THE NOVA SCOTIA MEDICAL BULLETIN

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"He Is No Good But He's Cheap"

A few years ago the late Dr. Evatt Mathers, in what must have been his last public appearance, spoke to a meeting of The Halifax Medical Society. In his discourse he dwelt at some length on the physical and mental tribulations associated with old age and, in passing, made the remark "Jim Reid is my doctor. He is no good but he's cheap".

It might appear to be a strange association of ideas to link such an incident with the future of medical practice in Nova Scotia but events and trends suggest that such a relationship is not meaningless. The connection between the two lies within the realm of politics and political thinking, and a little further elaboration of this link is in order.

When one thinks of federal politicians one is reminded of the lady whose maid was leaving her and had requested a letter of recommendation. Wishing to be kind but truthful her employer, after racking her brains to think of the nicest things she could say about the girl, wrote that she had a good appetite and slept well. Fortunately in the field of provincial politics the picture is not quite such a gloomy one and we believe that in Nova Scotia there are political leaders who genuinely want to provide the best possible medical care for their people. Assuming this, there are certain circumstances that they and we must bear in mind.

The first fact is that when Medicare comes into effect, Nova Scotia will have to compete for doctors with every other province in Canada and with every state of the Union. Those of us who have lived in Halifax for the past twenty years cannot help but feel that we are living in a medical railway station with a bewildering flow of arrivals and departures. Under Medicare the question must be first, whether there will be more departures than arrivals and secondly, whether the calibre of the departures will be higher than that of the arrivals. Not long ago a local paper featured the remark of a spokesman for a group of doctors in Ontario to the effect that if they were not considered well enough trained to practice in that province, they would be forced to go to Nova Scotia (surely a reflection contrived to melt the hardest Upper Canadian heart).

It is well to remember that after next year the kind of medicine practiced and taught in Nova Scotia will be determined largely by the wisdom and foresight of those members of the government responsible for the introduction of Medicare. It must also be borne in mind that it is easier to initiate a good service than to change a bad one. Having made these self evident points, we should ask that in order to avoid having a third rate service, a primary object must be to establish the most

favourable possible medical climate. By making this an attractive province in which to practice and teach Medicine we should be able to keep the maximum number of our own graduates and to induce the best and not the rejects to come from outside. In order to create such a climate we should give first place to a requirement expressed recently by the Ontario Medical Association "a respect for professional freedom and absence of restrictive and coercive legislation." Medical freedom in the past has never been divorced from responsibility and there is no reason to believe that such an attitude will change in the future. On the other hand responsibility without freedom can only do harm to ourselves and to those we serve.

The role of financial arrangements in open competition with the rest of Canada is an important one and doctors, being human, must be influenced by it in deciding in which province to practice. We believe a Nova Scotian doctor to be as good as a British Columbian one and that his material rewards should be comparable.

Our political leaders have no easy task and it is our duty, consistent with our principles, to cooperate with them in every way we can. In the final analysis, however, the type of service we have will be determined in a large measure by their decisions. If it is cheap, it will be no good. Let us hope they remember that Nova Scotia could only be the poorer if even Jim Reid, for all his cheapness and however meagre his talents, should be obliged to move away.

W.E.P. □

Introduction to the Special Issue on Medical Services Insurance

In keeping with the function of the Nova Scotia Medical Bulletin as the official organ of The Medical Society of Nova Scotia, and in response to the request of the Executive Committee of the Society, this month's issue of the Bulletin will contain the full text of the press release by the Medical Advisory Commission to the news media of Nova Scotia at the conference which took place on February 24th, 1967.

This report contains in capsule form a review of the composition, actions and sources of information of the Commission to date, with a review of the possible alternatives for formulating, setting up and administering a plan of insured medical services in this Province.

At the meeting of Council of the Medical Society during the course of the 113th Annual Meeting last November, it was suggested that the Memoranda submitted by the Physicians Services Insurance Committee of the Society to the Medical Advisory Commission were of such high quality and of such interest to all members of the Society, that they should be published in the Bulletin. However, since these were confidential memoranda directed to the Commission, they could not be published before the Commission reported its findings to Government. The Commission's Press Release printed here pays full tribute to the cooperation of the Medical Profession, and in particular to the P.S.I. Committee, and thus fulfills in some measure the wishes of Council to see the views of its P.S.I. Committee aired.

The second part of the Tumour Clinic Symposium on Cancer, which was to have been published this month, will now appear in the May issue of the Bulletin. □

Report of the Medical Care Advisory Committee*

Press Release for a meeting with representatives of News Media in Nova Scotia February 24, 1967

This material is intended as a background for those who may not have had the full opportunity to study the various Medical Care Insurance proposals. It may be of help in evaluating this Commission's Report when tabled and assessing any subsequent legislation.

It does not draw any conclusions, but does attempt to introduce the major problems and indicate alternative methods for their solution.

Since studies are not yet completed, a good deal of clarification must still come from Ottawa and because the Report can only be addressed to the Honourable the Minister of Public Health, it may be understood why specific answers cannot be given now. Nevertheless, the Commission does hope that the material and the meeting may be informative and helpful to representatives of all media.

If the following pages appear to consider physicians' services far more than the others, the so-called "Extended Health Benefits", it is because the possibility of the latter being part of a Plan was only introduced late last year. Also, we have not yet met with all the non-physician groups from whom we expect to hear and we plan additional meetings with others. Finally, progress must be slower in these fields since there is little, if any, valid experience known in Nova Scotia because these services have not been given on a prepaid-group basis and we do not yet know conclusively what the final cost will be. Apart from this, much applicable to physicians' services applies to the others. There is a special section for these considerations that are distinct.

*Bill 148(1966). An Act to Provide for a Study of Medical Care Insurance may be obtained from the Queen's Printer, Province of Nova Scotia, and Bill C227 (1966) An Act to Authorize the payment of contributions by Canada towards the cost of insured medical care services incurred by provinces pursuant to provincial medical care insurance plans, may be obtained from the Queen's Printer and Controller of Stationery, Ottawa, Ont.

Terms of Reference

This Commission's instructions are set out in Sections 5 & 6 of Bill No. 148 passed at the regular 1966 session of the Nova Scotia Legislature.

Briefly stated, the first requires the Commission to investigate the administration of Medical Care Insurance Plans including their establishment and scope, the provisions of physicians' services, Canada's role and cost sharing and other matters as directed. By Section 7, the Commission is to report and present to the Minister of Public Health, by no later than December 31st, 1966, amended to December 31st, 1967, a plan or plans for residents of Nova Scotia related to a federal plan together with proposals for operation and recommendations on such matters as are necessary or advisable.

In accordance with this Act a Commission of five Members was appointed on June 22nd, 1966.

