the requirements of our Recommendations respecting

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3 See Recommendation 39.
this Grant. Provision should also be made for greater flexibility in its bursary, book and fee allowances.

(c) The funds appropriated in the Public Health Research Grant and responsibility for its administration, as well as the amounts in other grants currently being allocated to research should be transferred to the Health Sciences Research Council.

198. That a Children's Dental Health Grant be introduced in 1967 to underwrite one-half the cost of a Children's Dental Programme to commence in 1968.

19. Priorities

We emphasized in Chapter 1 certain areas in which we consider the need for action particularly urgent. We are firmly convinced that most of the services recommended under the Health Services Programme\(^1\) can be proceeded with promptly and we wish to emphasize again what we have already said\(^2\) namely that:

"While we are aware that shortages of physicians, dentists, nurses, and other paramedical personnel will make it difficult to establish the full personal Health Services Programme our Charter envisages, none the less the fact that there are shortages must not be used as an excuse to delay initiating programmes and plans."

Where shortages of personnel exist or are anticipated, steps must be taken immediately for the education and training of adequate numbers of personnel and, where necessary, for the required expansion of education and training facilities, through the crash programmes we have recommended.

We present here priorities for the implementation of various parts of the programme but in so doing wish to make it clear that this does not mean that one stage of the programme has to be completed before another can be started: certainly one service can be planned while another is being implemented. Planning should normally proceed simultaneously for several services.

The introduction of any service must, of course, be preceded by administrative and fiscal planning.

The Commission recommends:

199. That a Federal-Provincial Conference be convened within six months of the tabling of Volume I of this Report:

(a) to initiate the necessary planning and fiscal arrangements for the co-ordinated implementation of the programme as a whole;

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\(^1\) See Recommendation 1.
\(^2\) See Chapter 1.
(b) to reach agreement on the implementation of the Health Services Programme we have recommended.

200. (1) That pending the holding of this conference, action be taken to implement the recommended changes in the scope of the Hospital Insurance and Diagnostic Services Act, in particular:

(a) designation of wards of mental hospitals in which patients are receiving active or convalescent care, and tuberculosis' hospitals as "facilities" under the Hospital Insurance and Diagnostic Services Act;

(b) provision of out-patient services as a condition of any further payment in respect to in-patient benefits;

(c) recognition of diagnostic facilities in recognized clinics and specialists' offices as "facilities" under the Act.

(2) That during the same period consultation should be initiated with the educational institutions:

(a) looking to the implementation of those recommendations concerning the crash programmes for the education and training of health personnel;

(b) the organization and allocation of the resources required to introduce the Children's Dental Programme.

(3) That the provision of services to retarded children and to crippled children be made available at an early date under the Mental Health Services and the Health Grants Programmes.

(4) That the necessary legislation be enacted as soon as possible expanding the Medical Research Council into the recommended Health Sciences Research Council and providing it with adequate funds.

With respect to all the other recommendations, these should be adopted as agreement can be reached with provinces and the organizational and financial arrangements can be made.

**IMPLICATIONS OF RECOMMENDATIONS**

We can now state what are the significant manpower, facilities and financial requirements implied in our recommendations over the decade 1961-1971 and, when applicable, the period 1961-1991.

Although efficient organization and a continuing re-assessment of the structure of health services will improve the amount and quality of health care, it will not, by itself, be sufficient to provide Canadians with the best possible health care. In the light of the growth and the changing structure of
the Canadian population, their increasing per capita incomes, the development of scientific and medical research, and the growing awareness of the benefits of health services, this can only be done by expanding the supply of qualified health personnel and appropriate health facilities. Despite the advances made over the post-war period and the fortunate position of Canadians, relative to many other countries in the world, the task of providing sufficient personnel and facilities is still a formidable one.

MANPOWER

To provide the health services Canadians will need in the future, the significant health personnel must be expanded in the following manner:

1. Physicians—Between 1961 and 1971, 7,100 physicians must be added to the existing supply. After migration, retirement and other losses, the net addition will be 5,340. Between 1961 and 1991, there must be a net increase in the supply of physicians of at least 19,350.

