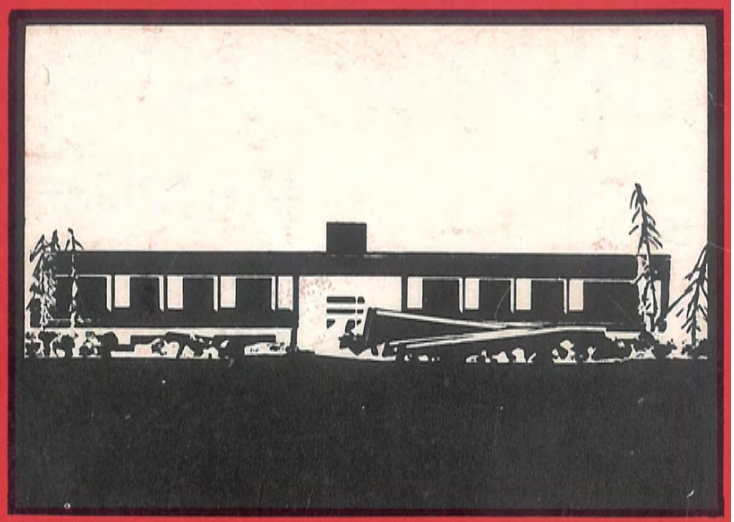
THE FIRST TEN YEARS



By DENNIS GRUENDING

CONTENTS

Cover Design BETSY NAYLOR

PREFACE

This brief history of the Community Health Services (Saskatoon) Association was written at the invitation of its board of directors. An initial draft, submitted early in the autumn of 1973, was read by members of the Association's staff and board of directors. Their comments and suggestions have, I believe, contributed to the accuracy and balance of the final draft. I thank them. Any errors, omissions, or inaccuracies, of course, remain my responsibility.

Dennis Gruending
March 1974

Saskatchewan's Community Clinics: Origins

Two black telephones sitting in a bare room of the third floor of Saskatoon's old Avenue Building was hardly an auspicious beginning for two doctors and a small group of citizens to pioneer the community clinic on that warm, gusty morning of July 3, 1962, armed with only their medical bags, doctors Joan Witney-Moore and Margaret Mahood settled into "a new venture in health care". Executive members of the fledgling Community Health Services Association (CHSA) went scavenging for equipment. They found folding tables at the Union Centre and hauled them back. Covered with mattresses, they became examining tables.[1] The doctors were busy until midnight.[2]

Events in 1962 precipitating the opening of community clinics had provoked deep and emotional rifts in Saskatchewan, grabbed headlines and filled newspaper columns throughout North America.

The Strike

On July 1, 1962 a majority of Saskatchewan's 725 practising physicians went on strike opposing the CCF government's introduction of the first universal, tax-financed, medical care insurance plan in North America.

Saskatchewan Premier T. C. Douglas, speaking in a 1959 provincial by-election, announced his government's intention to introduce the plan, fulfilling a promise made before the CCF rise to power in 1944. "The Premier had fired the first volley."[3]

A provincial election in 1960 became a "medicare" election. Provincial doctors, by that time conveners of their own insurance plans, united behind the powerful College of Physicians and Surgeons in opposing a government plan. Their opposition allied them with the Liberals and other forces of reaction in the province's basically two-party politics. Even before citizens returned the CCF with an increased majority in the 1960 election, a 12-member medical care advisory committee had been appointed under the chairmanship of Walter Thompson, former president of the University of Saskatchewan. The committee reported in September 1961 accompanied by two minority reports.

The committee unanimously agreed some form of medical care insurance should be extended to as many persons as possible. It agreed, too, that a medical care plan should support comprehensive complementary services and facilities which would achieve more than simply ensuring payment of doctors' bills. One minority report, signed by the three doctors representing organized medicine on the

committee, and the Chamber of Commerce representative, supported a plan available to everyone through existing, private agencies, with government subsidizing payments for those poor who could not pay premiums. Another minority report, tendered by the Saskatchewan Federation of Labor representative, supported a plan administered through the Department of Public Health, and one which would place doctors on salary.

In November 1961 the Saskatchewan Medical Care Insurance Act was passed, based upon the Thompson committee recommendations for a fee-for-service plan supported by taxes and a premium, and administered by a public commission. The profession was unhappy. It said the Thompson committee simply rubber-stamped political promises made in 1959 and 1960. Government legislation accepted the majority report rather than the profession's minority position. Relations between profession and government became more strained than ever. The doctors refused to collaborate in appointing a Medical Care Insurance Commission, which was finally named in January 1962 to administer the act. Although April 1 was the tentative date for commencement of the plan, the profession refused to negotiate terms of acceptance until late March.

Negotiations were hardly cordial, and both sides established battle plans. After negotiations broke down April 11, the government made emergency plans to recruit out-of-province doctors to practice under the plan. The doctors, supported politically by the Liberals and by other provincial organizations, were bolstered by Keep Our Doctors committees, allegedly initiated by Regina housewives fearing the loss of their physicians, but soon a catchall for anti-government forces. Government and medicare supporters rallied in their own groups, notably the Citizens for Defence of Medicare.

As negotiations resumed late in June in a last, hopeless attempt to avert a doctors' strike after the new implementation deadline of July 1, the Saskatoon Board of Trade dutifully warned tourists to stay away after July 1 or risk their lives. The Star-Phoenix, local Liberal daily, while pleading for calm, carried a "countdown" to the medicare date of July 1, and its editorial page compared Franco's Spain to Douglas' Saskatchewan, asking rhetorically, "Can't It Happen Here?"[4]

Fear, tension and emotionalism ruled in Saskatchewan between July 1 and July 23. While government and doctors negotiated, trading accusations, the KOD committees staged revivalist rallies and planned to converge in protest, 40,000 strong, upon the legislature. There

was talk of violence. The KOD's did march on Regina, drawing 4,000 peaceful protestors. Minor violence did occur, when opposition leader Ross Thatcher was widely photographed kicking at the door of the legislature, which Premier Woodrow Lloyd would not open for the special occasion.

The loudest call to arms during the tense days came from Father Athol Murray of Wilcox, collarless Catholic priest, "commie" hater and rugged individualist. Father Murray berated the government and its supporters in a series of KOD rallies. At a Saskatoon rally, carried live by provincial radio networks July 6, the père described a "wave of hatred sweeping Saskatchewan". He predicted violence and bloodshed, while admonishing the "reds, whom", he said, "he could smell in the audiences."[5]

Negotiations to end the strike continued in Saskatoon between provincial cabinet representatives and the College of Physicians and Surgeons with a member of the British House of Lords finally acting as mediator. An agreement to end the strike was signed July 23 in Saskatoon. Early in August a special session of the legislature passed amendments to the original act.

Community Clinics

In Saskatoon a small group of doctors and consumers began in January 1962 to make plans which would counter the profession's anticipated resistance to medical care legislation.[6] The idea of a medical clinic sponsored by doctors and consumers in partnership made the social circuit with several doctors sympathetic to medical care, labor and farm movement people, university professors and others.

Clinic pioneers were socialist in their thinking, supporters of the CCF and the provincial co-operative movement. They believed medical care was each citizen's right, not a privilege of the affluent. They supported a government introducing medical and other reforms. Many early clinic organizers were active in the CCF party and had campaigned for medicare in the 1960 provincial election. They did not want to see organized medicine and the Liberals defeat government on the medicare issue.

However, it was the immediate medical crisis, not theoretical socialist thought, which rallied thousands of Saskatchewan families to support community clinics in 1962. Less apparent is just how advanced the thinking was on alternative methods of delivering medi-

cal care involving consumers on a continuing basis, and increasing the emphasis upon preventive medicine. Some members of the Saskatoon clinic's original board of directors say they had little sophistication in the "politics of medicine" or alternative methods of its delivery. They were reacting to an immediate medical and political crisis. They credit the founding doctors with vision and a desire to make delivery of health a co-operative venture.[7] One of the founding doctors says her primary reason for getting involved with the clinic was a "philosophical attitude" toward medical care which considered the patient an equal in participating in the planning of the delivery of care. Support for the government on the medical care issue and a determination that citizens should not be without medical care during a strike were important, but secondary, reasons.[8]

The frequency and tempo of preparatory meetings quickened during June when a doctors' strike became imminent. A small gathering on June 24 led to the calling of a public meeting Wednesday, June 27 to plan for the emergency. The fifty persons attending the June 27 meeting established plans for a new group-practice, medical co-operative practicing under medical care insurance legislation. A five-member provisional board of directors was elected with Clarence Lyons as interim chairman. They were given the task of arranging finances, staffing and housing for the practice.

A press release emanating from the June 27 meeting attracted the first medical recruit, Dr. Joan Witney-Moore.[9] She was joined by Dr. Margaret Mahood, a psychiatrist, who resigned from the Saskatchewan Hospital in North Battleford to work in the clinic, and Dr. Sam Wolfe, professor of social and preventive medicine at the University of Saskatchewan, who said he would be available for house calls and consultation.

The immediate problem in July 1962 was to provide medical care for everyone seeking it. Provincial doctors, almost to a man (few were, or are, women) supported the college's directive to strike, although emergency stations were staffed. Dr. Wolfe, a member of the first medical care commission, and other commission members had recruited some doctors in Great Britain. The recruits became crucial to the clinic's survival.

Dr. Ida Fischer, an experienced doctor from a London group practice, had the misfortune of being sent to work in Biggar upon her arrival in Saskatchewan July 1. After being accused of being an incompetent and an opportunist by Biggar's striking doctors, the KOD and the local newspaper, Dr. Fischer was forced to leave the

town. She joined the Saskatoon clinic July 13. At the end of July she returned to London, her practice and her family, just as she had promised when she arrived.

Other British doctors worked during July and left. Dr. Moore left after the initial crisis. British "strike-breaking" doctors, who came to stay, were Reynold Gold and Michael Smith. Ted Tulchinski, a young Canadian graduate, joined the staff as well. Along with Dr. Mahood and Dr. Wolfe, who had resigned from his university post July 19, they formed a nucleus of doctors committed to the clinic.[11]

Few physicians during the strike would openly defy the college by supporting the concept of public medical care insurance. Fewer still came forward to lead the community clinic movement. However, several doctors in Saskatoon made themselves available to the clinic for emergency and house calls and consultation during the 23-day strike.[12]

While the medical group was being established, members of the Association began what was to become their continuing role of providing facilities and funds. By July 11 the board was contemplating a move to larger quarters. Early in August clinic facilities were relocated in roomier quarters on the second floor of the same Avenue Building. Initial financing was provided by Credit Union loans of $1,000 each, floated by two board members for the purchase of medical and office equipment.

Co-operation and Health

Contrary to romantic notions of some political historians, the works of Karl Marx are not required reading in every Saskatchewan home. Yet, the province, with its history of populist, third-party politics and co-operative ventures, was a logical host for medical co-operation. Saskatoon clinic pioneers were certainly aware of co-operative and political precedents which made their efforts the continuation of an historical process.[13]

Saskatchewan was settled by waves of immigration in the late 1800 and early 1900's. It was, and still is, a sparsely-populated, agrarian province dependent upon the wheat economy, vagaries of weather, and export markets. Its co-operative movement, and the rise of the Christian-Marxist CCF were responses to geographic, economic and political necessities.

Health care provided particular problems in an area where population was scattered and communication difficult. Health care

facilities in turn of the century Saskatchewan were rudimentary. In 1914 the rural municipality of Sarnia, about to lose its doctor, offered him $1,500 annually if he would stay. Sarnia did not develop a multi-specialty group practice, but the free-enterprise delivery of medical care was altered to meet social reality. In 1916 amendments to provincial legislation made it possible for municipalities to collect taxes for paying doctors. By 1930 there were 32 municipal doctor schemes operating in the province.

Hospital services also provided a problem, and citizens again took the initiative in organizing and planning hospital services. In 1916 legislation created union hospital districts, and union boards were established to levy taxes and build hospitals. By 1930, there were 20 union hospitals.

During the depression many Saskatchewan doctors were placed on "relief", receiving a guaranteed wage in the areas hardest hit by drought and poverty. The practice continued until 1942.

In 1938 the provincial government passed the Mutual and Hospital Benefit Act allowing for creation of voluntary health insurance agencies. In 1939 a group of health consumers established a co-operatively sponsored medical care insurance scheme, but they could not recruit doctors to work in their proposed clinic.

The new CCF government, elected in 1944, was committed to sweeping social reforms. Premier T. C. Douglas promised in 1944 his government would establish medical, dental, and hospital services on a universal, tax-financed basis. A health services study commission, headed by Henry Sigerist, professor of history of medicine at Johns Hopkins University, Baltimore, was established to make specific health recommendations. The Sigerist report in 1944 was a radical master plan for health reform.

