

Medical Economics

STATE OBSTETRICS*

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From the point of view of the physician in general practice in this Province the most important branch of medicine with which we are concerned, and probably the most important from a national health standpoint, is obstetrics. It is the beginning and foundation of every country practice. The lives of our mothers and the generations to follow depend on the skill and care with which it is conducted. Every one of us sees an occasional case of tuberculosis, carcinoma, cardiac disease, and quite a few abdominal conditions requiring surgical interference, but the obstetric case we always have on hand, the only one in which two lives are involved, one of which is subject to all the hazards of pregnancy in addition to the ordinary hazards of living.

That pregnancy is a hazard is borne out by the following figures. In 1933 the maternal mortality for the Canadian Registration Area was 5 per 1,000 births. Then we have an infant mortality rate of 73 per 1,000 births, many of which are the direct result of inadequate pre- and post-natal care. During the years 1929 to 1933, inclusive, there were 521 maternal deaths in the Province of Saskatchewan, a yearly average of 104. This is a high toll of womanhood for perpetuating the race. These figures, of course, refer only to deaths. I have no means of ascertaining the morbidity or the aftermath of gynaecological conditions secondary to unskilled attendance at birth.

I believe that this mortality rate can be very definitely reduced. My own experience is only for ten years, but during that time there have been 6 maternal deaths in our district of which I have positive knowledge. There were 3 from eclampsia and 3 from hæmorrhage. Not one of these patients was seen by a physician until the sudden onset of convulsions alarmed the family or the failure of the attending midwife to deliver the placenta and the volume of blood lost, coupled with the evident pallor and distress of the patient, finally moved the midwife, relative or neighbour woman to procure the services of a doctor, unfortunately in each of the above-mentioned cases without avail. I therefore submit that our maternal mortality is largely in that group who, for various reasons, never consult a physician at any time during the gestation period, or even at parturition. What then is the remedy?

During the past five years there have been more attempts at legislation to provide medical

service than in any other five years of our national history. For example, we have the Winnipeg Relief Plan, the Alberta Health Insurance Act, the Administration of Medical Relief by the Ontario Medical Association, and a very definite increase in the number of Municipal Doctors in our own Province, and, in addition, a lot of talk and writing about Health Insurance, State Medicine and Medical Economics. Most of these attempts are seriously handicapped by the lack of statistics. It seems quite impossible to estimate what a medical service may cost, and one plan at least is a definite attempt to ascertain these figures for a given area and population in the Province of Alberta.

It is my belief that State Medicine applied to the field of obstetrics alone offers two unparalleled advantages:—

1. A very definite contribution to the national health of our people by a reduction of maternal and infant mortality;
2. A fundamental measure towards a solution in great part of the medical economic problems of the man in general practice.

We already have complete State Medicine for tuberculosis, partial for venereal diseases in our larger cities, partial in public health, and to a limited extent in obstetrics, by way of small grants from the Provincial Government to indigents who make application early enough. I think, also, we can fairly include the operation of the Workmen's Compensation Act. I wish to point out that none of these innovations seriously upset our old system of practice, and each has been a definite advance.

I do not think for a moment that our present system is adequate, but I certainly do not condemn it in its entirety. It does not limit private enterprise and personal initiative and talent. It is founded on the fundamental principle of free choice of doctor and a sympathetic relationship between the patient and his physician. It provides keen competition, which is the most effective stimulus to the mental faculties of the average physician. The following are its chief weaknesses:—

1. *Limited Service.*

On account of the limited service now extended, especially in the field of obstetrics, more and more mothers have availed themselves of the services of midwives, all of whom are incompetent by training and equipment to care for even minor emergencies. You have all had experiences similar to the following. During the present summer I have been called to two cases which presented some difficulty. One was that of a large baby, 13 pounds, which apparently gave no trouble until after the birth of the head. The shoulders would have come easily with a bit of manœuvring, but when I

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arrived twenty minutes after being called the baby was dead. The second call was to attend a baby that did not breathe immediately after birth and was subjected to unreasonably rough artificial respiration which, in my opinion, caused its death.