2. Dentists—Between 1961 and 1971, at least 2,130 dentists must be added to the supply of dentists. After migration, retirement and other losses, the net addition will be 1,270. Between 1961 and 1991, there must be a net increase in the supply of dentists of at least 8,550.

3. Nurses—Between 1961 and 1971 our projections indicate that, as a minimum estimate, around 20,000 nurses must be added to the supply to match growing needs and to replace those leaving the profession, while a maximum estimate suggests that additional estimates could approach 42,000. Many of these additional nurses will require a university degree and post-graduate training.

4. Dental Auxiliaries—Between 1968 when the Children’s Dental Programme is projected to begin and 1971, the supply of dental auxiliaries must be increased by about 3,000. By 1976, this number must increase to about 9,000.

FACILITIES

To produce the health services and health personnel required the following significant educational facilities and hospital facilities must be provided:

5. Medical Schools—Between 1961 and 1971, 476 new places must be provided by the expansion of existing medical schools and the construction of 4 new medical schools. Between 1961 and 1991 the number of new places must increase by over 1,000.

6. Dental Schools—Between 1961 and 1971, about 100 new places must be provided by the expansion of existing dental schools, while
between 1961 and 1991 the number of new places must increase by about 300, which will require the construction of 4 additional schools by 1979.

7. Schools for Dental Auxiliaries—By 1968, between 7 and 10 new schools must be established to train dental auxiliaries.

8. Hospital Facilities—Between 1961 and 1971, our projection of the need for hospital care envisages the construction of 60,000 beds. Of these 40,000 are needed to meet the requirements of population growth and improved patient care for the mentally ill and retarded, and 20,000 for replacement of obsolete beds or to compensate for the shift in population from rural to urban areas.

FINANCES

The financial implications of the provision of health services in the future are presented here in two ways: in constant (1957) dollars, or real outlays, for a number of years between 1961 and 1991, and in current dollars for the years 1966 and 1971. The projection of constant (1957) dollar expenditures has been carried out only on the assumption that the programmes recommended in this Report are implemented. The projections of current dollar expenditures have been made in two ways: (1) assuming no change in the scope of public health care programmes as they existed in 1961, and (2) assuming the implementation of the programmes recommended in this Report. The proportion of Gross National Expenditure allocated to health care under these various assumptions has been outlined above on pages 84 and 85, the remaining estimates are presented below.

Constant (1957) Dollar Expenditures, 1961-1991: The major financial implications of these projections in constant (1957) dollars are:

9. Assuming the implementation of the programmes recommended here and including health research and grants-in-aid of education, between 1961 and 1971 per capita expenditures are projected to rise from $99 to $150 and total expenditures to rise from $1,813 million to $3,390 million.

10. Between 1961 and 1991, again assuming the implementation of the programmes recommended here, and including health research and health capital, per capita expenditures are projected to increase from $99 to $240 and total expenditures from $1,813 to $8,427 million.

Because of limitations on the available data it has not been possible to project expenditures on health research and health education assuming no change in the scope of public health programmes as they existed in 1961. For a discussion of this point see Chapter 20.
**Current Dollar Expenditures, 1961-1971:** The major financial implications of these projections are:

11. Assuming no change in the scope of public health care programmes and excluding expenditures for health research and grants-in-aid of education, between 1961 and 1966 per capita expenditures are projected to rise from $110 to $142 and total expenditures to rise from $2,007 million to $2,873 million. Between 1966 and 1971 per capita expenditures are projected to rise to $178, and total expenditures to rise to $4,015 million.

12. Assuming the implementation of the programmes recommended here, and excluding health research and grants-in-aid of education, between 1961 and 1966 per capita expenditures are projected to rise from $110 to $147, and total expenditures to rise from $2,007 million to $2,994 million. Between 1966 and 1971 per capita expenditures are projected to rise to $195, and total expenditures to rise to $4,407 million. If health research and grants-in-aid of health education are included with projected health expenditures, by 1971 per capita expenditures are projected to amount to $198 and total expenditures to $4,481 million.