Sigerist's recommendations included a province-wide hospital insurance plan, which was instituted in 1947, and a pilot project medical-dental care program for the 50,000 inhabitants of the Swift Current health region. The Swift Current plan was an important precursor of both the hospitalization and medical care insurance plans.

Lack of provincial funds, diversion of health money into building hospitals, paying for the hospital insurance plan, and establishing public health regions delayed implementation of medical care insurance, but the government continued to promise it would come. By 1962 hospitalization, Saskatchewan's "socialist experiment", had been adopted by all provinces in co-operation with the federal gov-

ernment, which by that time agreed to share hospital costs. By 1970 all provinces, again with Ottawa's assistance, had introduced universal, compulsory, tax-supported medical care insurance plans.

In Saskatchewan, by 1962 medical care insurance was a concept which had been considered for years. It was a logical aftermath of other reforms which had been introduced. Plans for co-operative methods of delivering health services supported by medical care insurance were a logical aftermath of its implementation. While the government in 1962 was preoccupied with the battle to get medical care legislation operative, pioneers of the clinic movement were already asking, collectively, "What lies beyond medical care?"

Medicine and Reaction

In breaking ranks with the strikers in 1962, the few community clinic doctors were committing professional heresy. Relations between clinics and the College of Physicians and Surgeons became mutually suspicious and defensive. However, time has blunted antagonisms, and it is fruitless to relive old disputes. It may be important for the future of health care in the province, though, to ask why organized medicine has remained a conservative force, hostile to innovation. Has the profession been a pragmatic group, batting down impractical proposals, or has it been a powerful lobby, jealously guarding the status quo and its own self interest?

The profession did not oppose municipal doctor schemes and the doctor "relief" of the depression. By 1943 provincial doctors were discussing the advisability of health insurance, although details of its financing and organization were not considered. The College of Physicians and Surgeons did oppose a recommendation of the Sigerist health services survey commission for a provincial system of rural "health centres" to be administered by a planning commission hiring doctors on salary. The profession opposed having doctors salaried, and said any planning commission should be comprised of persons selected by the college.

The college was not opposed to the Swift Current Health region, initiated in 1946 after a favorable vote in the municipalities affected. Doctors were paid on a fee-for-service basis. But later suggestions for similar schemes in Assiniboia and rural Regina were opposed by doctors in 1955.

A shifting attitude toward medical care insurance may have reflected increasing affluence for doctors, many of whom had begun to practice in Saskatchewan after the depression. Certainly, doctors did not oppose health insurance in principle. By the 1950's private doctor-owned insurance plans were flourishing. (Medical Services

Incorporated and Group Medical Services were the two major plans.) Health insurance had been accepted, but only if it were administered by the doctors' own plans. A new generation of post-depression, increasingly urbanized doctors had replaced the old guard in Saskatchewan. A substantial number of those doctors were British physicians who had opposed implementation of socialized medicine there, and they had little inclination to support Saskatchewan's endeavor in 1962.

The college not only opposed implementation of the medical care plan, but it was unfriendly to community clinics, those hopeless idealists who accepted the philosophy of consumer participation, group practice, and salaried physicians. The clinics were accused by the college's president in 1963 of being "centrally directed and politically inspired".[15] Clinic doctors experienced difficulty in obtaining hospital privileges in several provincial centres during 1962 and 1963. Anti-medicare doctors influenced the decisions of hospital boards. In 1965 the college attempted to force the Saskatoon clinic to cease distribution of a pamphlet, which advised its patients how to use the clinic. The college contended clinic doctors were committing unethical acts by "advertising" for patients, but had to back down when the clinic prepared legal action for the college's interference in clinic affairs.

Recently the Saskatchewan Medical Association (renamed) has challenged introduction of an experiment financing three community clinics on a global budget basis. The association, still chasing socialist bogeymen, has wondered aloud whether the experiment simply promotes "partisan oriented practice . . . a private deal for those who support them (provincial government) politically".[16]

Provincial physicians resisted the concept of group practice when the Hall Commission, appointed by John Diefenbaker's Conservative government, recommended its efficiencies. Dr. John Hastings, chairman of a federal health study which recently recommended establishment of community health centres (not necessarily community clinics), reports his most conservative reaction has been from the Saskatchewan Medical Association and the Saskatchewan daily press.[17]

Like its friendly press, medicine traditionally has been organized along entreprenurial lines. In their book, **The Family Doctor,** Sam Wolfe and Robin Badgely describe the average doctor as a person of prestige and affluence derived from an individual private practice. The skills of physicians have become more and more specialized with the technological explosion in medical science. Left to their free market allocation, the most specialized medical services are concentrated in the richest, technically most advanced countries, and gener-

ally in the urban areas where financial rewards are greatest. If particular sectors of a population do not have an equal access to the services, that is seen as natural within the framework of a society where goods and services are not allocated equally.

Medicine, like industry, has a power elite which makes most of the decisions affecting the profession, its members, and the conditions under which they work. The cohesiveness of individuals behind the power elite may be explained, at least partially, by the education and background common to most doctors. Medical students are drawn from a relatively small pool of upper middle class families where adherence to the free enterprise ethic is strong. Selection procedures for the schools stress academic ability and a background in the physical and biological sciences. Little attention is paid to social sciences and humanities, and in many medical schools departments of the sociology of medicine are either non-existent or considered unimportant. Class and attitudinal similarities in the backgrounds of the students lead to a narrow spectrum of interests. The student's values are reinforced by many medical educators.

The cult of the individual and free enterprise, however, are contrasted by a public which is recognizing medical care as a right, basic to each citizen. A wider accessibility of services has been made possible by the government accepting greater roles in financing medical care. If the public is paying the bill, it should have more influence in the organization and distribution of those services. Organized medicine and individual doctors have opposed what they consider to be an infringement upon their way of doing business. Wolfe and Badgley conclude the cohesiveness of the profession, the influence of its elite, and the structure of medical education all contribute to a paradox. "Although medical technology is at its zenith, the organization of medicine has evolved slowly through the years".[18]

A Waning Movement?

Creation of the Saskatoon clinic in July 1962 coincided with a larger provincial movement. Saskatoon's organizational meeting June 27, 1962 came with a consumers' association already working in Prince Albert, and others in the process of formation. Plans were made for a provincial association to co-ordinate development of the clinics. By mid-July a three-member provincial executive had been named and local organizations were channelling funds to the provincial body. Clinic members, doctors and lay, from populated centres travelled the province helping establish association in smaller towns. The provincial association hired two field workers, one with experience in group practice, consumer-sponsored clinics in the United States. The Group Health Association of America sent speakers to

discuss American experience in group practices. A provincial office was opened.[19]

The Community Health Services (Saskatchewan) Association intended to co-ordinate establishment of a network of clinics, recruiting doctors, publishing a newsletter, acting as a provincial spokesman and lobby for the movement. But hopes for a strong provincial movement faded as anticipated clinics were unable to organize and existing associations failed.

At its peak, the provincial association represented 25 associations which had succeeded in establishing facilities. The provincial office was staffed by two field workers. But, with the end of the strike, both the association and individual clinics experienced hard times. Resumption of medical care in late July 1962 led to a waning popular interest in consumer facilities. The restrictive terms of the Saskatoon agreement ending the strike, opposition of the medical profession, and marginal support from the government all crippled the movement. The provincial office had to close in 1966. The association's deficit of approximately $50,000 was underwritten by $25,000 from Federated Co-operatives Ltd. and an equal amount from the Saskatchewan Wheat Pool. By 1972 only 10 associations were operating small clinics. Only in the cities of Saskatoon, Prince Albert and Regina had clinics been successful in maintaining multi-specialty group practices.

However, the Community Health Associations maintained a desire for some form of unity. In 1970 the remaining organizations regrouped in the Community Health Co-operative Federation with representatives appointed from local clinics. With a new interest in community health centres, there is some optimism that a provincial movement might be rejuvinated.[20]

Saskatoon's clinic shared the difficulties which afflicted the provincial clinic movement. But it has survived as one of the few success stories. It was in an atmosphere of considerable apprehension and tension that the clinic opened its doors July 3, 1962. But, working against the odds, by the end of 1972 the clinic had replaced its two third floor rooms with a $625,000 facility; its initial staff of two doctors had become a 14-member, multi-specialty group practice; 5,000 clinic member families represented a membership population of 15-20,000; more than 50,000 items of service were being provided to clinic and non-clinic patients; an increasing number of member programs and services were being offered.

SOURCES

[1] Interview with Frank Coburn and Clarence Lyons.
[2] *Saskatoon Star-Phoenix,* July 6, 1962, p. 3.
[3] Robin Badgley and Sam Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan.* Toronto: Macmillan, 1967, p. 22. Much of the following section is based upon this book.
[4] *Saskatoon Star-Phoenix,* June 12, 1962, Editorial.
[5] Ibid, July 9, 1962, p. 3.
[6] Interview with Ed. Mahood.
[7] Interviews with Frank Coburn and Clarence Lyons, Ed. Mahood, Jim Naylor, Stuart Thiesson.
[8] Interview with Margaret Mahood.
[9] *Saskatoon Star-Phoenix,* June 29, 1962, p.3.
[10] Interview with Frank Coburn and Clarence Lyons.
[11] Membership meeting (CHSA) Saskatoon, July 30, 1962.
[12] Interview with Margaret Mahood.
[13] Interview with Frank Coburn and Clarence Lyons.
[14] E. A. Tollefson, *Bitter Medicine: The Saskatchewan Medical Care Feud.* Saskatoon: Modern Press, 1963, p. 30.
[15] *Saskatoon Star-Phoenix,* Oct. 15, 1963.
[16] *Toronto Globe and Mail,* July 5, 1972, p.9.
[17] John Hastings speaking in Prince Albert, June 1, 1973.
[18] Samuel Wolfe and Robin Badgley, *The Family Doctor.* New York: Millbank Memorial Fund, 1972, pp. 143-156. The quote may be found on page 151.
[19] L. G. Crossman and Stanley Rands, "Citizen Involvement in Community Clinics". Regina 1972, p. 2. A paper prepared at the request of Community Health Centre Project.
[20] Interview with Stanley Rands.

CHSA (Saskatoon)

Crises and Co-operation

Saskatoon's clinic was a child of crisis. In 1962 it was a new endeavor in organization, drawing upon co-operative precedents, but with no specific model to follow. Doctors found themselves in a group practice, attempting to provide services in co-operation with health consumers. What was a new situation for the doctors was also a novel experience for the consumers. In spite of their zeal and good intentions, the clinic's lay pioneers knew little about organizing structures for the provision of health. The lay board of directors had to learn by experience. A nucleus of committed doctors provided a vital leadership role.[1]

During the first years the whole Association seemed to "run from one crisis to another".[2] Financing was a constant problem. Facilities had to be located and expanded and new equipment had to be purchased. Harassment from the provincial medical establishment and awkward relations with the provincial government threatened the clinic's solvency and its existence. The Saskatoon Agreement was not conducive to delivery of health care by a co-operative of physicians and consumers. The main source of clinic income was earned by the doctors under the Saskatchewan Medical Care Insurance Commission (SMCIC) fee-for-service schedule. At considerable financial sacrifice, doctors used a part of their income to establish and administer the co-operative and to help the provincial community clinic movement. It became difficult, as the Saskatoon Association grew, to recruit doctors who shared a commitment to meaningful consumer involvement in the organization. Ideological differences among doctors were not soothed by the Association's administrative problems and the deficit financing employed by the board. In a co-operative of doctors and consumers problems for either group meant problems for the whole Association.

The difficulties encountered by the clinic must be seen in relation to the tasks which it undertook. Its pioneers were committed to basic changes in the system of delivering health care, a social system which has been most resistant to change. The desired changes reach into the doctor-patient relationship. They would force doctors to trade their individualist mode of practice for one in which they would become accountable to fellow doctors, other health professionals, and to consumer partners. The change is no less significant for the patients, who would be challenged to become involved in planning and running health services, overcoming the "halo of magic and mystery"[3] which traditionally has surrounded the practice of medicine. Ideally, patients would also be expected to demand services which meet the real needs of the population and which are accessible to everyone.

There are apparent difficulties in creating co-operative organizations and maintaining a co-operative mentality within the framework

of a competitive society. The mortality rate of the smaller community health associations created during 1962 in Saskatchewan prove that. However, within a system hostile to it, Saskatoon's Association has developed a respected group medical practice, with auxiliary medical and member health services. It has attempted through its organization to build a co-operative responsive and accessible to its members. And it has been a proponent of change in the organization of health care at the provincial and national levels.

FINANCING: CONSTANT DIFFICULTY

In 1963 the fledgling Saskatoon clinic decided to provide all services medically advisable in a group practice.[4] That decision, sound in terms of providing adequate health care, also provided a constant demand for money. Much of the financing came from the doctors' payments under the SMCIC fee-for-service schedule. The doctors pooled their earnings, paid themselves salaries, and used the money remaining to establish and maintain the clinic. But they could not cover the entire cost of establishing and expanding the practice. The Association's lay membership became a continuing source of loan capital.