There were certain obstacles in the way of completion of a Report as required. First was the announcement on September 8th, 1966, that the indicated implementation date for Dominion participation had been postponed from July 1st, 1967 until July 1st of the following year. Later it appeared that July 1st, 1968, was just the latest possible starting date and introduction could be at any time earlier. Also, the Ottawa Bill, the Medical Care Act, did not become law until December 21st, 1966.

In addition it was felt that certain portions of the Bill might be objected to by some provinces and indeed some provisions, as will appear, did not seem satisfactory to this Commission. Finally, the Ottawa Bill seemed to be somewhat general in many of its provisions with more than one course of action open and it has been difficult to judge what policies would be adopted by Ottawa.

The Medical Care Act

It is perhaps easiest to consider one aspect at a time. Therefore, the following deals with medical services only and not, until later, such other services as dentistry, pharmacy, etc.

Any introduction to such a complex Act must oversimplify, but in essence Canada will make contributions at one-half of the per person cost of plan services, calculated for all provinces in the plan, multiplied by the number of insured persons in Nova Scotia.

To date there is no indication that anything but medical services costs will be considered in this calculation. The calculation will exclude all administration. Also excluded are contributing co-insurance or deterrent charges which a province may receive from its subscribers.

Among the conditions qualifying a province for Dominion contribution are four criteria. These may be paraphrased as

(a) Provincial responsibility
(b) Comprehensiveness
(c) Universality
(d) Portability

The Plan must be administered and operated by a public non-profit authority and accounts and financial transactions are subject to Provincial audit.

All physicians' services must be available on uniform terms and conditions with no group or groups either preferred or discriminated against, and the amounts paid doctors must be determined by the Province on a basis of reasonable compensation. Any deterrents, contributions or co-insurance charged must not be on a level which would preclude the services to any person or groups.

For Ottawa to contribute, 90% of the Province's insurable residents must be covered during the first two years and this excludes three categories set out below. From and after the third year this percentage rises to 95%.

The Dominion Plan is designed so that an insured resident of one province may go to another participating province and continue his original coverage until a waiting period, not to exceed three months, elapses and permits him to be enrolled in the province's plan. Similarly, temporary absences will not preclude a person from receiving the services; for instance, if he is temporarily in a non-participating province or outside of Canada. He may be reimbursed probably to the cost level of his own province for payments he made elsewhere for these services.

When discussing physicians' services this means services provided by a medical doctor licensed to practice in Nova Scotia. Services provided by such persons as dentists, pharmacists and optometrists are discussed later.

To be entitled and eligible, the individual must have a right to stay in Canada and make his home and be ordinarily present in Nova Scotia. He must require the services and they must be provided by a medical doctor.

Certain services are not covered, being those that can be obtained by entitled persons from a Dominion source, as for example those available for some Indians and mariners, or from the Provincial Workmen's Compensation Board.

Excluded are members of the Armed Services, R.C.M.P. and penitentiary inmates and they are not part of the calculated population. From the residence requirements it follows that tourists, transients and visitors are not covered.

There are still doubts and uncertainties because more than one interpretation of certain provisions in the Act is possible, and criticism now may be neither valid nor constructive. There have been indications of policy which will be unacceptable to many.

The universality requirement will certainly be repugnant to some individuals and likely so to one or more provinces. It may introduce an element of compulsion requiring some to abandon their present insurance methods and submit to a plan not of their own choosing and not necessarily superior to what they now have.

Some persons have contended that all the wholly or partly medically indigent could be provided with total medical services and the remainder still be given a choice of enrolling in the government plan or continuing to provide for their own needs on a personal basis. This approach might substantially reduce the demands on the Provincial Treasury.

There is already extensive coverage when all the various government provided services are added to existing voluntary plan enrolments. In some provinces this may already satisfy the 90 to 95% requirement. Yet it does not appear that the Dominion Plan will take this into consideration and to avoid compulsion where it is not necessary.

There is doubt too over what type or types of administrative agency will qualify for Federal contribution. Representations have been made in this Province for the employment of such a doctor-sponsored Plan as Maritime Medical Care. The persons making these representations claim that this agency is experienced and particularly qualified to administer those phases of a plan including assessment of claims, utilization controls, pattern of practice studies and the establishment of safeguards for both the profession and the recipients of services. They claim there is a demonstrated public acceptance of its programs and it could operate as an agency under a Provincial Commission, Board or Department and so make contributions which no other known agency is qualified to do.

Such a solution will not have any merit unless the agency can continue with its operation and identity, relatively unchanged, and this approach does not appear to be precluded by the wording of the Act.

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"SCOUTENNIAL, 1967"

Opportunity for Unusual Holiday

Medical staff is needed for service in camp hospital and to provide medical services for this event, to be held near Middle Musquodoboit, Nova Scotia, from July 15th to 22nd, 1967, with anticipated attendance from two thousand to two thousand five hundred boys and leaders.

Offers of service either the whole period or parts thereof would be welcomed from practising physicians or residents.

Please contact Dr. Norman Glen, Assistant Provincial Commissioner, 183 Victoria Street, East, Amherst, N. S."

IF YOU DRIVE, DON'T WEAR BLINKERS

The wrong kind of eyeglass frames can increase your chances of having a car accident, says eye specialist H. P. R. Smith, M.D., consultant to Britain's Ministry of Transport. In a recent article in the British Medical Journal he showed that some modern frames interfere seriously with over-the-shoulder vision.

Fancy sunglasses and heavy-framed "executive" glasses with wide side-pieces obstruct the driver's vision when he turns his head to see if it is safe to pass or change lanes. Frames with a clawlike downward projection of the lens mount are also dangerous.

Dr. Smith approves of driving glasses with narrow lens mounts and thin side pieces attached at the top of the mount.

ADVERTISER'S INDEX

If a province fails or ceases to satisfy the qualifying criteria, Ottawa's contribution will not be made. The Act further provides that Ottawa is the sole judge if a question on qualification arises. Negotiation and arbitration, where necessary, would be a better course for although advances made are not recoverable, a unilateral and hasty decision could be made on wrong facts. Even a correct decision to cancel contributions could harshly penalize a province where established programs could not be quickly changed.

There are still other matters which have not been resolved and these also introduce uncertainty as to the validity of other possible provincial programs. Among them are the doubts arising from a plan's affect on present provision of services for certain federally assisted groups such as some convicts who cannot be treated in prison, certain foreign students and the Indians and mariners mentioned earlier, problems for those Canadians in transit who can have no immediate permanent residence such as servicemen's families on transfer from abroad, the affect on tuberculosis and mental health programs which are currently operated by the Province. Other doubts arise in reference to Ottawa's intended controls regarding overservicing or utilization and the nature and extent of the required Provincial audit. Several provinces, including Nova Scotia, have unique problems, and approaches and established programs differ widely province to province. Thus one inflexible plan imposed for all parts of the country does not appear to be satisfactory to some people.