13. By 1971, the annual cost of continuing our present system of health services, with all its limitations, and inadequacies, would be $4,015 million or $178 per person. For an additional $466 million, or $20 per person, we will be able to finance the universal, and comprehensive Health Services Programme we recommend. This would make available to all Canadians the best possible health care which we can now foresee, but above and beyond that it would provide the foundations upon which the genius of Canada’s scientists would flourish and open up vistas of better things to come as science proceeds to uncover the secrets of disease and to discover new methods in the age old struggle to conquer it.

**CONCLUSION**

In conclusion may we be permitted to hope that all concerned with the good health of Canadians will work together in harmony and dedication at all levels of government. Impressive results can be expected when real co-operation exists and a sense of urgency prevails. For example, we might instance the achievements of busy people with the co-operation of the

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1 For a more detailed discussion, see Chapter 20.
Federal and Provincial Health Departments in the wake of the thalidomide tragedy. An interprovincial committee formed in August 1962 met one month later and during the next six months visited appropriate centres in the United States and Europe assimilating and consolidating all relevant information. In November 1962 a preliminary course was held for representatives from each province, followed by a much more comprehensive course attended by 110 selected representatives from all provinces in May 1963. Research grants applied for and promptly provided by the Federal and Provincial Governments on a cost-sharing basis made possible the establishment of three prosthetic research and training centres in Montreal, Toronto and Winnipeg, which have already produced significant contributions to the care of the children involved. May Canadians not hope for similar prompt action and co-operation in other fields of health care?
Changing Concepts of Health and Health Care

Our Terms of Reference require us to define "the best possible health care", yet despite the advances in medical knowledge in recent decades the concept of health evades precise definition. The more we discover of man's physical and social nature, the more difficult is the task of arriving at a consensus. Through the centuries man has tended to define health in terms of its negative manifestations evident in disease. For primitive man disease was a disaster due to the action of evil spirits; therapy aimed at destroying or driving out the evil spirit. The Egyptians attempted to postulate principles of disease causation based upon observation and experience. Their limited success in determining the nature and treatment of surgical disorders was due to their idea that disease was related to pus formation, fever and rapid heart beat.

The Greeks based the idea of health on empirical observation and the relationship between observations. In this way they attempted to formulate universal laws. The "Hippocratic Corpus", a collection of medical treatises, attempted to explain the relationship between the sick person and the world in which he lived. Life was held to be worth preserving only as long as it could be useful.

The Judeo-Christian tradition stressed the worth and dignity of the person and the sanctity of human life. Since disease caused suffering, the healthy were exhorted to care for the sick; to do so was considered an act of grace. With the Renaissance came experiment and measurement and a greater interest in the physical and spiritual nature of man. This interest in verifiable data concerning man's physical nature was invaluable for the study of disease and its manifestations.

The scientific approach to the nature of man was carried forward by Descartes and Kant, and into the era of scientific medicine in which man was viewed in mechanistic terms and disease the result of the introduction of virulent micro-organisms into the body. This doctrine of specific

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aetiology, while a dynamic force in medical progress, overlooked the fact that "most disease states are the indirect outcome of a constellation of circumstances rather than the direct result of single determinant factors". This view is now giving way to the idea that the social and psychological as well as the physical characteristics of the total environment, in large part, affect the disease patterns of the community. This theory is related to the Greek idea of health as a proper balance between the mental and the physical, between mind and body.

These ideas of the nature of disease are closely tied to the prevailing philosophical beliefs about the nature of man. They are also related to the individual's experience and learning in a particular social milieu. This experience colours his definition. Professor E. L. Koos considers that, "educational achievement, variations in experience, the ability or inability to purchase medical care, group-held beliefs—all of these can play a part in determining what is to be considered an illness". Robinson, Redlich and Myers have shown that mental illness is defined differently in various socio-economic strata in the same society. These differences affect a person's recognition of the symptoms of illness and his decision to seek assistance. Human attitudes are the basis for much of the untreated and mistreated illness in our society.