Initial financing was secured by two directors negotiating $2,000 in Credit Union loans. By the end of July 1962 a membership and loan committee was created. Although the committee was to be known by different names over the years, it had a constant task soliciting funds.

Monthly deficits at the Credit Union continued throughout 1962. At the year's end a request to the Credit Union for $50,000 line of credit was refused. The board then went to the membership, contacting 30 persons who would each provide $1,000 loans. To fund the expansion of services, the board initiated a special clinic expansion fund during 1964, and $60,000 was raised.

Hospital Privileges

The difficulties encountered by Saskatoon clinic doctors in obtaining hospital privileges during 1962-63 and the legal expenses involved provided a threat to the life of the young Association.

British "strikebreaking" doctors working with the co-operative clinics were hardly favorites in the wider medical community, and they encountered sudden and uncommon difficulties obtaining admitting privileges in Saskatchewan hospitals. Hospitals are publicly financed and they have elected lay boards. However, doctor-controlled medical advisory boards make recommendations to lay

boards concerning the applications of new doctors for privileges. New doctors in nine provincial centres experienced delays in obtaining privileges during 1962-63. Two Saskatoon doctors were among those denied privileges. Complaints from the clinics prompted the provincial government to establish a Royal Commission under Justice Mervyn Woods in May 1963. In Saskatoon, the hearing centred upon Dr. Reynold Gold, a British doctor who had come to the clinic during the summer of 1962. Dr. Gold was refused privileges at City Hospital in February 1963, six months after his application. Dr. Gold's competence was represented by legal counsel and the hearing continued for 15 days.

A report appeared from Justice Woods in December 1963. In Dr. Gold's case, the report concluded that City Hospital, in spite of its "lengthy" investigation, had made no real effort to discover his experience and training. Justice Woods cited "overtones of the medical politics of Saskatchewan . . ."[5] in the evidence he had heard. Acting upon his recommendations, the government passed the Hospital Standards Act in 1964, providing an appeal procedure for doctors denied or delayed in obtaining privileges. That legislation was later repealed by a Liberal government but appeared again after the NDP defeated the Liberals in a 1971 election.

Reviewing Deficits

A continued expansion of membership and services, some inexperience at board and administrative levels, and harassment such as that concerning hospital privileges had combined to make crisis financing a way of life. In spite of the financial sacrifices of the doctors and a membership ready to dig into its pockets, there arose a growing concern over burgeoning deficits and the methods of finance being employed.

A special finance committee was struck in 1965 to review the deficits and suggest methods of "pay-as-you-go" financing. The committee estimated clinic income would not meet expenditures until 1968. It suggested new loans be solicited from the membership to repay old notes coming due. Wherever possible, it wanted old notes re-negotiated for new 10-year periods.

There is evidence the financial problems of the organization were disquieting to the physician group as well. A letter from the medical director to members of the board in October 1965 expressed the group's concern with the "constant financial crises at the level of clinic administration" which were making it difficult to carry out usual operations and plan the necessary expansion.[6]

At its annual meeting for 1965 the CHSA membership accepted finance committee and board recommendations for methods of reduc-

ing indebtedness. The membership also agreed with a recommendation from the facility committee that no new building be constructed until the problem of deficits had been acted upon.

When a legal agreement was signed between the physician and lay groups in 1967, the doctors accepted responsibility to repay $85,000 of what had become a $130,000 deficit. The Association's deficits had been simply classified as back rental owed by the doctors. Payments were to be made to the Association in 15 annual installments of $5,868. The Association agreed to pay the remaining $40,000. During negotiations of methods to repay the deficit sums, it was decided the medical group was in a better position to accept a heavier financial burden than the lay Association. The physicians agreed to accept the greater responsibility.[7]

Under the agreement the Association also agreed to provide funds for the medical social worker, member relations officer and health education programs. Until that time the physicians had paid the social worker and had funded some of the health education programs. Member relations did not become a separate function until 1968. To pay for those activities and to retire deficits, the 1967 membership meeting accepted further finance committee recommendations that membership fees of $10 per family and $7.50 per single member be introduced. An annual membership assessment of $8.50 was introduced as well. The Association also ceased contributions to the provincial community health association in an attempt to curb costs.

Threats from the College of Physicians and Surgeons in 1965 were added stimulus for the Association and its doctors to set their house in order. To inform its members and to attract new ones, the Association published a booklet, "How To Use The Clinic". Late in 1965 the medical director received a letter from the college advising removal of the booklet. Informing health consumers of available services was construed by the college as advertising for patients, unethical medical conduct. Again the Association's doctors encountered unwanted legal bills and the hostility of organized medicine. The Association went to court to get an injunction against the college for interference in CHSA's provision of information to members. The college action was subsequently withdrawn. The booklet soon re-appeared in slightly edited form.

However, the college's hostility emphasized the Association's vulnerability in the absence of a legal agreement between consumers and doctors. Until doctors and Association were recognized as two legal entities, a necessity inherent in the Saskatoon agreement, any successful action against doctors could also leave the Association liable, jeopardizing its ability to provide a service. Lack of any formal agreement among the doctors concerning their share of the deficit

also kept open the possiblity of all debt reverting to the remaining doctors, should several of the group decide to leave.

New Facility

A new facility to replace inadequate housing in the Avenue Building had been considered as early as 1962. The facility committee recommended against building in 1965 at a time when deficits were large. But, after a rental agreement with the doctors and a move by the Association to increase assessment and membership fees, a decision was made late in 1967 to proceed with the new building.

Land was purchased and a debenture drive commencing in 1968 procured $250,000 from members for terms of 10 to 15 years. Once again members were asked to convert their existing demand loans into loans payable after 5 years or more. Co-operative Trust Company Ltd. provided $250,000 in loans and the Co-operative Credit Society $100,000 for a 20-year period.

Consumers and the medical group were both involved in planning a facility for existing and future health needs. At least one physician became a frequent companion of the contractors as they built a modern health facility for an Association which had rented one third floor room just seven years earlier. The Association moved into the new building at the end of 1969. It was designed to house a group practice of 22 doctors, with laboratory, X-ray, physiotherapy, social worker, and member services. It contained additional space which has been used for prescription drug and optical facilities.

Deterrent Fees

A Liberal government replaced the Saskatchewan CCF (by then NDP) in 1964. The Liberals did not, as might have been expected from their stance in 1962, destroy medical care insurance. But they did take measures which the community clinics interpreted as threats to their particular form of organization and to their desire to emphasize comprehensive health services and preventive medicine. The provincial government suspended the clinic's contract for outpatient minor surgery in 1966 arguing the service was available in hospitals. In 1969 the clinic cancelled its contract with SHSP for laboratory and X-ray services because SHSP had reduced the budgets. Pathologist services were arranged by the clinic and lab tests and X-rays began to be billed under fee-for-service. Only physiotherapy continued to be contracted.

However, it was the deterrent fees introduced by the government in 1968 that posed the most serious threat to the clinic's emphasis on

the practice of preventive medicine. They were in direct conflict with the philosophy of giving service to patients at no cost at the time of need. By 1967 the government claimed that patients were abusing the health service system. After the introduction of medical and hospital deterrent fees, patients paid $2.50 per day for their first 30 days in hospital and $1.50 for each additional day. They paid $1.50 for each visit to a physician and $2.00 for home, emergency, or hospital outpatient visits.

Saskatoon clinic personnel became instrumental in a campaign against deterrent fees and in the creation of plans to minimize their effect. The Citizens for Defence of Medicare, a committee representing community health associations in Saskatoon, Regina, Prince Albert and Moose Jaw described the legislation as a "sick tax", a deterrent for the poor in receiving health care, and contrary to the principle of universal accessibility to health care. They argued it was doctors, if anyone, who abused the system. Saskatchewan had the lowest rate of increase of any province in the per capita costs of medical care between 1963 and 1969, and the citizens challenged the government to prove the alleged abuse.[8]

The Saskatoon, Regina and Prince Albert clinics introduced a Mutual Protection Plan. It offered members the option of buying a plan membership for $15 a family or $7.50 a single member and having the clinics pay the deterrent fee. A second plan introduced in 1969 paid hospital deterrent fees and fees of specialists, to whom referrals had been made. Family rates for the second plan were $30, single rates $15.

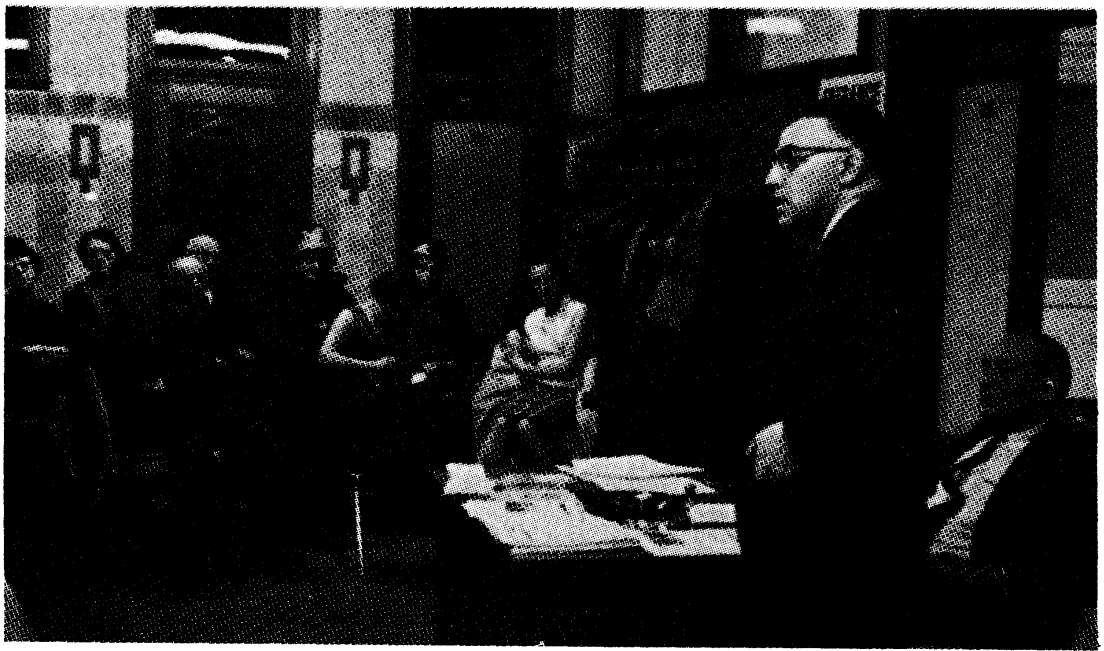
In an effort to attract new members and to make the mutual plans more accessible, the Saskatoon clinic reduced its membership and annual assessment fees. Family memberships were reduced from $10 to $5.00, individual memberships from $7.50 to $2.50. Annual assessments were lowered from $8.50 to $5.00 per family and to $2.50 for single members.

Ironically, deterrent fees, seen as a special threat to community clinics, were instrumental in strengthening them. In a mobilization of public opinion against the "sick tax", the Citizens for Defence of Medicare were able to get 35,000 names on a petition. Deterrent fees combined with the mutual plans resulted in a rapid membership increase in the Saskatoon clinic. In spite of agitation against the fees, they were not removed until the NDP replaced the Liberal government in 1971.

More Deficits.

Expanding membership and services, and a new clinic facility by 1970 may have been interpreted to mean that all was well. However,

Dr. Sam Wolfe and his wife Mary, with Mr. Kalmakoff, Administrator in the background.



Dr. Frank Coburn addresses the third meeting of the 1965-66 C H S A Health Education series. In the chair is Dr. Ed Mahood, C H S A president.

Clinic pioneers Dr. Gold and Dr. Bury.

Dr. Stanley Rands,
early Chairman of C H S A
Provincial organization

Dr. Ed. Mahood
Member of first executive and organizer
of Provincial C H S A

Mrs. Grace Deverell
First Head Nurse at the Clinic

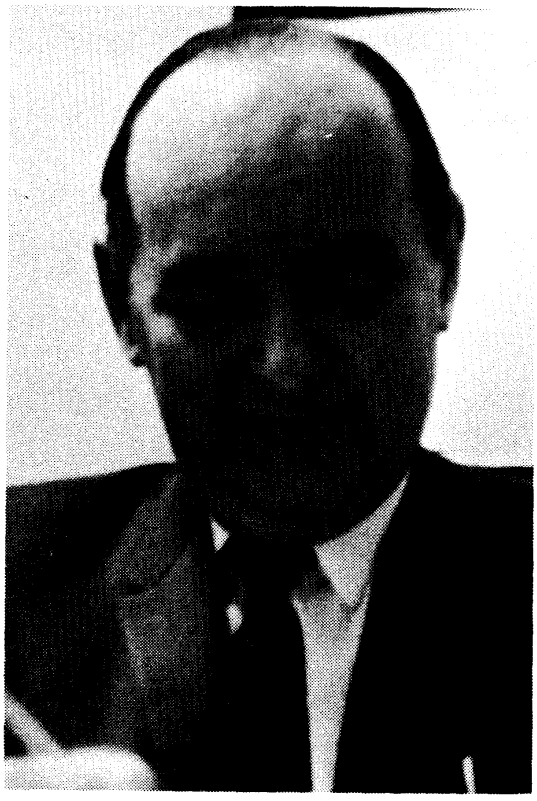
Miss Cunningham
First Medical Secretary

Nurse Enid Smith takes time out of her busy day to look after the needs of the younger set.