At least some of these doubts and misgivings could have been resolved had officials from Ottawa and all the other Provinces met and discussed the Bill at a series of working and technical conferences from the time of first reading. Actually, only one such meeting was held and that after third reading.

Composition of the Commission

Members of the Commission were appointed by Order-in-Council dated June 22nd, 1966. The Chairman commenced his duties April 4th.

Members are R. MacD. Black, Q.C., of Halifax. A barrister and businessman, he served on the Hospital Planning and Nova Scotia Hospital Insurance Commissions from 1957 to 1960 and has had Hospital Board experience.

John H. Delaney. Mr. Delaney is a UMW International Board Member from Glace Bay and has had many years' experience in the development and administration of hospital and medical services plans.

T. W. Gorman, M.D. Dr. Gorman is a surgeon practising in Antigonish, is a Past President of The Nova Scotia Medical Society and has also served on its Executive and other committees. He has been prominent in the studies and investigation by the profession of prepaid services for many years.

S. S. Jacobson, B.Com., M.B.A. Mr. Jacobson is a Halifax businessman and has been a Member of the Children's Hospital Board for several years and has been active on its executive and committees.

J. C. Wickwire, M.D. of Liverpool. Dr. Wickwire is a general practitioner and internist, and is the continuing member from the Medical Insurance Advisory Committee. He is a Past President of Maritime Medical Care and of The Nova Scotia Medical Society.

The Commission's Executive Secretary is D. H. Waller, B.Com., of Halifax. Mr. Waller has been an executive of Maritime Medical Care for the past 15 years.

Mr. R. G. Conrad, Solicitor of the Attorney General's Department, is the Commission's Counsel. He was formerly Solicitor for The Nova Scotia Hospital Insurance Commission.

The Commission's Role

Members do not consider that they are acting in representative capacities as to their particular backgrounds but rather bringing a variety of views to the consideration of recommendations which would affect almost the entire population of the Province. The Commission has considered the interests of all parties likely to be affected including government, recipients, and the providers of the services.

It has proceeded as a Board of Inquiry and has attempted, in meeting and hearing a wide variety of groups and individuals with diverse opinions, not to indicate conclusions. No decisions were disclosed at any time since the reference was to report to the Honourable the Minister of Health.

The Commission's Activities

The Commission's first meeting was on June 9th, 1966. Since then 29 other meetings have been held. The pattern has been to have one formal meeting a week although on several occasions meetings lasted two days. Sub-Committee meetings were also held.

On June 21st and 22nd the Chairman and Executive Secretary went to Ontario. In Ottawa they met the Deputy Minister of National Health, Dr. J. N. Crawford, and the Department's Director General, Dr. E. H. Lossing, for discussions on Dominion proposals. The next day, in Toronto, they discussed with Dr. J. C. Charron, Deputy Minister of Health of Ontario, that province's plan. From August 25th to September 2nd all members and the Executive Secretary travelled to British Columbia, Alberta and Saskatchewan. They met various departmental officials, representatives of doctor-sponsored plans, commissions, private practitioners, members of the public and also visited one teaching hospital. Office layouts were demonstrated, data centres were visited and forms and documents were examined.

Mr. M. G. Bradley, Co-ordinator of Administrative Services, Department of the Provincial Secretary, visited Ontario and Saskatchewan on August 14th - August 19th on behalf of the Commission. He inspected data processing and computer centres in Toronto and Regina and discussed Medicare data problems with officials.

Messrs. Black, Conrad and Waller went to Ottawa November 4th and discussed Bill C-227 with Department officials. These latter came to Halifax for a further conference on January 17th last.

Every courtesy and assistance was extended to the Commission and its representatives in all these provinces and at Ottawa. In addition, various other representative persons attended before the Commission.

Information Sources

(a) **"Medical Insurance Advisory Committee Report"**

The Report was prepared under the chairmanship of Mr. Frank Rowe, Q.C. Other members were Mr. William Keough, Mr. Donald MacLean, Miss E. A. Electa MacLennan, R.N., and Dr. J. C. Wickwire.

The Commission found this the most useful document of all. It was used as a starting point and as a constant reference. The information concerning other Provincial plans was used for briefing material before visits were made to the four provinces mentioned above.

(b) **The Hall Report**

The Report of the Royal Commission on Health Services, or, as it is commonly termed, "The Hall Report", is an exhaustive study of the health services of Canada, past and present, with a projection into the future.

Twenty-six special studies were prepared by eminent scholars from universities and other organizations. This well-documented information was augmented by many relevant tables and graphs.

Permeating through the report, one will find the following principles, as announced in the preamble to the Charter of the World Health Organization: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition".

To this end the authors have propounded a Health Charter which includes, among others, the following conditions: -

(1) Financed through prepayment arrangements.

(2) "Comprehensive" - To include *all* health services, preventive, diagnostic, curative and rehabilitative.

(3) "Universal" - means that adequate health services shall be available to *all* Canadians.

(4) "Freedom of Choice" - means the right of a patient to select a doctor or a dentist and the right of the practitioner to accept or not to accept a patient, except in an emergency or on humanitarian grounds.

(5) "Free and self-governing" - means the right of members of the health professions to practice within the law, the free choice of location and type of practice, and to self-government.

(6) That voluntary agencies have an integral place in any comprehensive health care programme and that they participate actively in the work of the various planning councils.

It is the expressed opinion of "The Hall Commission" that an enormous gap exists between our ability to provide and the existence of adequate health services. This Royal Commission recommends that in Canada this gap be closed.

Two hundred fifty-six recommendations in all were made. These included:

(1) More and larger grants to students, universities and hospitals.

(2) Treatment of alcoholism and drug addiction. All discrimination between physical and mental illness is to be removed.

(3) To be gradually phased into the programme would be the provision of dental services, home nursing services, paramedical services, drugs, optical and prosthetic appliances.

If and when a Provincial Government fulfils the conditions of the Health Charter it may qualify for a Federal grant. The Federal Government is then to finance its share of costs of the health care programme consisting of a 50% contributory grant of the actual costs, and an administrative grant of 50% of the administrative costs of the programme not to exceed 5% of the actual costs, and a fiscal need grant to financially weaker provinces through an equitable system of taxation.

To finance the greater requirements a larger part of the taxpayer's dollar must be directed to the field of health. Yet with the projected increase in our Gross National Expenditure "The Hall Commission" states that the relative amount spent on health services will still remain well within our ability to pay.

The Medical Insurance Advisory Commission (Rowe Commission) and the Medical Care Insurance Advisory Commission have used the "Hall Report" as a veritable encyclopedia to which we, perforce, repeatedly referred.