Nevertheless, all societies are similar in that they have recognized certain practices that attempt to transform a state of illness into a state of health. Such practices represent the body of medical knowledge in the society and its application. The extent to which these practices are based on scientific principles and not merely mythical beliefs will affect the rate of progress in the health field. Furthermore, medical knowledge helps to identify and deepen the meaning of illness and the possibilities of regaining "good" health. It is the relationship of these three factors within the total environment which largely determines what a community will consider at any moment of time, as the best possible health care available.

The changing attitude towards sickness, and thus to provision of health care, can be seen in the privileged status that the sick person has come to achieve in western societies. While we expect the healthy person to perform his social and economic tasks at optimum capacity relative to his age, sex, education and the like, the sick person is recognized as unable, in some degree, to fulfil these responsibilities. This takes account of four

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1 Aetiology is the science of the causes of disease.
5 See, for example, The United Church of Canada, brief presented to the Medical Services Insurance Enquiry, Toronto, January 1964, pp. 8 and 9.
main features of the status of the sick person: (1) the incapacity due to illness is seen as being beyond the powers of the individual to overcome through his own decisions; it requires some form of therapeutic process for recovery; (2) the fact of recognition of sickness and the resulting incapacity serves to justify the exemption of the individual in varying degrees, ways, and periods of time from his normal obligations; (3) the realization on the part of the sick person that along with the recognition of illness as a legitimate state there goes a corresponding obligation to co-operate in the therapeutic process; (4) the obligation on the part of the sick person and his family to seek adequate help and to co-operate with the competent individuals and agencies in their efforts to bring him back to health.

The tremendous strides of medicine in the last century and more specifically in the past 25 years in industrialized societies have become an accepted fact of social and economic progress and have changed the whole concept of health care. The investigation of cellular structure has been made possible with the improvement and introduction of new types of microscopes and microscopic techniques while organic and physical chemistry and physics have revolutionized physiology. Bacteriology has led to spectacular advances in the field of public health, and in other areas of medical and institutional care. New scientific techniques have facilitated the diagnosis of a wide variety of illnesses, while the introduction of psychiatry has revealed new and hitherto hidden conditions. The rate of progress in medicine as in science generally has increased with the passage of time so that today the unusual discovery is almost common. Complicated surgery, the electron microscope, isotopes, poliomyelitis vaccines and antibiotics and many other new devices and techniques have become part of everyone's vocabulary. This undeniable progress has stimulated the public demand for the very latest innovation in medical care. An example is the increased demand for the so-called "wonder drugs" which, in the eyes of many, completely replace the traditional ways of relieving or curing a variety of ills. This outright demand for "wonder drugs" or other forms of "miracle therapy" is a consequence of the great successes achieved by medicine. A generation which can remember the introduction of the sulpha drugs and the advances which medical technology has made since that time has come to expect "miracles". The growing confidence in modern medicine and health institutions generally is motivating more people to seek health care, sometimes perhaps even to the extent of making excessive demands for services.

While the gradual removal of financial barriers has, no doubt, contributed to the growth of the demand for health care, phenomena like the

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increasing proportion of voluntary admissions to mental institutions are evidence both of a changing attitude towards what is the appropriate level of health care as well as an indication of the effectiveness of such care.

In spite of the advances in medical care and the substantial improvement in the provision of health services we cannot say that Canadians as yet receive the best possible health care. In part this is the consequence of changes in the environment. But it is also due to the changes wrought by improved medical care itself. The incidence of certain illnesses all vary, for example, according to geographic area, population structure, socio-economic status, occupation, and ethnic background and similar environmental characteristics. Thus increased urbanization, a changing labour force, a different distribution of ethnic groups all may be associated with an increase in the incidence of certain illness and a decrease in the incidence of others. Again the very effectiveness of communicable disease control through the application of medical science to the problems of environmental sanitation and immunization has resulted in a very great reduction in mortality from these diseases. Greater numbers of children are saved to live out their lives. But these changes brought about by medicine, in turn, result in changes in the age structure of the population. As people are saved from dying at an early age, medicine has been faced increasingly with the medical problems of the aged: cancer, cardiovascular-renal diseases, certain types of mental disorder, and chronic disease in general.