850 guests attended the dinner honoring Dr. Sam Wolfe and his family. Seated in the foreground of this picture is the late Woodrow Lloyd, Premier of Saskatchewan and developer of Medicare. Mrs. Lloyd is seated next to him.

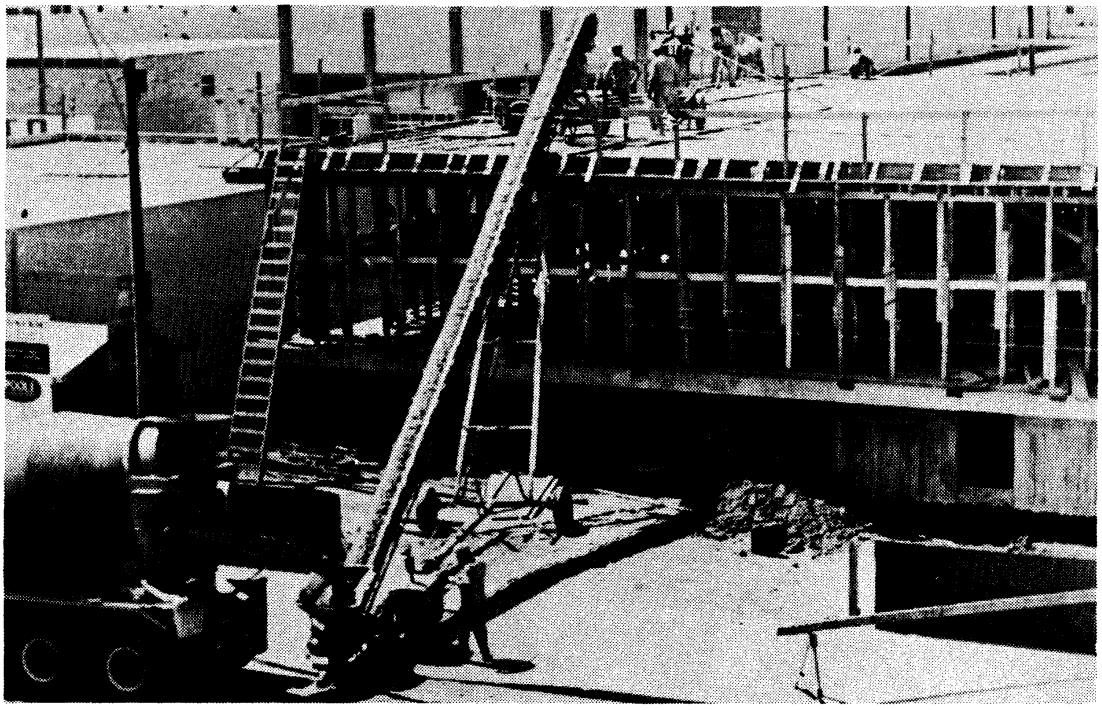
Tekla Deverell, nurse in the Avenue Building with her daughter Tamara

Mother and child await appointments in the kiddy corral.



Dr. Langer
pioneer Surgeon at Clinic

Turning the sod for the new Clinic was Mrs. Carol Buchanan



Work on the new Clinic building was well under way when this picture was taken in 1969.

Mr. Clarence Lyons
First Board Chairman

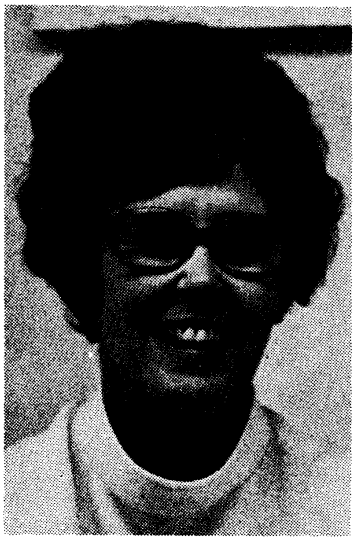
Mr. Robert Carr
Member of CHSA

Mrs. Gwen Belyk
Board Member

Mrs. Greta LeBeau
First Administrator
of the Clinic

Twelve health workers receive 10-years service awards Nov. 14th, 1973

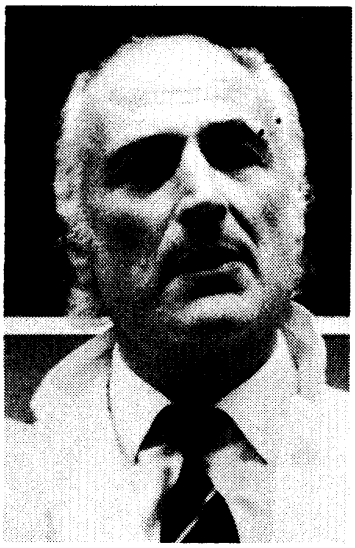
Dr. Margaret Mahood
Clinic Co-ordinator.



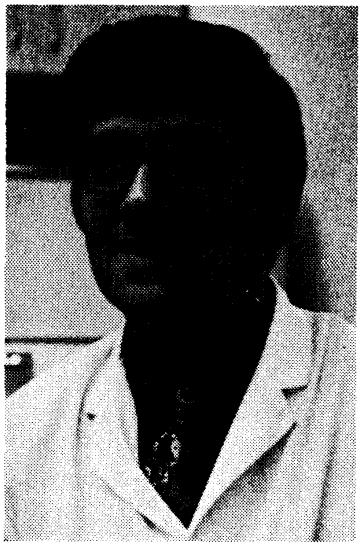
Mrs. Mina McLeay
Receptionist.

Dr. Mel Langer
Surgeon.

Miss Rita Cunningham
Office Supervisor.

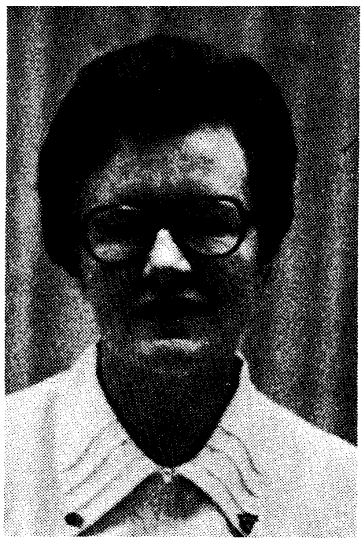


Dr. John Garson
Family Physician.



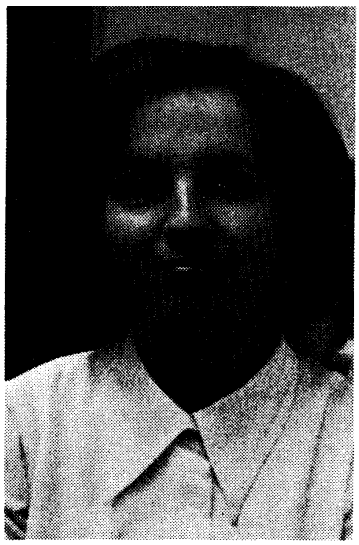
Mr. Al Wonsiak
X-Ray Technician.

Twelve health workers receive 10-years service awards Nov. 14th, 1973

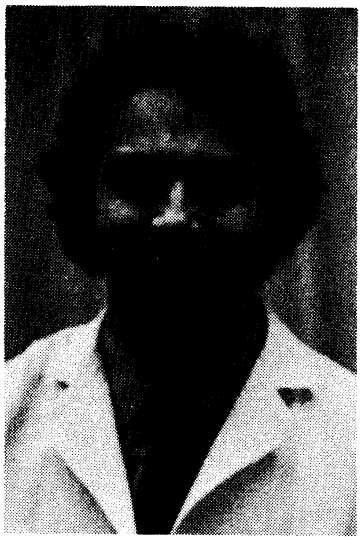


Miss Margaret McIntosh
ECG Technician.

Dr. John Bury
Family Physician.

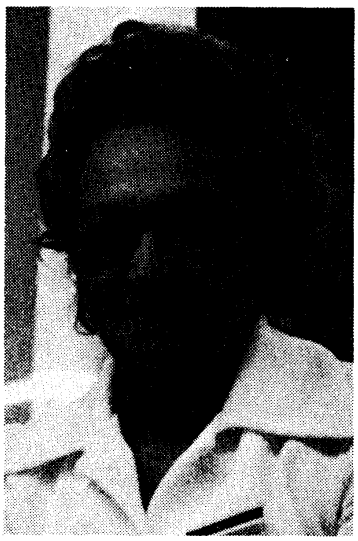


Mrs. Lucille Lavallie
Medical Stenographer.

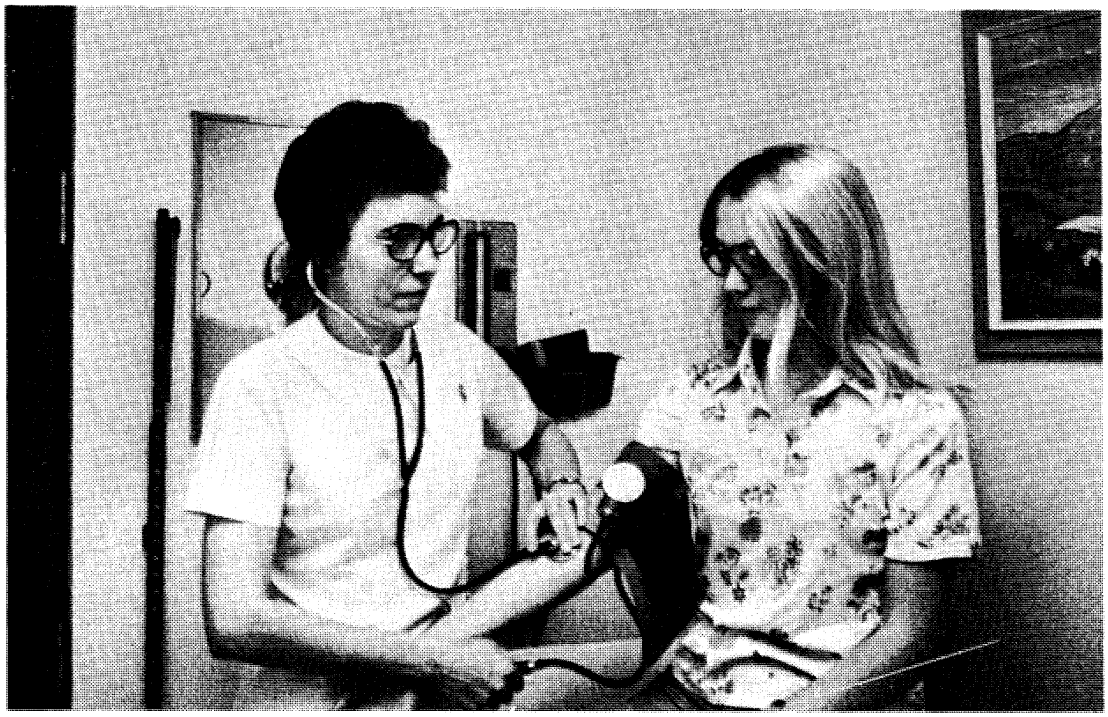


Mr. Clifford Elliott
Medical Records
Technician.

Mrs. Peggy Altwasser
Reception & Records
Supervisor.