(c) **The Medical Profession**

The Profession has been of particular assistance, both individually and as representatives of The Medical Society of Nova Scotia. From almost the first, the Commission had the benefit of the views of its Physi-

cians' Services Insurance Committee. This Committee was appointed by the Society to indicate to the Commission the thinking of the profession on a wide range of subjects. In no other way could the Commission have received such precise information on medical services in so short a time. It met formally for joint conferences with the Commission on ten occasions, generally one afternoon each fortnight.

The Committee Members are Dr. G. M. Saunders, President and Chairman, Dr. A. J. M. Griffiths, immediate Past-President of the Society. Dr. A. L. Sutherland, President-Elect, Dr. F. A. Dunsworth, Dr. C. L. Gosse, Past President, Dr. D. M. MacRae, Dr. H. C. Still. Dr. C. J. W. Beckwith is the Committee's Secretary as well as Executive Secretary of the Society.

A number of submissions were received, most initiated by the Committee but others prepared at the request of the Commission.

It was obvious that much study and thought had gone into the preparation of all submissions and that they were the product of substantial experience. The Commission was convinced that these men, and the Society they represented, were motivated by an over-riding concern for the welfare of the patient and to the end that the finest quality of medical care might continue, that there be no relaxation in medical standards.

(d) **Department of Public Health**

The Department was the first source appealed to for assistance and the Deputy Minister, Dr. J. S. Robertson, placed its full facilities at the Commission's disposal. Not only did he meet with the Commission himself, but he provided written advice and information from time to time as well as arranging for office space, equipment and stationery.

Dr. Clyde Marshall, Administrator, Mental Health, also appeared and gave most useful information to the Commission on Mental Health.

(e) **The Nova Scotia Hospital Insurance Commission**

The Hospital Commission was similarly of great assistance. Since there is a distinct possibility of overlapping spheres of operation, it was early decided that every effort be made to avoid duplication or conflict.

That Commission's Executive Director, Dr. G. G. Simms, and Mr. C. H. Kennedy, its Director, Administration and Standards, both came to meetings and provided written material as well. Their experienced advice should greatly assist this Commission in its recommendations.

(f) **Outside Consultants**

After meeting for some months it became apparent that there were certain areas where a thorough appreciation requires investigation of a wealth of detail. As the Commission was authorized to seek help elsewhere and since sufficient time to thoroughly explore all these matters was not available, the firm of Peat, Marwick, Mitchell & Co. was retained on November 17, to provide this type of detailed research.

It is necessary to consider the administration cost, or retention ratio, in every plan examined. No two plans account for this cost exactly alike and valid comparisons are impossible. Thus one task of the consultants is to place these costs on a common footing.

An analysis of fee schedules is similarly difficult and time-consuming. The consultants will consider items of high frequency in all other provinces and also attempt to equate them on a common basis.

Some statistics set out originally in the Rowe Report are now out of date. Our advisers will revise them.

(g) **Public Submission**

Because of the short time under the original reference and because the Rowe Committee had so recently publicly requested and received submissions from groups and individuals, and as many organizations had submitted representations to the Hall Commission, it was first not thought necessary to repeat this approach.

However, since the extension of the implementation date it was decided that the policy might be revised. Accordingly the Commission held a hearing here in Halifax and another is scheduled to be held in Sydney on March 1st and 2nd.

Financial

In assessing alternate methods of plan financing much that is applicable to other provinces is not at all relevant here. Nova Scotia, and indeed the Atlantic Region as a whole, has relatively lower gross incomes, fewer persons with substantial taxable incomes, a greater number of seasonal workers, more unemployment, lower enrolment in existing plans and few really large participating groups. These situations all have some bearing on what the financing solution will be. When solved, this solution then tends to shape or control the type of plan possible, particularly administration and data processing.

For the purposes of this section and to know what the maximum impact may be, we assume that there will be universal or nearly complete coverage of the entire population for payment of insured services. The best projection is that the cost of Nova Scotia's share may well be more than $15,000,000 in the first year alone.

Thus we must consider the Province's capacity to pay, and to continue to pay, such a tremendous and new expenditure. This naturally leads to a consideration of whether or not an added burden will be placed on the individual and, if so, his ability to withstand it. There is no completely accurate forecast possible now. Perhaps the total cost will not greatly exceed the present health dollar expendi-

ture. Now, these come from many sources. When they are reduced or eliminated there will still be a commitment on the part of the Provincial Treasury and required funds are not now being levied by the Province.

Although there are those with a contrary view, it does seem inevitable that utilization and costs will rise more sharply than they have without a plan. Therefore, it is futile to argue that the only change will be a transfer from the private to the public sector of the economy. There is some merit in the contention that the demand for medical services has increased faster than that for goods and services generally since the end of the last war. Indeed the economic adviser to the Rowe Committee, Professor L. E. George, contends that not only will there be this greater expenditure, but that there will also be a consequent dimunition of expenditure for other services.

Even if controls on utilization and services work perfectly costs will rise. A plan will virtually eliminate charitable work and some without means who once held back from pride are now going to receive attention. Thus the person with means must necessarily be called upon to pay more support to Medicare. Planners and administrators must do everything possible to ensure that costs are kept as low as they can be while still providing high standards, and find methods for raising the needed monies on an equitable basis for all and as least burdensome as can be devised.

Among the possible tax raising alternatives are premiums, an extended hospital tax program and income taxes.

With approximately half of the population of the Province having gross incomes below the income tax paying level, a universal premium would of necessity have to be low. In Saskatchewan where the present premium is $12 per annum for a single person and $24 for a family, approximately one-sixth of the total receipts is obtained under a fairly ideal system of municipal collection which does not obtain in Nova Scotia. The cost of collection in this Province including in many cases a resort to compulsion and other equally objectionable features would be out of all proportion to the amount received.

With reference to an extended hospital tax it must be noted that the proceeds of the present tax on the sale of certain goods are ear-marked by law for various hospitalization purposes. To cover the Province's share of medicare it would have to be increased substantially from the present five per cent and to avoid such an increase consideration could be given to broadening the tax base reserving the exemptions for essential purchases. In favor of this type of tax is the fact that machinery for collection is already in operation and it is geared to ability to pay since essential purchases which comprise the bulk for the low income worker, are exempt, and as incomes and, consequently, spending increases, returns will also automatically increase.

The provincial share of income tax is now 21 per cent of the basic rate. A substantial increase would be needed to finance the Province's share of "Medicare" if this method were selected. Some of the advantages of this method are; easy collection, tax geared to ability to pay, and with medical care costs rising continually increased tax returns from incomes which are also rising would make unnecessary any increases in rates.

While there is no doubt that establishing a direct connection between taxes and costs has a salutary effect this is largely lost where half the population pays no tax. It could also be argued that the ability to pay theory is more equitable for other purposes than medical care.