2. Poor Distribution of Physicians.

Another outstanding failing in our present system is the poor distribution of physicians. General practice in the country has few rewards and many griefs. The natural tendency for those engaged in such practice is to hope for a time when they may work under more favourable conditions. The Municipal Doctor scheme is nothing more than an attempt of various municipalities to secure the services of a competent physician in a rural area to provide primarily a good obstetrical service.

3. Schedule of Fees.

Our schedule of fees favours clearly the surgical side of practice. For example, the fee for a simple interval appendectomy, not including the assistant or anaesthetist, is three times that of a maternity case. The former requires 25 to 40 minutes with adequate facilities and help, the latter rarely less than three hours, and the doctor is handicapped by lack of facilities, no help, with usually a more or less lengthy drive included.

4. Lack of Cooperation.

We know that in a properly conducted case of obstetrics the patient should consult her physician immediately after conception, remain under his supervision throughout the period of gestation, be attended at parturition, and get the final examination six weeks later. If the patient is thirty years or older, routine examination of the cervix by speculum when the baby is one year old is good prophylaxis. Under our present system it is impossible to secure adequate cooperation, to say nothing of fees, for such services.

5. Lack of Adequate Care.

So far as obstetrics is concerned the tendency is to minimize adequate care, perhaps because the remuneration is insufficient, and because of the natural human tendency to devote ourselves to better gain. The unfortunate result is that surgery is the objective of the majority with any sort of hospital facilities, whereas it should be obstetrics, to the inevitable detriment of both.

The remedy I propose is similar to that in effect for tuberculosis. Chapter 263, Revised Statutes of Saskatchewan, 1930, An Act Respecting Sanatoria and Hospitals for the Treatment of Tuberculosis, states:—

Section 25.—(1) The Board shall apportion that part of the net estimated expenditure to be borne by the municipalities among all the municipalities of the Province, both urban and rural.

(2) The proportion of the net estimated expenditure to be borne by the urban municipalities shall be 40 per cent, and the proportion to be borne by the rural municipalities shall be 60 per cent.

(3) The Board shall apportion that part of the net estimated expenditure to be borne by urban municipalities among all such municipalities, and that part of such expenditure to be borne by rural municipalities among all such municipalities on the basis of their total equalized assessment for the preceding year, as shown in the statement forwarded to the Board by the Saskatchewan Assessment Commission under Section 30.

Section 26.—On or before the fifteenth day of April in each year the Board shall mail to the clerk or secretary of each municipality a notice showing the portion of the net estimated expenditure to be borne by the municipality, and giving the following particulars, namely:—

- (a) The number of patients who received treatment and care under Section 40 during the previous year;
- (b) The cost of such treatment;
- (c) The total sum received or payable on account of such patients by grants from the Province during the preceding year;
- (d) The total equalized assessments of the municipalities of the Province;
- (e) The total amount of estimated expenditure to be borne by municipalities.

As specific examples under Section 26 I quote the particulars for the Province, which also shows the proportion payable by the Town of Rosthern and the rural municipality of Rosthern, No. 403, for the year 1935:—

1. Number of patients who received care and treatment during 1934.	7,056
2. The cost of such treatment. \$	655,210.49
3. The total sum received or payable on account of such patients by grants from the province for the year 1934.	284,081.00
4. The total equalized assessments of the rural municipalities of the province.	889,831,934.00
The total equalized assessments of the urban municipalities of the province.	220,122,640.00
The total equalized assessments of the municipalities of the province.	1,109,954,574.00
5. The total amount estimated expenditure to be borne by municipalities:	
Urban.	137,485.09
Rural.	206,227.63
Total.	\$ 343,712.72
6. The equalized assessment of the rural municipality of Rosthern, No. 403, is.	3,964,017.00
The equalized assessment of the town of Rosthern is.	881,279.00
7. The share of estimated costs of treatment payable by the rural municipality of Rosthern, No. 403.	918.60
The share of the estimated cost of the treatment payable by the town of Rosthern.	550.44

This system has worked well. We rarely hear of anyone complaining of the tax being a burden, and the results achieved have been excellent. Saskatchewan today boasts one of the lowest death rates from tuberculosis in the world.