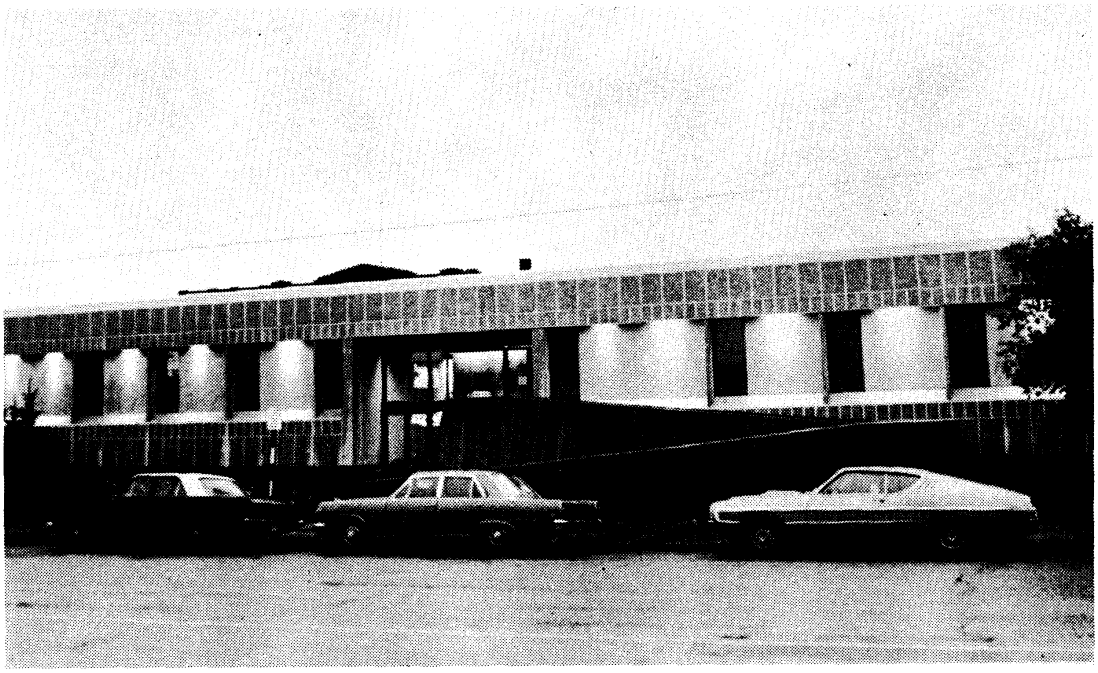
Mrs. Grace Deverell
Nursing Supervisor.



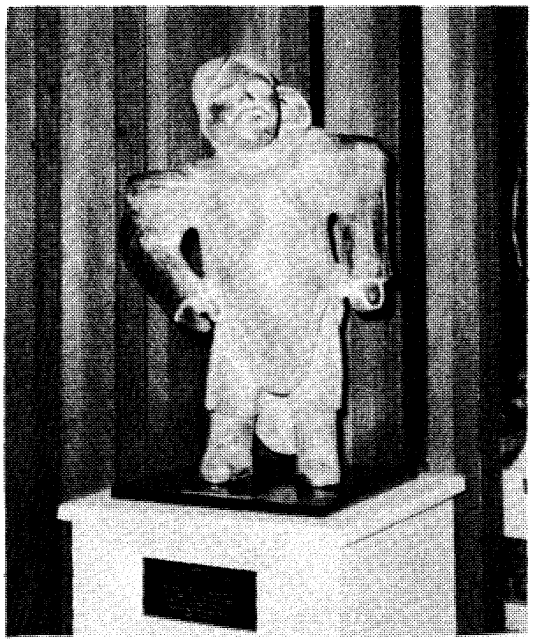
Nurse Lydia Boldt
with patient

Dr. Elsie Hart
long time member of CHSA

Betsy Naylor
Member Relations Officer



The new Clinic at 455-2nd Avenue, North.

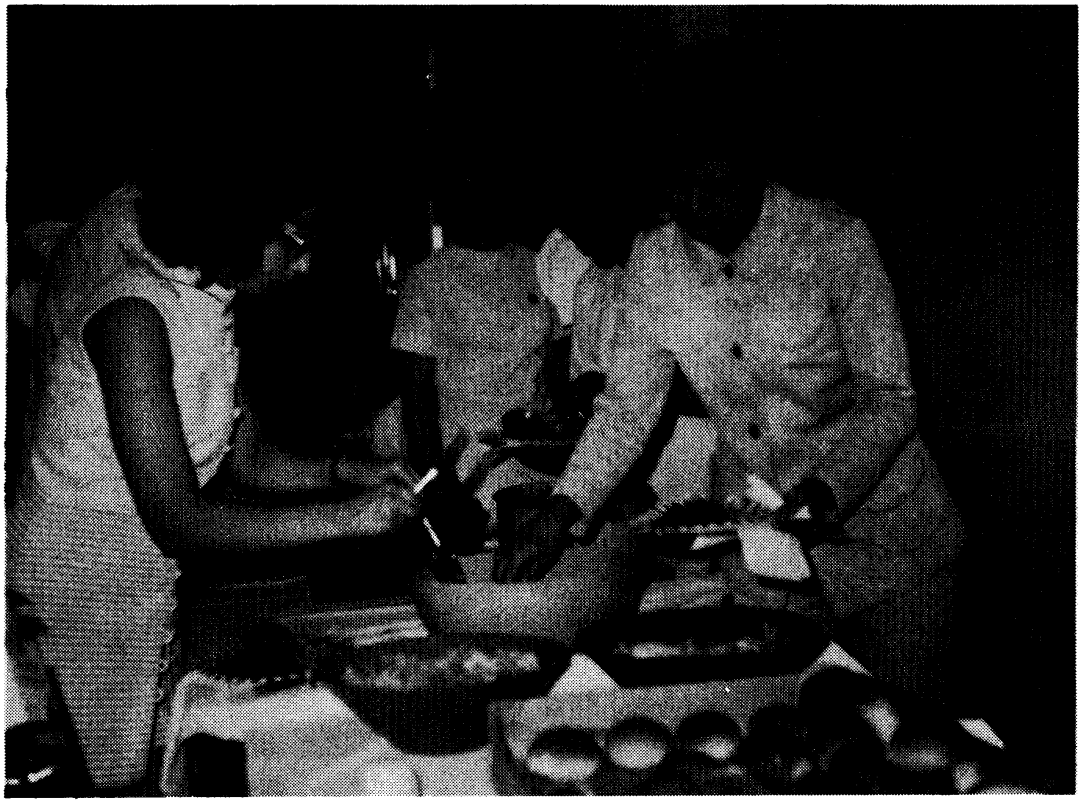


"Mother and Child"
This beautiful carving stands in the main reception area of the Clinic — a memorial donated by the family to the late Mr. Godfrey Chelsom who died in November, 1970. Mr. Chelsom worked on the development of the first Pharmacy.

Anarouk and wife
Anarouk of Ranklin Inlet, N.W.T. is the artist and carver of "Mother and Child"

Health Education — Left to Right: Doug Coxon, Helen Kudryk, Genevieve Teed, Vivian Fisher, Roger Soonias. Member Seminar dealing with the subject "Poverty and its Related Illness."

Our new children's playroom is an added attraction. It is situated beside the reception desk where personnel can keep a watchful eye on the small fry.



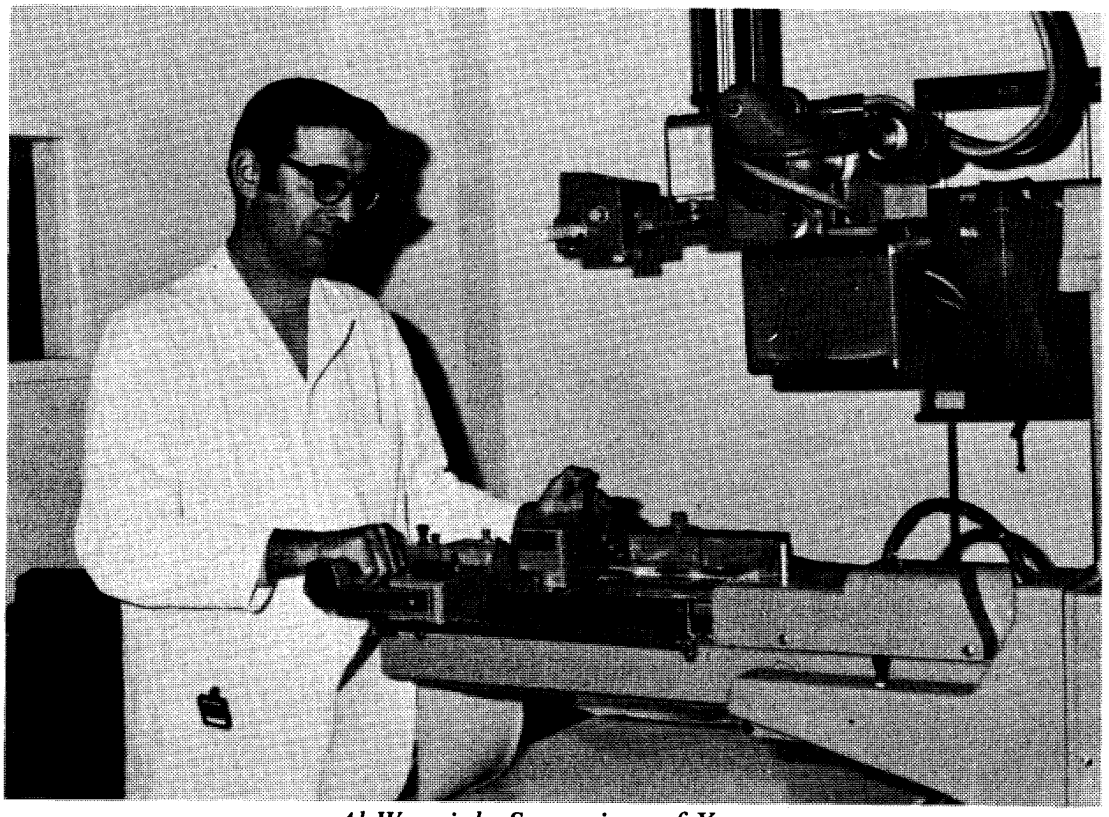
Staff takes time to have a social pot luck together.

C. A. Robson and Dr. Margaret Mahood at sod turning ceremony

Architect Roger Walls taking another shot of the work well done.

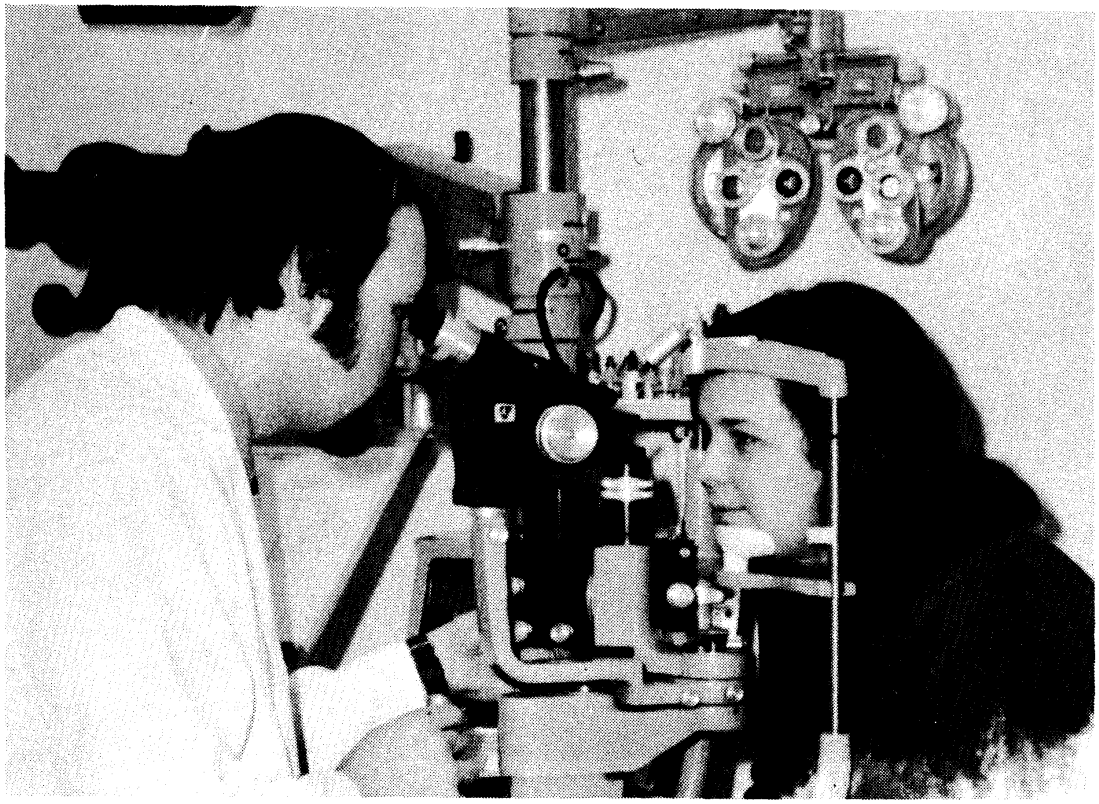
Saturday morning at the Clinic.

The Handicraft and Baking group is one of the member activities that raises money to maintain the Members' Room in the Clinic, for Health Education, and special needs of the membership.