It must also be emphasized that while it is possible to measure what Canadians spend on health care, it is much more difficult to define and to measure their need. We are able to measure the volume of hospital care received by Canadians under the Hospital Insurance Plan, the volume of physicians’ services rendered by many of the voluntary prepayment plans, and we possess limited data on the consumption of many other health services. In addition, we can measure expenditures on health services and capital. There are, unfortunately, still many areas in which the available data are so limited that it is difficult to measure accurately the volume of care received and the statistics cannot measure the extent of the need of those who do not seek health services. We can, however, identify general areas in which unmet needs exist and where certain services are required and this we must do if we are to be certain that Canadians get the best health care possible.

The concept of health care has spread beyond a narrow definition of health services. In its attempts to control disease the medical profession today is giving increasing recognition to the concept of social medicine which views man as an integral part of his environment. The practitioner tries to evaluate the health of the individual not only in terms of symptoms, but by taking into account the physical, biological and social forces which impinge upon the sick person, and which may affect the course of his
complaint. With this perspective the physician attempts to treat the whole man rather than a specific disease. For example, in a particular ailment he may find it necessary to consider the effects of housing conditions, occupational and family relations as these affect the patient's health.

The recognition that the health of individuals depends on a complex of interrelated factors has posed problems. According to our Terms of Reference this Commission was directed to examine the provision of health services in which we have included the following items: physicians' services, dental services, nursing services, hospital services, prosthetic devices, prescribed drugs, eye care services, home care, rehabilitation, environmental and other public health services. These services are discussed in detail later in this Report. An examination of these services must take account of a number of factors.

The development of the concept of social medicine has led to a greater emphasis on health planning as an integral part of good health care, including measures such as annual physical examinations especially for persons in the older age groups, an emphasis on balanced diet, a planned regimen of exercise for the various age groups, and good health habits in general. This leads our discussion back to the respective role of the individual and society in the prevention as well as the treatment of illness. Positive and enlightened attitudes towards his health and habits to promote it are part of the individual's responsibility which cannot be replaced by compulsion or by public health measures. Health education, aided by increased levels of living and general education, have contributed greatly to many improvements in our health status. Better general hygiene and nutrition, for instance, have no doubt played a considerable part in reducing illness and death from certain diseases though the extent of this contribution would be difficult to measure.

Besides the factors promoting health in general, there are habits and customs which can either help to reduce or, on the other hand, cause certain diseases. Medical science has recently made us aware of the causal relationship between cigarette smoking and lung cancer or certain other chronic conditions. We know—perhaps less specifically—of some connection between exercise or nutrition and heart disease. In the less serious but nevertheless important area of dental health the need for proper dental hygiene has been stressed, as has the need for prevention in the area of venereal diseases. Cigarette smoking, the intemperate use of alcohol, malnutrition, and lack of dental hygiene, are all among the areas where the responsibility for promoting better health lies with the individual. But the individual must be...

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1 In limiting our discussion to these services we have excluded certain borderline areas. See Foreword, p. 4, and World Health Organizations, The Cost and Means of Financing Medical Care Services, Geneva: The Organization, 1962, pp. 24-29.
provided with the necessary guidance by competent professional people and voluntary and government agencies. Accidents, particularly motor accidents, are another field where the responsibility for prevention rests heavily on the individual though public measures such as traffic control and safety devices are also required. While some cancer may be prevented by curbing the smoking habit, some of it will have to await public measures such as more effective control of air pollution and radiation. The division between public and personal responsibility is not always clear cut or easy to define nor does it remain static. While today, for example, we look to the government to prohibit the sale of certain drugs or food additives because of their known or suspected detrimental effects on health, we are inclined to leave to the individual the responsibility of abstinence or moderation in regard to smoking, the consumption of alcohol or tooth decaying sweets. In all cases, however, we look for scientific research to establish the causal relationships between health, personal habits and environment. All this indicates a new emphasis in the physician's effort directed towards minimizing the health hazards of everyday living, and on new areas of research. The success in terms of increased life expectancy which has attended public health programmes of immunization, sanitation and other preventive measures in the control of environmental health hazards has given weight to this shift of emphasis.