Another method, assuming collection could be made through present Income Tax channels, is by the addition of a fixed amount of tax payable. Taxpayers could be segregated into the classes usually used under the voluntary insurance plans, viz., single married, married and family and rates set for each in amounts sufficient to produce the aggregate required. Variations in the amount of the individual tax and of the tax bracket to which it is applied are possible as circumstances or equity might demand. While the non-income-tax payer would still escape all liability this would satisfy those who argue that any whose income is below the tax paying level as "medically indigent". On the other hand it would lack the salutary effect of having everybody except possibly the genuinely indigent, pay something, however small, thereby being constantly being made aware that services are not free and that increased demands can be met only by increased taxes.

The Commission has been giving consideration to these and other sources of revenue which might be recommended to cover the cost of the Province's share.

Administration

(a) **General**

The broad administrative duties and responsibilities would be:

(1) To specify the services to be insured from time to time;

(2) To determine an acceptable basis of remuneration for insured services rendered;

(3) To process and assess claims in respect of insured services rendered and to determine amounts payable by virtue of those claims;

(4) To disburse funds for insured services or reimburse enrolees for payments made in respect of charges;

(5) To include in the administrative set-up acceptable procedures to deal with disputes;

(6) To prepare, analyze and maintain data as required by the Commission;

(7) To furnish Ottawa with the information required by the Act.

(b) **Alternatives**

Final policy is the prerogative of the Government, the Legislature and Parliament, but there are some policy decisions that may well be made within an administrative structure. Thus the entire administration and the ancillary policy function can be set up under one roof as for example the present Department of Health or the Nova Scotia Hospital Insurance Commission.

There is no doubt that the task could be done, and done well, by our Department of Health. However, this Department is already involved in many programs. To start this new one it would have to set up what in effect would almost be a distinct branch of the Department. It is doubtful whether such an arrangement would outweigh the establishment of a completely separate administration.

The Hospital Insurance Commission is the closest existing government body to the role visualized. It, too, could do the job but although it does not have the number of programs of the Department of Health, administering two broad spheres, it does deal with a multiplicity of groups, such as nurses, various technicians, labour groups, laundry and kitchen personnel and many more, with many urgent, diverse and complex building programs as well. Thus it might be said that if medical services insurance were added to the Hospital Insurance Commission the requirements of those providing services could be submerged.

From another viewpoint it is arguable that a new program needs flexibility in its early years more than at any other time, so that an absolutely fresh approach and with entirely new personnel could be highly advantageous.

The selection of a carrier from among the commercial companies could present difficulties as well. First, one company would have to be singled out and given preference. We have been advised that over fifty of them operating in Nova Scotia already offer medical care insurance along with their other lines. Keeping one line immaculate as far as profit is concerned would involve close scrutiny and perhaps considerable administrative expense. Few if any of these carriers have had the relatively intensive experience of claim assessments and doctor-practise studies as have had the doctor-sponsored plans. None, to our knowledge, have their own data processing or computer centres in this province.

These insurance companies are joined in the Canadian Health Insurance Association. The Association's President, Dr. J. C. Emmett, and Messrs. R. E. Foster, Managing Director, and D. E. Watts represented it before the Commission. In addition to making a presentation to the Rowe Committee, they sent a considerable number of written submissions and all were most helpful and informative.

The remaining alternative is a doctor-sponsored plan such as the Maritime Medical Care operation. It is noteworthy that more than one of these plans operate in every province save Manitoba and here. The Maritime Hospital Service Association, known as Blue Cross-Blue Shield, operates in Nova Scotia.

(c) **Other Responsibilities**

In addition to the broad areas of responsibility there are many other administrative decisions which ought to be made during the planning period.

As recounted before, detailed studies are being made by consultants on administrative costs. These must be kept low so that virtually all funds available are spent on the services themselves.

Data processing decisions must be made at once as personnel are hard to find and need much training. Equipment is very short too.

Eligibility, entitlement, residence, waiting periods and out-of-province benefits must be considered with a view to achieving a high degree of uniformity with other provinces and with our own Hospital Commission. All these matters inevitably breed controversial decisions. Any imagined right refused brings appeals against administrative decisions and a quasi-judicial role is thrust upon the operating body. It is not unlikely that disputes will start on the first day of implementation. Review committees or boards must be set up in advance.

Third-Party Liability recoveries cannot be decided upon until Ottawa's viewpoint is known, but again, if it is a responsibility, a uniform or common program must be developed with the Hospital Commission.

One significant asset of Maritime Medical Care is how speedily it makes its programs, policies and decisions known to the profession. Most misunderstandings and possible resultant hostility, are avoided. It is highly important that a similar method be continued.

As of now, four agencies have in varying proportions, some responsibility for discipline or control of the profession. All of this is administered by doctors themselves, as it should be. Medicare will likely impose added responsibilities and careful preparation is required.

Medical

(a) **General**

As has been said, the doctors' co-operation with this Commission has been splendid. Official statements, from The Nova Scotia Medical Society, and the Canadian Medical Association, as well as expressions by individual doctors have made it abundantly clear that the profession believes that phys-

cians services insurance must be available and acceptable to all regardless of age, state of health or financial status.

The establishment of doctor-sponsored plans by the profession itself, in Ontario as far back as 1937 and since 1948 in Nova Scotia, are validation of the public utterances. Last year twelve of these plans provided prepaid benefits for upwards of 6,000,000 Canadians.

Doctors hold strong views indeed on how plans should be operated so that the best in medicine is preserved. Freedom of practise, to be in or out of a plan, continues to be the prominent point in their scrutiny of all planning.

The following, paraphrased, are some of the aims and objectives placed before the Commission for its consideration by the initial submission of the P.S.I. Committee: -

I The use of Maritime Medical Care, Incorporated as the fiscal agent for payment of physician services;

II Appreciation of the need for extended health benefits, such as payment for prescription drugs, so that the maximum benefit of insuring physician services may be enjoyed by the poorer citizens of the Province;

III The freedom of physicians and patients to be in or out of any plan; the so-called "opting out" privilege;

IV That machinery be established for negotiating and reviewing financial arrangements between government and the profession;

V That arrangements be made for regular joint review of terms and conditions of service by government and the profession;

VI That there be a review of physician services available under existing legislation with a view to their inclusion under one comprehensive plan;

VII That there be freedom of choice on methods of remuneration for any practitioner;

VIII That there be consideration of inducements to persuade doctors to practise in isolated or underpopulated areas;

IX That disciplinary problems and their management be considered;

X That statutory safeguards for the profession and the public should be written into the legislation.