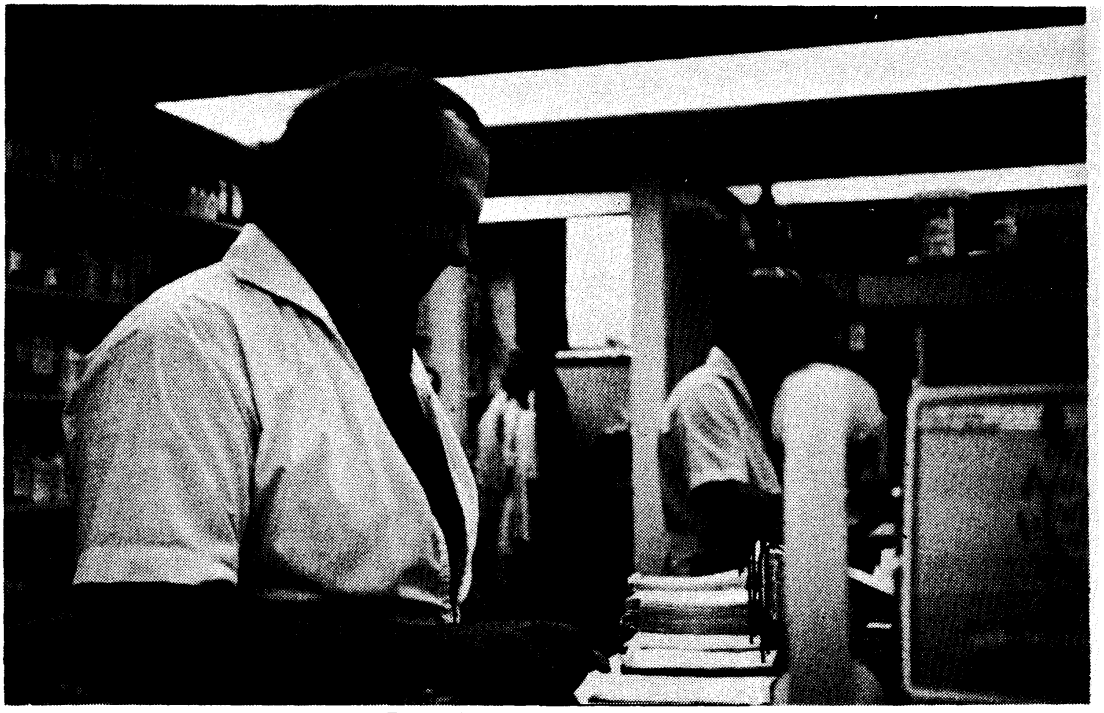


Al Wonsiak, Supervisor of X-ray.

The Health and Fitness Club, at one time named The Diet Club, is an active member group in C H S A



Dr. Hutton, Optometrist, at work.



Stan Rice, Pharmacist.

the clinic experienced some "bad administration". Moreover, the new building, built for a future contingent of 22 doctors, contained only 14 and thus did not produce medical economies of scale.[9] High rental costs in the new building weighed heavily upon physician earnings which still paid most of the clinic's costs.

For a combination of reasons to be discussed later, rifts developed within the medical group. While the board was canvassing for funds to equip the building for expanded services, six physicians left during 1971. A corresponding decline occurred in the items of service provided. A peak of 67,000 items of service in 1970 slid to 63,000 in 1971 and to 50,000 in 1972. It is difficult to assess the impact of the medical migration, but under a fee-for-service system of payment, a declining number of services was bound to affect income. By 1972 the medical group had accumulated a substantial amount of back rental. Approximately $22,000 remaining in the Mutual Protection Plan was applied to that rental after the membership voted the funds to be used at the discretion of their board. The remaining deficit was written off by the Association as at December 31, 1972.

Global Budget

The community clinics had to live with the Saskatoon Agreement. But they never appreciated it. While the medical profession in general opposed any controls over the organization and profitability of the distribution of health care, doctors committed to co-operative structures were eager to work within the province's medical care legislation. The first doctors at the Saskatoon clinic would have preferred to work for a salary rather than under the fee-for-service schedule. The province would have provided money to the Association which in turn would have paid doctors' salaries. A majority of the clinic's doctors have tried to negate the effects of the fee schedule.[10] However, the doctors' role as the money earners reinforced their dominant position in the co-operative.

The circumstances imposed by the Saskatoon agreement made it difficult for the board to accept that it had a really important role to play. One of the lay pioneers says, "It was a job to foist enough non-medical responsibility onto the board so they felt they had some sort of responsibility."[11]

Representations were made by the community clinics over the years for some capitation method of financing which would eliminate the distortions and inequities they found inherent in fee-for-service billing by doctors. Some Saskatoon clinic personnel were involved in drafting NDP health policy prior to the 1971 provincial election, which swept the party to power.[12] That policy vaguely mentioned "alternative" methods of financing health services. In August 1971

clinics in Saskatoon, Regina and Prince Albert began negotiating with the government for the alternative methods mentioned in the health policy statement. Global budgetting, effective March 1, 1972 was the result.

Budgets negotiated between provincial health officials and consumer-sponsored non-profit clinics were established on a baseline, using the previous year's provincial payments under SMCIC and SHSP as a guide. The most basic departure from the old system of reimbursement allows the Associations to hire doctors on salaries negotiated between the lay group and the doctors. Services recognized for budgetting purposes also include outpatient and social services, health education, and nutritional counselling. Negotiations for global payments will occur each year. Expansion of recognized services will be handled in the budgetary negotiations. New programs, or major additions to those existing, must be submitted to the government for negotiation. If accepted, they will be integrated into the new baseline.[13]

There is considerable optimism among clinic personnel that global budgetting may provide an opportunity for better planning of a total health service. Funding will be available in assured amounts, and, depending upon the level of participation health officials demand in clinic affairs, local planning and responsibility may be greatly increased.

While doctors will still be powerful within each clinic organization, both doctors and the board in Saskatoon hope global budgetting will allow consumers to become more completely involved in planning and executing their health service. Serious problems have arisen in the community clinic at Regina between doctors and the board over the degree and type of consumer involvement desired under global budgetting. The problem does not seem to have occurred in the Saskatoon clinic.

Now that global budgetting is being tried, community clinic spokesmen argue that their past sacrifices should be acknowledged. If the government is now going to support and encourage consumer-sponsored clinics, it should assume some of the deficits remaining in the pioneering organizations. A pool of capital providing money at reasonable interest rates should be created for consumer clinics which will develop in future.[14]

MEDICAL GROUP

The nucleus of Saskatoon clinic doctors in 1962 was committed to using a co-operative mode of organization to change the system of

delivering health care. Although the doctors who first joined the clinic had not worked together previously, they shared common interests in supporting the government's medical care legislation and the idea of a consumer-sponsored clinic. The structure and size of the group and of the entire clinic made informal discussion of problems possible and the existence of factions unlikely.

There was no formal agreement among the doctors nor between doctors and the board. Under the fee-for-service arrangement, the doctors earned the money, the board provided the premises, and agreements between the two groups were handled through temporary, constantly revisable agreements.[15] Already in 1962 physicians and the board agreed, quite informally, that Dr. Sam Wolfe should become the medical director.

Within the setting of a group medical practice, it became the responsibility of senior physicians to monitor medical activities and ensure that proper standards and principles were being met. Physician functions became more sharply defined after 1962. The medical staff had an executive; committees were created for technical standards, education and research, records and audit.[16] Doctors developed a regular procedure for reviewing patient charts. Each week a different member of the medical staff would have selected at random the charts of two patients seen by a colleague during the week. The evaluation would then be sent privately to the colleague whose charts had been reviewed. Periodically, open reviews were done by the group of doctors for special cases.[17] The physicians have developed a set of principles and standards corresponding with the ideal practice of medicine and suited to the principles of group practice and co-operation with consumers.

Emerging Formality

As time passed, it became evident the "informal, constantly revisable arrangements" [18] between the board and doctors could not go on indefinitely. By the end of 1964 the medical group had eight members. Rapid expansion of the practice had produced deficits which were being charged to the medical group as unpaid rent. Doctors and the board became especially concerned in 1965 with the deficits and methods of finance being employed. When clinic doctors had difficulty obtaining hospital privileges in 1962-63, and when they were threatened with legal action for "advertising" in 1965, they sought legal advice. Their advisors, upon reviewing the informal arrangements within the clinic, suggested a legal contract was necessary.[19]

The persistence of informal arrangements was also causing some jurisdictional problems by 1965. As the number of doctors and other

clinic employees increased, one staff member became a part-time business manager in 1964. Later the same year a full-time administrator was hired. By 1966 there was evidence of some minor frictions between the medical director and the administration. Stating his desire for a more formal understanding of medical-consumer relationships, the medical director announced that medical care planning, professional and technical matters, and standards of medical care should be responsibilities solely of the medical group. Doctors, in turn, should not interfere with the board's basic task of providing and maintaining the facility. The medical director and administrator should work as a team representing the two groups in co-operation.[20]

When an agreement was signed between the physicians and Association in 1967, it formalized a division into doctor and consumer entities which had really existed all along. The nine signing doctors entered into a partnership which accepted a responsibility to pay a share of the Association's indebtedness. Only the partners in the medical group assumed that responsibility, and partners leaving the group were not liable for a share of the debt, providing that seven partners remained. The partners retained decision-making power within the medical group. After a new doctor had been with the group for a year, he would normally be invited to join the partnership if his peers were satisfied with his competence. Occasionally the partnership was not offered and occasionally a doctor invited to become a partner refused. Medical group meetings were open when they dealt strictly with medical matters. Meetings dealing with relations to the board or with decisions considered philosophical were reserved for partners and full members of the group.[21]

Medical Crisis

As the clinic's medical group grew, it experienced greater internal tensions which eventually led to a "palace revolution" in 1970.[22] There are complex reasons given for disagreements among the doctors which saw three general practitioners and three specialists leave during 1971. The problems were largely ideological and crucial to the continued existence of consumer-sponsored clinics.

In **The Family Doctor** Wolfe and Badgely accept a degree of internal dissension and personal conflict as natural to growing, complex institutions, especially when workers are performing within a new institutional setting. They add the clinic problems were also related to "money and ideology", to rifts in "professional values and personal lifestyles."[23]

A veteran doctor, still with the clinic, describes the differences as mainly ideological, concerning the role of the consumers in the organization. The clinic, as it expanded, often had to hire doctors

opposed to consumer involvement, or at best, neutral to the idea. By 1970 enough of those doctors had become full members of the group to put its philosophy in jeopardy. They formed a faction, which wished to take complete control of the clinic, severing the relationship to the consumer board.[24]

If the problems were philosophical, they also contained financial overtones and disillusionment with some of the Association's administrative problems. The organization was receiving "bad administration" after the move to the new building in 1970.[25] The original administrator was hired for 1965, left the following year, and returned as administrator in 1967. As a move into the new clinic building became imminent late in 1969, there was some concern that the administrator, while loyal to the clinic, lacked the necessary management skills. There was also a desire to move from a manual to a computer system of keeping medical records. Maintenance of records had become a problem as the clinic's caseload increased., It was thought that a "systems man", also an efficient administrator, would be preferable.[26]

A change was made late in 1969. But within a year doctors and the board became alarmed with their new administrator's performance and undertook an appraisal. The complaints included a lack of communication with the staff, questionable hiring and promotional procedures, and circumvention of the board in some matters. The computer plan for maintaining medical records, one reason for hiring the administrator, did not materialize. He was asked to resign, and the present administrator was hired in June 1971.[27]

Problems arising from administration were aggravated by the level of doctors' salaries. Salary levels at the clinic had never been competitive with what most physicians could earn in private practice. In the early days, doctors worked for minimal advances equivalent to little more than half of the gross earnings of the average Saskatchewan practitioner. In 1965 clinic doctors were earning $5,700 less than other urban doctors in the province. Even in 1972, when it was necessary to pay competitive rates to attract young doctors, a senior physician earned $10,000 less than his counterpart in private practice.[28] With the move into the new clinic building in 1970, costs of overhead increased, and a further strain was placed upon the physicians' pooled income. In that situation, some of the physicians, particularly specialists, believed they were not getting a just financial reward.[29]

A joint meeting of doctors and the board in March 1971 to discuss administrative problems saw some of the tensions surface. A summary of the meeting indicates disagreements about medical politics, salary levels, new services, use of space in the new building, and allegations that the medical group was undemocratic. The board of

directors were able to do little about the situation although the chairman was involved in attempts to mediate.