We cannot help but emphasize that while the development of the last thirty years has brought undoubted benefits to industrial nations like Canada, such rewards have their attendant costs. We live in a period of rapid social change; the questions society has to answer are constantly changing in dimension and kind. Problems are created when social institutions are slow in adjusting to change while the unprecedented development of cities can be considered as a factor creating special demands that modern social organization is failing to answer adequately.

How are these observations related to the field of health care? This might best be answered by a recent quotation from the Reith Lectures given by Professor Carstairs: "Every stable society imposes rules of behaviour which inhibit the realization of some individual potentialities. This is compensated as a rule by the gratifications which only life in that society can provide. In times of social change, however, this equilibrium tends to become upset, and when this happens conformity to social norms can be maintained only by subjecting some individuals to considerable stress, and causing many of them to break down". Modern medicine is increasingly associating mental and even physiological disturbances with the emotional

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tension created by the points of social stress inherent in a rapidly changing and increasingly complex society.

There are certain marked features of modern society that are likely sources of tension. Ease of communication and travel has enabled people to extend their range of contacts outside the immediate communities where they were born and where, prior to World War I, they would probably have lived the remainder of their lives. The break-up of small communities and the concentration of economic activity in large industrial units has forced people to look beyond their family and residential area for employment. Outside these limited spheres the individual establishes an even wider range of social contacts. The sheer weight of numbers involved increases the complexity of social relationships, and the superficial and fleeting nature of the majority of them. The realities of the situation contrast sharply with the norms that are held to govern personal and social relationships. Industrial firms seek to shape their management policies according to the precepts of the human relations manuals, but the shopfloor complaints concerning arbitrary decisions and impersonal contacts illustrate the discrepancy between the ideal and the practice.

The family occupies a place of shrinking importance in the field of social relationships; it has long since ceased to be the unit of economic production. The range of kin embraced by any one family has declined, and this is accompanied by a tendency for the modern family to limit its recognition of kin. Many of the functions formerly performed by a large body of relatives are now carried out by specialized agencies. Modern society is based on the division of labour and believes in the value of specialization. Accordingly, the composite functions of the kinship structure have been whittled away and assumed by specialized bodies outside the family.

This brief discussion of some of the significant changes that are occurring in our society may provoke a desire for a more static social order, but

"The Garden of Eden, the Promised Land that each generation imagines anew in its dreams, and all the Arcadias past and future could be sites of lasting health and happiness only if mankind were to remain static in a stable environment. But in the world of reality places change and man also changes. Furthermore, his self-imposed striving for ever-new distant goals makes his fate even more unpredictable than that of other living things. For this reason health and happiness cannot be absolute and permanent values, however careful the social and medical planning. Biological success in all its manifestations is a measure of fitness, and fitness requires never-ending efforts of adaptation to the total environment, which is ever changing".1

1 Dubos, René, op. cit., p. 25.
As long as change in our society was not rapid, our ideas of what constituted good health for Canadians presented few pressing problems. The more rapid changes that have occurred in this century have widened our knowledge and definition of good health, and this in turn has increased the problems associated with the provision of health services.

The growth and shift of population, its mobility, increased urbanization, and the changing income distribution have all led to a growing concern with the mechanics or organization for the maintenance of the best possible health care for all Canadians and the provision of service facilities and finances to reach this goal.

In order, therefore, to be able to assess objectively the facilities and personnel needed to achieve this goal we concluded that we had to examine in detail the health status of the nation; the existing health services; present problems, deficiencies and future requirements; the educational potentialities for health personnel; health costs, present and future, and their effect upon the Canadian economy as well as the ability of the Canadian economy to support an extended programme.

This we have done in the succeeding chapters of this volume, citing in support of every recommendation made in Chapter 2 the background material and evidence upon which we have acted, so that the merits of each recommendation may be weighed in the light of that evidence.