(b) **The Partnership Concept**

Coercion cannot make a poorly devised plan successful. Even the best of plans will leave much to be desired if there are in it elements of unnecessary compulsion. No plan can work without the co-operation of those giving the services. If there is the necessary freedom then compulsion becomes unnecessary and it was early recognized by the Commission that the profession ought rather to be considered as one of three prime partners together with the Government and the patient. Partnerships too fail, if one of the parties is dominant and overrides the others. In a Medicare Plan there must be the utmost good faith and the fullest co-operation. It may well be that the Saskatchewan Government and that province's doctors were not as far apart as they thought at the time of the regrettable cessation of services. Unless there is quick access and ease of communication there will be a rupture of the partnership. The interests and viewpoints of all three must be readily able to be brought before the others.

(c) **Objectives**

It bears repetition that a paramount aim for any plan is the maintenance of present high standards of medical practice in the province. It has been put to us forcefully that without freedom of choice standards are bound to deteriorate.

Recognizing that higher utilization will develop under Medicare, the following seem to be primary objectives, in the medical sense, for both planning and operation: -

- development of successful policies for the recruitment of more doctors for the province;
- adoption of working procedures which will reduce the doctor's non-medical workload;
- selection of methods of remuneration which will insure income proportionate to his onerous duties, responsibilities and long training and consonant with our capacity to pay;
- adoption of sensible and adequate controls.

Those Who Will Receive the Services

(a) **The Partnership**

High medical standards are equally important to the patient partner. A properly informed and understanding public will agree that the best cannot be given unless certain freedoms and autonomies are preserved. Some patients will always choose their own doctor. There ought not to be any conflict over these aims between those giving and those receiving the services.

The individual will also want the freedom to leave his home province without losing coverage, the right to receive services on identical terms with his fellows and without isolation into categorized groups, the right of redress if aggrieved and a reasonable approach to all his medical needs.

These are all logical and reasonable hopes and should not prove too difficult to satisfy.

(b) **The Need**

The burden of the division of some basic needs, such as education, is already widely distributed. A somewhat similar distribution of the health care burden must now be made, for the health of the individual citizen is properly the concern of the

whole of society. Experience has shown that a publicly supported program is necessary if all Canadians, regardless of their economic condition or the part of the country in which they live, are to obtain the quality of care which medical science can provide.

This is true principally because of the very nature of medical services. Advances made by medical science in the past few decades have made it possible to conquer disease to an extent once undreamed of. But the cost of the prevention and treatment of illness is of necessity so high that few people can bear it alone. The long expensive training of physicians and of specialists in many branches in medicine, the cost of facilities and equipment for practise and the remuneration which is properly due to the profession may cause some of the services to be beyond the private resources of many groups. It is undoubtedly true that medical care is the most expensive of all specialized services which a person needs and uses at any time in his life. Moreover, it is a service which cannot be accurately foreseen and for which it is impossible to budget, without insurance, in advance of the need.

There is no other way by which the right to adequate medical care can be provided for everybody. Voluntary insurance plans, although they are good as far as they go, do fall short. These plans do not usually cover chronic illness or treatment for pre-existing conditions. They do not always include treatment by specialists. They may exclude certain medical and surgical procedures. They may require a waiting period before claims can be made and they do not always pay bills in full. Even with voluntary insurance plans, long periods of intensive care can still be catastrophic for a patient and his family.

Primarily, voluntary insurance plans are concerned exclusively with the diagnosis and treatment of illness. All the other services which should be included in a full program of health care, such as preventive medicine and rehabilitation, need a publicly supported plan.

Voluntary insurance plans are available to a limited number of people. There are many who cannot join these plans because they are too old or because they cannot afford the premium. In the latter group are those who are unemployed, or who are too irregularly employed to take advantage of group plans, or who are ill or disabled. Only by means of a publicly supported plan can these people be guaranteed payment for insured services.

It is no answer to the problems of these people to say that doctors will never refuse to treat patients who cannot afford to pay. This is true and the generosity of physicians in this regard is well known. But few patients forced to rely on a physician's charity will look for and accept anything but a minimum of care. Charity precludes preventative care and early treatment of disease. Every Canadian has the right to get the benefits of medical science without the loss of self respect that must accompany the acceptance of charity.

(c) **An Informed Public**

There are heavy responsibilities on government to set wise policy and on an administrative body to exercise it skillfully. But after this, a plan's success or failure will depend on the other two partners. The need for self discipline within the profession has never been as great as it will be with Medicare. The best plan will fail if doctors do not show restraint in approach and demands. Still, the finest efforts of government and the profession will be worthless if those served are heedless of what is required of them and do not respond to their own obligations.

There is wide concern that even now there are not enough doctors and that shortages can actually be dangerous with Medicare. This opinion has some foundation. The doctor-patient ratio is low in Nova Scotia compared to the national average. Canada's ratio is fairly well down the Western world's scale. We must have much better doctor recruitment.

Critics of government hospitalization felt that the plan's implementation ought to be delayed until ideal bed requirement objectives were met. Others thought that construction goals could not be satisfied without public administration. Today hospitalization is as accepted a privilege as mail delivery. If there are not enough doctors without a plan it need not follow that implementation cannot improve the situation.

Nevertheless, this Commission is convinced that some doctors, particularly general practitioners, are being worked far too hard. If they are now, demands on them will be even heavier under Medicare. But part of the problem has its origin in the many patients' understanding of the whole problem; we just will not recognize part of the doctor's productive hours are being wasted; some portion of each day is not being devoted to medicine; this might not be alarming if there was a doctor-surplus rather than the reverse.

Most house calls are wasteful of medical man hours. A seriously ill patient should be in hospital. If not, and if mobile, he should go to the doctor and not dilute his working hours with needless driving time, parking problems and wasteful absence from his equipment, records and office staff. Actually the purest employment of doctors' time will only obtain when his office, or offices, are located in a hospital.

Therefore, there is a patient responsibility. Our deep-rooted patterns for summoning the doctor must be changed and to do this we must make sure that everyone really knows what the situation

actually is. Only an informed public can be a co-operative one. There has to be an educational program. Pamphlets, advertisements and addresses by government leaders will all help. Perhaps an active program to teach grade schoolers who the doctor is, and what should and should not be asked of him would be a good starting point. Nevertheless, as long as the present doctor-patient ratio continues, effective medicine is impossible until those who expect to receive the services distinctly change their demand habits and no longer squander a portion of the doctor's working hours.

Other Problem Areas

As mentioned before, the Atlantic Region has some distinct problems. There are others which are the same across the country. Some of them are: -

- Isolated areas with scant populations
- The concentration of specialists in larger communities and around teaching hospitals and medical schools
- the heavy burdens of many physicians, particularly on the family doctor, and a hesitation to adopt this branch of medicine and often later, a reluctance to continue in it.
- the profession's traditional, but understandable, reluctance to relinquish or share fields of present self government
- the great difficulty in choosing sensible methods to arrive at reasonable physician remuneration; this is a highly complex field and the realization of desired and proper objectives will cause a great deal of concern.