In retrospect, doctors whose service to the clinic dates back to 1962-63 describe the conflict as one between idealists, committed to co-operation with consumers, and pragmatists, who wanted a doctor-controlled clinic.[30] A former chairman of the lay board admits it was basically an idealist-pragmatist split. But he adds the medical group and Association had become inflexible over the years, adding to the possibility of conflict. While there were doctors who came to the clinic for reasons of expediency, there were also socially concerned doctors who were disillusioned with a somewhat intransigent group of veteran doctors insistent upon retaining power. The problem was intensified because the organization did not contain mechanisms to deal with such disagreements.[31]

Partnerships were not offered after 1971. The present medical director says over the years the medical group vacillated between a desire to be open and democratic, and a fear that the group would become diluted with points of view in no way compatible with the idea of a lay-sponsored group. Additional doctors were hired to replace those lost in 1971, but some of the replacements left during 1972. The retiring medical director suggested to the general membership meeting in 1972 that the Association should consider limiting the number of patients served if success in recruiting doctors did not improve. However, senior doctors say they have received a great number of applications from doctors who appear to agree with consumer sponsorship. Additions to the medical staff are being planned.[32]

The medical partnership is being dissolved with the introduction of global budgetting. Although the change is expected to have little impact on the day-to-day running of the clinic, it is potentially significant. With a more predictable source of income, the clinic should become more competitive in salaries, working hours, and other benefits for its doctors. And, if global budgetting strengthens the role of the board, doctors will spend less energy in administration and finance and more in the practice and supervision of quality care.[33]

Medical Services

The number of clinic doctors rose to eight by 1964 and expanded to 14 in 1970. There were 14 doctors working full time early in 1973. Six specialist services are offered, although presently there are specialist gaps. A psychiatrist and surgeon complemented six general practitioners by the end of 1964. Later, obstetrics-gynaecology, internal medicine, radiology, ear, nose and throat specialists were added. Pathologist services were introduced on a consultant basis in

1972. An ideal physician group has been described as 14 general practitioners and 6 specialist services (this might include more than 6 specialists).[34]

Ancillary services were incorporated early, consistent with an intention to provide a comprehensive range of services under one roof. Laboratory services came quickly in 1962; minor surgery, X-ray and physiotherapy were all under SHSP contracts by 1964. In 1970 a check-up centre was implemented, providing patients with a self-administered questionnaire and a battery of tests **before** they see their doctor. Occupational therapy was added on a part time basis in 1972. There are new plans for a foot clinic, a nutritionist, a public health nurse and possibly a dental health program.

The addition of a medical social worker to the staff July 1, 1964 was an unique and important contribution to Canadian group practice. A study designed by the social worker and one of the doctors recorded each referral made over a period of fifteen months. The worker defined the specific nature of each referred patient's problem. The completed study argued that doctors tend to provide principally medical care, while a social worker in a group practice might serve to reduce the length of some hospital stays, prevent others, and direct patients to other sources of help.[35]

The study popularized the opinion that a medical social worker is an integral member of a medical group, and contributed to an almost negligible North American knowledge of the role of a social worker in a group practice. The service has been expanded to two fulltime workers and another is being sought. The workers work with the doctors, especially the pyschiatrist, in providing therapy. They are involved with patient clubs, including group therapy session. One worker works mainly with elderly people.[36]

Drug costs to patients were an object of concern to the board already in 1962. In 1966 a clinic sympathizer, Godfrey Chelsom opened a pharmacy in the Avenue Building. Later that year, in preparation for a clinic pharmacy, research was conducted into the prescribing habits of the doctors. A drug formulary consisting of 225 preparations in 500 dosage forms was prepared. A pharmacist was located and a pharmacy opened in the new clinic building. Since provincial statutes allow only pharmacists or co-operatives registered under the Co-operative Associations Act to run pharmacies, the CHSA acted to incorporate the Community Health Pharmacy as a limited company. One of its three shareholders is the pharmacist, who is also the director and manager of the company.[37]

Two pharmacists and two clerks supply Association members with drugs at cost plus a dispensing fee. Prices to non-members are higher. The drug formulary card kept on every patient allows the pharmacist to watch for compatibility in prescribed drugs and to

avoid drug allergies. In its first full year of business the pharmacy's average prescription cost was $3.11, a 24 per cent saving on the provincial average.[38] Reducing the number of drug preparations and brand names chosen allows bulk purchases, which, combined with realistic dispensing fees, means substantial reductions. In 1972 43,000 prescriptions were filled at an average cost of $3.04.[39]

In 1970 the Association entered an arrangement whereby an optical dispenser provided a 20% discount on retail prices for optical supplies. His assets were acquired in 1971 and he became a salaried staff member. In 1971 an optometrist was hired on a salaried basis. The optical dispenser provides the service at cost plus a dispensing fee similar to the pharmacy. The optometrist, in his first full year ending in October, 1972, saw 2,842 patients.

CO-OPERATION

The basic premise of community clinics is that better health will result when non-profit consumer organizations are involved in planning and providing that care. However, co-operative clinics can flourish only in settings where it is possible to bring together sophisticated groups of citizens and socially-oriented doctors in sufficient numbers.[41] Since consumers were involved from the first in the Saskatoon clinic, they may have been expected to demand that health professionals be responsive to consumer needs and in some way accountable to the consumer partners. The challenge has been to build an organization reflecting that co-operative ideal, and to educate health consumers in the potential of co-operation.

Participatory Health

If a patient accepts good health as something which is his responsibility and not entirely that of the doctor-magician-miracle worker, he is more apt to be interested in acting to prevent visits to the doctor and stays in hospital. When patients are actively involved in their own health and in changing habits which influence it, the emphasis on preventive services, counselling and rehabilitation becomes more important.[42] A preventive approach to illness recognizes there are social causes of disease which may only eventually be diagnosed in medical terms. Disease may arise from the society or the immediate environment in which a patient lives. Counselling, educational and referral services are integral to the "cure" of any malady. The patient, his family, acquaintances and several health professionals may have to participate.

The Saskatoon clinic has attempted to co-operate with patients in providing preventive services and the early diagnoses of conditions. A consumer suggestion made in 1963 that patients be called back for annual examinations has been used. In 1970 the check-up centre was introduced. As a group practice of general practitioners and specialists, the clinic has a built-in possibility for patient referrals. Multi-specialty group practices have a potential for improving delivery of care because they bring under one roof curative medicine with some elements of preventive medicine and rehabilitation. Such practices may also form more effective referral agencies by knowing what public and social agencies are available for patients.

The Association has attempted a number of member services which are not traditionally understood as health services. On the basis of a suggestion made by a consumer committee, seminars have been held since 1963. These deal with various health matters. Clinic health professionals, staff and members often serve as seminar resource persons. A number of patient clubs have been organized around patients with particular interests or conditions. A few of them are the diet club, the home visiting club, and a club for mothers with small children.

The Association's newsletter, **Focus,** which commenced publication in 1964, serves as a tabloid for health information as well as communicating clinic or other activities to the members. **Focus** is apt to carry an article on the common cold or on the arrival of a new staff member. It reports on meetings, carries columns from the administrator and medical co-ordinator, and occasional letters from members. It is financed by the consumers, edited by the member relations officer, and it appears bimonthly. Copies are sent to other community health associations and some of their news is carried.

Programs of consumer education follow logically from the introduction of publicly-financed health plans, which, theoretically, are accessible to all. One problem with plans supported by the public, however, is that not all citizens have equal access to services. Many of the barriers to use of health care follow the divisions of class, income and education, racial origin or location. The question of accessibility to care cannot be left to the unequal distribution of practices characteristic of the free enterprise mode of organization. The issue of public accountability for health professionals, especially doctors, has been opposed by their professional organizations, and it is a sensitive political issue. Members of the Saskatoon clinic learned during the 1962 medical care crisis and the deterrent fee controversy in 1968 that they must not hesitate to take firm, political stands. Patients and health professionals committed to consumer involvement have no choice but to enter a debate which is occurring in the public forum and the political arena.

Clinic personnel admit that not enough has been done in the areas of professional counselling, in reaching out to the low income population, and in educating the mass of health consumers to the potential of consumer-sponsored, non-profit clinics. A lack of funds and trained personnel have been the main drawbacks. One concept being talked about by the membership and staff is that of a "total man clinic". The health centre of the future is conceived as being an organization involving consumers and providing a range of social, preventive and curative services. It would be based upon the needs of the community whereas the medical model of group practice has been based mainly upon the provision of physician services.

Member Relations

In a free enterprise mode of medical practice, consumer satisfaction is judged on whether or not the customer returns. Attempts have always been made in the Saskatoon clinic to provide channels for patient complaints. Dissatisfied consumers could always approach a member of the board. But a more direct mechanism has been built into the member relations function. The first officer doubled as business administrator, but, when an administrator was hired fulltime in 1965, member relations became a separate function, which later was financed by consumer funds. A new officer was hired in 1968. Her most important task has been to hear complaints from patients, doctors, or staff, and direct them to the appropriate individuals or groups. Complaints or suggestions received from patients can be forwarded to the board directly because the officer attends board meetings. A formal, regulated procedure does not exist for her to take patient complaints directly to physicians, but the group has requested her to do so.[44]

In an attempt to reach out to patients and gain a wider response to what they think of the services offered, the officer has, in recent years, conducted member surveys.

The second important member relations task is in consumer health education. The officer co-ordinates activities of patient clubs, is editor of **Focus,** plans and organizes printed material and educational seminars. It is perhaps significant from the point of view of consumer education that she was directly involved in the clinic's opposition to deterrent fees and in the creating of the mutual plans which attempted to negate the legislation.

It has been due to a lack of consumer funds over the years that the member relations function has been staffed by only one person. The officer has also served as a nutritional counsellor and she co-ordinated a drive for clinic expansion funds. The global budget did not recognize member relations as a budget item, but it did recognize

nutritional counselling and health education as health services. More staff working in member relations would free the officer to devote most of her time to the important task of liaison.[45]

Staff and Assembly

Early in July 1962 two doctors and a receptionist staffed a new clinic. Volunteers performed some tasks for the first days. By 1972 the clinic employed approximately 75 people. For the first few years, with a small staff, issues such as salaries, working conditions, or the role of the staff in the co-operative were not a problem.[46] But expansion made necessary some bureaucraticization and a specialization of labor. By 1966 the staff had formed a local of the Canadian Union of Public Employees to bargain on behalf of non-supervisory staff. Local 974 now bargains collectively for about 45 members. A committee of the local and a CUPE representative negotiate with a committee of board and management. Conditions such as an eight-month maternity leave and a rationalization of hiring and promotional procedures have been negotiated by the workers.[47]

As the clinic grew and its organization became more complex, there was a sentiment that staff was not as involved as it could be in the processes of decision making. In 1971 the union appointed a non-voting observer to the board. A union member was added to the list of nominees for the 1972 board and elected at the annual membership meeting. By-laws have subsequently been amended so that up to three clinic workers, who are Association members, are eligible to be nominated for election to the board.

During 1972 some members of the medical and non-medical staffs met to discuss the collective involvement of workers within the clinic. A four-member committee was established to prepare a general meeting to which everyone working in the clinic was invited to discuss the quality of care being provided and morale among the workers. The meeting decided to establish a health workers Assembly. An eight-member executive was elected, and an initial project was a canvass of staff about possible ways of improving the level of service.

The Assembly is voluntary and has no formal links with either the board or the medical group, although there are Assembly members on each. it has the tacit approval of both the doctors and board although neither had to approve its organization. It is too early to judge whether an assembly of doctors, receptionists, social workers and supervisors will result in a free dialogue or have a democratizing effect on decision making. But the Assembly is an attempt to increase the amount of inter-personal communication, and may signal a new sense of looking inward after years of crisis and relative uncertainty.

Administration

The Saskatoon agreement and subsequent legal agreements between doctors and consumers created two distinct groups within the Association. Control over professional matters naturally was assumed by the physicians. The group holds separate meetings, has its own committees, executive, medical director and deputy director, The director or a substitute attend board meetings as non-voting members.

Consumers have a 12-member board of directors elected for staggered, 3-year terms. The board has two major committees: a Landlord committee and an Education and Organization committee, which resulted from a board reorganization of its seven committees in 1968. The Landlord committee is responsible for facilities and equipment, relations with the medical group, clinic staff, and the provincial government. It negotiates the rental agreement, budgets to repay remaining deficits, and commissions research into new health services. The Education and Organization committee plans and budgets for educational facilities and activities, patient service facilities and member information programs. It supervises the programs of the member relations officer, plans for the distribution of **Focus** and other educative materials, and supervises member recruitment. Both major board committees can create sub-committees to meet specific needs.