A fee of fifty dollars for every maternity case should be paid the attending physician directly by the Provincial Government. This would apply to everyone, irrespective of means. The cost of such a scheme can be accurately estimated, the following being the Table for the Province of Saskatchewan:—

<u>Year</u>	<u>Number of Births</u>
1932.....	20,814
1933.....	20,145
1934.....	19,959
Average.....	20,306

With the foregoing average the cost of the scheme per annum would be \$1,015,300. The equalized assessments of the Municipalities of Saskatchewan for 1935 having been set at \$1,109,954,574, a tax of one mill would produce the sum of \$1,109,954.57, more than enough to cover the average yearly cost. According to the 1931 census the population of this Province was 921,965, divided as follows:—Rural, 630,880 (68.4 per cent); urban, 291,085 (31.6 per cent); making the per capita cost of the scheme \$1.11. The tables used above, which are based on data provided by the Saskatchewan Anti-Tuberculosis League, are offered out of compliment to the excellent work of that League.

Some of the benefits which would result from such a plan are as follows:—

1. Our obstetrical cases would be properly conducted.

2. With our cases properly conducted the aftermath of bad obstetrics would be minimized.

3. There is no interference with competition, and personal initiative and skill would receive its own reward.

4. The foregoing three would ensure that every case would receive the same amount of good care.

5. Most of the financial problems of the man in general practice would be solved.

6. Some remedies already introduced would be discarded, *e.g.*, nearly every municipal doctor would receive sufficient remuneration from his obstetrical service to enable him to tear up his contract and continue to practice in the same district without being subjected to dictation, interference, or unfair dismissal.

7. We can accurately estimate the cost of such a scheme to the people of this Province, and the present machinery for the collection of taxes in the Province could carry on without being increased.

8. The present system of medical practice would not be disturbed. The fundamental principle of free choice of doctor and the sympathetic relation between the family physician and his patient would be conserved.

9. The problem of midwives would be practically eliminated.

10. Surgery and obstetrics would be improved, as the incentive to avail oneself of a more attractive branch of medicine would be largely removed.

11. There would be a better distribution of physicians. Any district that offered a population with thirty to forty maternity cases per year would be assured of a resident doctor.

12. It would be a measure of considerable assistance to a major problem confronting our young married people in these trying times.

13. A routine visual examination of the cervix of every woman over thirty years of age one year after each confinement would reveal early carcinoma in quite a few cases and gynaecological defects which could be readily remedied.

14. Hospitalization of patients, especially primiparæ, would be facilitated.

15. The rural population would not be penalized by way of fees for mileage because of being resident at a distance from a doctor.

16. Vital statistics would be accurate and promptly recorded. This, no doubt, would be more appreciated by the Department of Public Health than by us individually.

Our Province is essentially rural. From Prince Albert to the International Boundary we have no raw materials but grains, and these can be stored and transported much more cheaply and easily in the raw state than after milling. We are lacking in coal, iron and oil. Under such conditions it is fair to assume that for many years to come we, as a profession, will be mainly doctors in small towns serving adjacent rural communities.

The foregoing plan, if adopted, would provide: (1) proper maternal welfare; (2) assurance to the practising physician of the backbone of his economic structure in return for this national service; (3) freedom from any political stigma. It is not a new form of State Medicine. Attempts to socialize a profession or industry in an unsocialized State have so far been futile or impractical. It is however a subsidy which can be counted upon to preserve the merits of the existing system and obviate the evils of an untried one.

* DOLLARLESS DOCTORS AND PENNILESS PATIENTS*

President Roosevelt may yet tell you how to pay your doctor's bills. In his message on social security he refused to touch on the matter, but he promised to do so soon. You may expect some legislation right away, although the American Medical Association, for your good, will oppose it! Three broad systems of paying for medical treatment are in sight:—

One, the present system of Private Practice.

Two, the spreading system of State Medicine.

Three, the budding system of Sickness Insurance.

Experts with vested interests are fighting over these systems most maliciously.

I have no special interests in any one of them. Therefore I shall tell you without excitement or prejudice what each system stands for. Then you can choose the one which fits your principles

* Speech by Myron Weiss, Associate Editor of *Time*, The Weekly News Magazine, New York, over the National Broadcasting Stations.