Health Services Given by Other Than Medical Practitioners

Although the provision, Section 4(3) of the federal Medical Care Act, is a rather sharp departure from conditions applying to medical services, it can best be judged after some familiarity with the rest of the Act. Interpretation of this Section may well prove most troublesome.

A Summary of Section 4(3)

First, although there is no express provision, impliedly it is open to any and all provinces to make submissions or requests under it.

Second, contributions will only be made for those services "prescribed" by the Minister as "required".

Third, they may only be given by a person so authorized by the Province's law - (in Nova Scotia only dentists, dental technicians, physiotherapists, optometrists, pharmacists, registered nurses, nursing assistants and X-ray technicians) - (thus, even with the best will in the world towards portability coast to coast, we could not include services unlawful here,

Fourth, only "under terms and conditions" as established by the Governor-in-Council.

when all above are met then the services are to be considered, for purposes of the Act only, as medical services.

At present there is no indication what is going to be "prescribed", what the word "required" means or what the "terms" and "conditions" will be.

Note that the rest of Section 4 dealing with *provincial authority, comprehensiveness, universality and portability*, may not apply here at all.

"Lawful" health services vary from province to province. For instance, podiatry, while not lawful in the East is acceptable in some of the Western provinces. Will these services be provided which are acceptable and become lawful in all provinces, or in one-half of the provinces, or what?

Will the Governor and the Council approve all terms and conditions which will not result in comprehensiveness and universality?

No province can confidently plan a shared program until these questions are answered. □

Dalhousie Notes

I. HOW MANY MEDICAL SCHOOLS ARE NEEDED IN THE ATLANTIC PROVINCES? (PART III)

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The Size of a Second Medical School

Medical schools are very expensive to establish and to operate. As already indicated, a minimum of staff is required to provide a well-balanced educational program. With the increase in specialization in the medical sciences as well as in clinical practice, this number is not likely to lessen in the future, and is in fact increasing. While there are few clearcut studies on the optimum size of a medical school that is an economic unit, it is revealing that the U.S. Public Health Service has modified the second edition of "Medical Education Facilities - Planning Considerations and Architectural Guide" to eliminate all reference to the small school of 48 students per class. The smallest unit for which staff and space requirements are estimated in the 1964 volume is a class of 64.

In a second medical school in the Atlantic Region, it would seem wise to plan for a class of 64, both for reasons of economic operation and in the light of the preceding estimates of enrolment. It is to be hoped that governmental action to improve support for students and to provide opportunities for practice in this region will increase the enrolment in the near future.

There is probably little to be gained in commenting on the choice of a site for a second medical school in the Atlantic Region. The Commission established by the Government of New Brunswick is charged only with the responsibility of recommending for or against a medical school in that province and in selecting a site. Nevertheless, in reaching such a conclusion some of the alternatives must affect Dalhousie as well.

It is unfortunate that there is no regional planning body in the Atlantic Provinces in a position to advise the governments on such an important matter. The Royal Commission on Health Services (Hall Commission) recommended a study by the Health Sciences Research Council of the feasibility of organizing a medical school at Memorial University in St. John's. The Health Sciences Research Council has not yet been set up. The Royal Commission also recommended the establishment of a French-language medical school at the University of Moncton, but on this recommendation it made no suggestion of the need for prelininary study. Obviously, little or no consideration was given to the interrelations of these schools with each other or with Dalhousie. The MacFarlane Report to the Royal Commission, "Medical Education in Canada", suggested that it would be presumptuous to designate the specific institutions where new medical schools should be placed, or even the section of the province, but a strong plea was made for coordinated planning. The Royal Commission, disregarding its own advisers on medical education, had no such hesitation in selecting sites and did not indicate the need for regional planning.

An Atlantic regional body, faced with the problem of choosing the next center for medial education would have a difficult but not an insoluble problem. It seems obvious that a second medical school is not required in Nova Scotia, and Prince Edward Island would be too small to maintain one. The main problem for this organization would be a decision as to the number and size of the medical schools to take care of the requirements. If only two are required, as would now seem to be indicated, the choice between New Brunswick and Newfoundland should be based upon the factors which are well outlined in the MacFarlane Report, pages 230-231.

Only a few comments will be made on the factors influencing the site of a medical school, as reviewed in the MacFarlane Report. One pertains to the adequacy of hospital facilities and outpatient

clinic facilities and the problems of adapting these to an educational program.

Dalhousie Medical School was able to maintain a relatively high standard of medical education even in the 1920's and 1930's when the population of the City of Halifax was small and the hospital facilities were very limited. The advantage of Halifax as a center of medical education lies in the fact that it is a provincial referral center. The main teaching hospitals receive approximately forty per cent of their patients from outlying areas of the province. Clinical experience for medical students is therefore acquired on patients selected from the total provincial population. Any small city in the Atlantic Provinces will find it difficult to maintain a medical school with a class of 64 students unless there is a considerable inflow of referred patients from a large hospital region.

Emphasis is placed on the importance of having university and hospital facilities in geographic proximity to each other and preferably inter-connected. It is very important to have a new medical school contribute to the education of teachers of the future whether for their own or other medical schools. A graduate program of education in the medical sciences within the university and a postgraduate training program in the clinical specialties within the teaching hospital are both essential to a good undergraduate training program. These advanced training programs and the research studies which are so essential to both are best conducted where rigid inter-departmental organization does not create barriers and where physical proximity encourages cooperation. The disadvantages of having preclinical departments scattered in several buildings and the clinical departments in separate hospitals, even though these are closely grouped, are so obvious at Dalhousie that this factor is more heavily underlined than others.

Financial Considerations

It has been already been indicated that Dalhousie has served as a de facto regional medical school of the Atlantic Provinces for approximately forty years. However, there has been no formal agreement between the University and the four Provincial Governments according it that status. The Faculty of Medicine of its own accord established priorities for students from this region, reserving up to 90 per cent of the places in each entering class for residents of the Atlantic Provinces. In selecting students no special privileges are accorded Nova Scotia students nor those who have had their premedical training at Dalhousie. Students who have taken premedical courses at other Atlantic Province universities have received the same consideration, based wholly on academic standing.

It was many years after Dalhousie had accepted this responsibility to serve as the Regional Medical School before any of the provincial governments contributed to the financing of this faculty. Nova Scotia began to do so in 1940, and, since 1947, all provinces have made a financial grant to the Faculties of Medicine and Dentistry. However, such financial aid is still based on independent negotiations by the University with each of the four governments annually, a system which makes long-range planning almost impossible. No inter-governmental agreement has been worked out to assure stable support for Dalhousie or to apportion the costs among the provinces according to a prearranged formula.