Initially, doctors had to assume many administrative chores, but there has developed a greater sharing of responsibility with the board and its administrators. The doctors recruited staff which became responsible to the medical director. The director was involved not only in personnel administration, but had responsibilities for financial planning and expansion. Since 1965 administrators, hired by the board and acceptable to the medical group, have been responsible for the day-to-day functioning of the organization. The administrator handles the Association's resources and has responsibilities for short term financial management and longer term financial planning. Presently, the administrator has also been appointed by the board as its treasurer. He is responsible for co-ordination of all non-medical staff through their medical supervisors. The hiring, promotion, or firing of non-medical staff are the administrator's task, but he remains responsible to the board. His contacts with patients are usually indirect, through the member relations office. Staff contacts are through the supervisors, while the medical co-ordinator usually represents the medical group.[48]

Doctors and medical staff remained under the authority of the medical director and senior physicians. Recently, however, doctors chosen by the medical group have to receive the board's approval

before being hired, and advertisements for medical staff are cleared with the board as well.[49]

The board has also had a growing influence in the important matter of choosing a medical director. The first medical director was chosen in an informal agreement between the board and the clinic's first doctors. When he left to set up another health clinic in 1968, his replacement was chosen by the medical partners with the informal approval of the medical group, clinic staff, and the board. The medical directorship changed again after 1972, and the board felt a responsibility to appoint the medical director. The medical group, supporting medical staff, and the union were all canvassed for their choice of director, but the board made the final choice.[50]

The lines of authority in an organization including doctors, allied health professionals, administrators and a lay board of directors are certain to remain dynamic. Disagreements have risen from time to time when non-medical staff thought they should report to the medical director, although they were answerable, in theory at least, to the administrator.[51]

According to the administrator, the greatest single administrative difficulty he faces is one of involving the medical staff in the total planning process of the clinic. The most desirable solution, he says, would be to have either the medical co-ordinator or the administrator charged with total responsibility.[52] The medical co-ordinator cautions that board control and maximal health worker-lay participation have the danger of placing too much power in the hands of the administrator. That can be dangerous if an administrator has been trained only in traditional administrative approaches. Individuals combining both administrative competence and experience in organizing medical care are rare.[53]

In spite of any problems in its first 10 years, CHSA remains convinced it can continue to provide quality medical care if there remain doctors willing to work with lay groups, and lay groups interested in the quality of medical care. The new challenge seems to emerge from the debate surrounding Canada's entire system of health delivery. The potential role of community health centres in a revamped system is being considered. Can CHSA and other community clinics convince planners and the public that the medical-consumer co-operative model should become prevalent?

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An Idea Whose Time Has Come?

COMMUNITY CLINICS: By the Millenium?

Community clinics are an idea whose time has come. Once the radical, unwanted offspring of the provincial medical care dispute, they have achieved a new respectability. Canada, early in its post-hospitalization and medical care insurance ages, is no health utopia. Federal health costs are rising at a rate of 10 to 13 per cent annually. In Saskatchewan health consumed over $200 million, 25 per cent of the budget for 1973-74. Between 1963 and 1972 SHSP costs have mushroomed from $43 to $102 million, MCIC costs, from $18 to $42 million.

Canada's health system is one of the world's most expensive in per capita expenditure. Despite its expense, the health delivery system, based upon its costly, heavily-utilized hospitals, is considered neither adequate nor economical.[1] There is a heavier run on health services, but, even with hospital and medical insurance, the economically and socially disadvantaged are not having their health needs met. In Saskatchewan there is an additional disparity between urban and rural areas in availability and quality of health care.

Governments, always concerned about costs, have become alarmed about insatiable health budgets. A federal-provincial health task force reporting in 1969 indicated a new willingness to examine alternatives, especially those which would cut costs of hospital inpatient care. One task force recommendation was that community health centres be investigated more fully. A Toronto medical researcher, Dr. John Hastings, was given $400,000 in 1971 with a request to report within one year.

Hastings' report in 1972 recommended provincial governments, in consultation with public and professional groups, develop "a significant number" of non-profit community health centres, and, at the same time, re-organize and integrate all health services into a health services system.[2] Hastings' recommendation in favor of community health centres, as non-profit facilities in which the local community has a major administrative authority, gave belated recognition to a mode of organization espoused since 1962 by community clinics in Saskatchewan and elsewhere in Canada.

The Hastings' report recommendations are flexible and general, perhaps too general for the community clinics who would have preferred more detail on methods of financing and the extent of the consumer involvement in the proposed centres.[3] The recommendations, however, indicate a new thrust in the provision of health care and provide a new basis for public debate. Still, Dr. Hastings has wondered aloud if Canadians will "wait until the millenium to change their health services system."[4]

Vehicle for Debate:

Even before the discussion of community health centres became national in scope, Saskatchewan's community Clinics were using government sensitivity about health costs to create a public debate.

Although many provincial health associations were early casualties of the circumstances following the Saskatoon agreement in 1962, clinics in Saskatoon, Prince Albert and Regina succeeded in developing multi-specialty group practices during the 1960's. (Six other associations are operating with smaller groups.)

Early in 1969 the chairman of the Saskatoon association's board of directors announced that clinics were providing a "startling" reduction in the use of inpatient hospital services by their members, and thus saving health dollars for the government.[5]

Provincial clinics, Saskatoon in particular, had been monitoring their practice over the years, creating a body of social science around their delivery of medical care. A Saskatoon Community Health Foundation was created in 1968 to research the cost and delivery of health care. The foundation sponsored a major health conference in Saskatoon during 1969, where statistics were presented indicating that the clinic was providing savings through fewer hospital admissions.

Those claims interested provincial and federal health officials. Dr. Donald Anderson, a University of British Columbia health science researcher, was commissioned in 1969 to determine whether community clinics showed economies not present in other provincial group practices. A report from Dr. Anderson and Anne Crichton, a UBC associate professor of health care and epidemiology, appeared in late 1972.

What is it in the community clinic organization and delivery of health care which might make it less costly while maintaining a high level of service?

Objectives of the CHSA (Saskatoon) have been repeatedly stated. They are: to provide, through a multi-specialty group practice, as many diagnostic and treatment facilities as possible under one roof; to provide a preventive health service with regular examinations, and a program of health education; and, to have consumers own and sponsor the health facility, working in partnership with health professionals. A final objective, as the Saskatchewan government learned in 1968, has been to support a concept of health services available to everyone, regardless of ability to pay.[7]

Dr. Anderson had an initial difficulty in attempting to compare economies because the existing medical records system did not "define" the clinic patient population. In other words, a patient may have used the community clinic and other physician services, but a referral

to hospital may have been made by a doctor not in the clinic. Perhaps a fragmentary medical records system reflects a condition common to the whole health care delivery establishment.

To provide a general study of group practices, Dr. Anderson chose clinics of varying complexity and sponsorship in eight regions of the province. In Saskatoon, because there was no suitable group to compare with the community clinic, a pseudo-clinic was formed by using the records of physicians who did not really operate as a group. Record systems of the provincial department of health provided a data base.

Briefly, Anderson concluded certain complex, multi-specialty clinics, "and particularly consumer-sponsored clinics do have economies in clinic operation which result in higher investigative costs but lower hospitalization rates." His study was to discuss costs, not quality of medical service, but Anderson suggested anything keeping a patient out of hospital might be argued as "good" particularly if total costs were lower.[8]

Complex clinics in urban areas generally provide a combination of higher investigative and diagnostic costs, while reducing hospital costs.[9] But Anderson warns that hospital savings are "fragile at best". They might result from the lowered fecundity ratio of persons attending complex clinics; they might result from the fact that there are fewer hospital beds per 1,000 persons in the cities; they might occur in a practice with high proportions of British doctors, who usually refer less than their Canadian counterparts.[10]

Anderson found the value of consumer sponsorship in controlling costs and quality in consumer clinics an "open matter".[11] Consumers' greatest influence is apparent in fund raising and providing facilities. Other studies provide little evidence to show important differences between the use of plans where consumer sponsorship is important and where it is not. Sponsorship provides little difference in health information and information programs or in consumer satisfaction.[12]

The Anderson report, like the Hastings document preceding it, is concerned with the potential lack of influence community health centres will have upon a cumbersome, disjointed Canadian health care system.[13] If investigative emphases replace a hospital oriented sytem, what will be the effects upon family costs and burdens associated with arranging home care? To date, none of the Saskatchewan clinics have had finances to provide adequate home nursing and homemaker services, which would reduce the potential family costs of illness. If hospital closures accompany more elaborate outpatient services, would lower costs in rural areas be the result of a lack of specialist staff and resources? What checks are there upon entrepreneurial multi-specialty groups, ensuring there will be no exploita-

tion, no treating a patient to a cafeteria of choices which, in some cases, he may not need? How effective can global budget arrangements and consumer sponsorship be in the present system?

Although he is cautious about ascribing to community clinics any advantages which cannot be proven, Anderson supports the position taken by Hastings. Before the multi-specialty community health centre is promoted, the health services system should be treated as a social system under a single authority, providing health care, surveillance, maintenance and restoration; centres should be assessed realistically and funded through global budgets; social security measures may have to be expanded to include sickness benefits to overcome incentives for hospital rather than ambulatory, outpatient diagnostic care. Anderson warns the price will be high, but he predicts incorporation of the health centre concept into a traditionalized health care system "could produce greater returns than anticipated".[14]

Anderson's assignment was to supply a cost-benefit analysis. It was occasioned by Saskatoon clinic claims that it was providing savings through its operations. The clinic was aware of government concern about rising health costs, and used the cost debate as a "useful vehicle to ride upon". But clinic personnel are reluctant to enter any competition pitting them against other groups to cut costs to the bone. It is not paring of costs, but a shifting of priorities, which is needed.[15]

Government may be disappointed if they expect community health centres to provide a short-term cost savings. The long-term potential, however, may be in reducing the amount of institutionalization in hospitals and other care centres through provision of better ambulatory care. The public could be provided with a more direct access to health and social services earlier in the stages of a condition. It may be only in the long term that such a system begins to provide savings and noticeably better health.[16]

Consumer: Active or Passive?

What is the role of the consumer in proposed models of a health service system? On the basis of its experience, the Saskatoon clinic argues greater public participation in health facilities may result in improved health.[17] Reviewing clinic performances, Anderson was less convinced that consumer involvement has had significant effects upon the delivery of health.

Consumer involvement and its effects may be as intangible and difficult to measure in the short term as are the effects of having a health system change from institutional to outpatient emphases. Anderson, in attempting to be tangible and to measure, seems to have

underestimated the effects of consumer involvement on the practice of medicine and the health of consumers.

Provision of a facility and raising funds are two apparent consumer roles. But, the Saskatoon clinic has argued that consumers and their board of directors have a subtle, but significant effect on the way doctors practice.[18] In Saskatoon there is also evidence that impetus for programs has frequently emanated from the lay association. The drug formulary was discussed by the board of directors already in 1962. It was a lay suggestion which led to recalling patients for periodic health examinations. Presently, it is the lay association which is active in the community, assessing what expanded health and social role clinics might shoulder. The success of health education programs and patient clubs maintained over 10 years is also difficult to quantify. But it would be cynical to suggest they have had no effects upon the health of participants.

There are criticisms from within the clinic membership, that consumer involvement has been token while the organization has been handled by "professional co-operators";[19] that the clinic is dominated by its senior staff and insensitive to its members, whose complaints and suggestions are not always accepted or passed on.[20] On the other hand, the clinic is credited with being much more sensitive to the needs and desires of its members than other organizations in the provincial co-operative movement.[21]

Theoretically, global budgetting puts the onus upon the clinic lay associations to become more involved in planning a total health service and budgetting for it. There are, however, indications that government is reluctant to relinquish lump sums of money to be used by health consumers. A Prince Albert community clinic doctor recently criticized the government for approving clinic global budgets "line by line" after ten years of proof that the clinics are responsible.[22] In other cases (not Saskatoon), it is clinic doctors who oppose having the lay association control the finances.[23]

Shopkeepers or Evangelists?

After the crisis of 1962 citizens succeeded in establishing 25 of their own health associations. There was a heady enthusiasm about revamping the delivery of medical care in co-operatively organized institutions. By 1972 only 10 associations were operative, and only those in Saskatoon, Regina and Prince Albert provided a comprehensive range of services in a group practice. Reasons for the demise of other associations have already been discussed. The government, sapped by the struggle with the profession, did not provide incentive or leadership. The profession was opposed. A large percentage of the population was more concerned about emergency medical services in

1962 than in alternatives to the health care system. Community clinics remained the exception rather than the norm.

However, there is a new debate about health care — a renewed interest in the community clinic approach to providing health services. After some successes and many failures the clinic movement appears to have the potential to be instrumental in revitalizing the system. But the changes will not just happen. The process of change will be a public one, publicly debated, and publicly implemented.

Support for community clinics exists among relatively few ideologues, but the ideas have not become "poltical currency". Until they do, and are debated in the public forum, there seems but a slight chance for community clinics to flourish.

Will the few surviving clinics become merchants, content with their corner of the "medical market"? Will their inspirational leaders become administrators, pragmatically running smooth organizations and forgetting about the movement? Can evangelism, similar to that which sent original clinic organizers to every populated corner of Saskatchewan during the summer of 1962, be continued indefinitely?

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MEMBER INVOLVEMENT