The Report of the Royal Commission on Higher Education in New Brunswick in 1962 described the situation and made a recommendation which has not yet been implemented.

> "While it has been impressed with the progress made in the establishment of central educational services for the Atlantic Provinces in certain fields, the Commission is concerned with the apparent lack of inter-governmental machinery to coordinate financial support for these central services. The institutions which now rely upon inter-provincial support have no assurance of the total amount to be received from year to year, but must conduct an annual canvas of each of the participating governments. On the part of the individual provinces, it has been virtually impossible to develop a reasonable policy of joint support without a prior inter-governmental understanding on appropriate cost-sharing criteria . . . The ad hoc arrangements which now exist serve only to produce unreasonable disparities in the various provinces' contributions to jointly-supported programs, and financial crisis for the institutions which provide them. The Commission believes that the present situation would be considerably improved by the establishment of inter-provincial machinery to coordinate the various measures of joint support. Efficient machinery of this kind would permit the attainment of both an equitable, clearly-understood cost-sharing formula among the various provinces requiring special central educational services and a firm basis for planning by the schools relying upon joint assistance."

Since Dalhousie University has been laboring too long under this extremely unsatisfactory financial problem, it is hoped that with the establishment of a new school, wherever it is, there will finally be some inter-governmental agreement on the financing of medical education in the area. Unless this is done, it will affect both the new school and Dalhousie. Presumably there will be an initial period during which the new school will be enrolling first year students, then second year, etc. Dalhousie will still have to complete the education of students already enrolled from that province. It would also be advantageous for the new school to have some students from other provinces. The Dalhousie Faculty of Medicine has recently reiterated its policy of keeping 10 per cent of the places for stud-

ents from other regions, because of the value of having good students from a different background trained with our students. The same would surely apply to a new school. On the other hand, it would be unfair to expect the province or university to accept the burden for any large number of students from other provinces. An inter-governmental agreement is therefore essential in order to ensure stable support for all of the medical schools in the Atlantic Region.

The other major factor is simply one of the adequacy of financial support. During the past twelve years the budget of the Medical School at Dalhousie University has increased from the totally inadequate sum of $350,000 in 1954 to an annual expenditure of $1,500,000 in 1965-66, and the budget for the current year has started a sharp upward swing to two million in order to increase staff for the larger classes of 1967. The budget is still low in relation to other Canadian medical schools of comparable size. In a datagram from the Association of American Medical Colleges dated January, 1966, it is shown that of the 84 medical schools in the United States, only one is operating with a budget of less than $1,000,000 and only 22 with a budget of less than $2,000,000. This excludes research funds from external fund-granting bodies and includes only those sums obtained from tuition and fees, State and City appropriations and subsidies, restricted gifts, grants and endowment income, transfers from University funds and income from the service activities of the school (for the most part clinical practice by the full-time medical staff in the teaching hospitals).

It should therefore be emphasized that a new Medical school must be assured of a budget of at least $1,000,000 per annum for a class of 64 students (approximately $5,000 per student when full enrolment is achieved). The budget is likely to reach $1,500,000 within a few years. In addition, the enlarged medical school at Dalhousie will require a budget of approximately $3,500,000 by 1970-71. The two schools must receive at least 70 per cent of their income from provincial and federal governments.

These figures, which are conservative, give some indication of the reasons for making a careful determination of the needs for additional medical schools in this region. Their timing and inter-relations must be carefully worked out so that there is not an excessive financial demand on the economy of the area. They must also be assured of a stable financial set-up.

The lack of such a long-range plan as recommended by Dr. Deutsch has been the chief problem of Dalhousie during the last twenty years. Unfortunately, this deficiency has created more strain in the relations between Dalhousie and the Province of New Brunswick than with the other three provinces.

As already indicated, an increasing proportion of the students from all four provinces entered Dalhousie Medical School during the 1930's and 1940's. However, the University received no financial support from any government until a grant was made by Nova Scotia in 1940 to assist in the operation of the Faculties of Medicine and Dentistry. In 1947, the governments of the other three Atlantic Provinces also provided grants. Table 5 shows the amounts of these grants to date.

In 1954, requests were made for increases totalling $144,000 for the two Faculties. On the basis of enrolment, New Brunswick should have provided a grant of $54,000. Instead, the increase was only to $30,000, less than 60 per cent of what was requested. Newfoundland provided the full amount based upon its student enrolment and Nova Scotia and Prince Edward Island almost the full amount, although the latter increase did not begin until one year after the others.

In 1957, an approach was again made to the provincial governments for increases over a three-year period to 1960. The Province of Nova Scotia

TABLE V
PROVINCIAL GRANTS TO THE FACULTIES OF MEDICINE & DENTISTRY AT DALHOUSIE UNIVERSITY

Year	N. S.	N. B.	Nfld.	P.E.I.
1948-49	62,000	20,000	10,000	3,000
1949-50	80,000	20,000	10,000	5,000
1950-51	80,000	20,000	10,000	5,000
1951-52	80,000	20,000	10,000	5,000
1952-53	80,000	20,000	10,000	5,000
1953-54	80,000	20,000	10,000	5,000
1954-55	80,000	20,000	10,000	5,000
1955-56	150,000	30,000	26,000	5,000
1956-57	150,000	30,000	26,000	12,000
1957-58	150,000	30,000	26,000	15,000
1958-59	258,425	30,000	64,315	15,000
1959-60	258,425	30,000	64,315	18,000
1960-61	294,566	30,000	77,087	25,000
1961-62	294,566	30,000	77,087	25,000
1962-63	294,566	30,000	77,087	40,000
1963-64	294,566	60,000	77,087	50,000
1964-65	564,722	100,000	116,000	50,000
1965-66	650,000	150,000	152,000	60,000
1966-67	913,000	225,000	250,000	80,000

and Newfoundland met our request in full with two increments in 1958 and 1960. Prince Edward Island increased its grant from $12,000 to $25,000 in three increments. New Brunswick refused to make any increase in its grant between 1957 and 1960. Annual visits to Fredericton by the President and Deans of Medicine and Dentistry resulted in a very cordial and sympathetic hearing but no money. Over the three years, the University had to incur deficits of $150,000 on behalf of New Brunswick students.

Partly as a result of the failure of New Brunswick to provide grants between 1957 and 1960, the other governments also refused to increase their grants from 1960 to 1963. In effect, they were not prepared to meet deficits which were incurred on behalf of New Brunswick students.

The Royal Commission on Higher Education in New Brunswick recommended in June, 1962, that an interim grant of $60,000 be made, but suggested an early review of the matter at an interprovincial level. The grant was not increased to $60,000 until 1963. At that time, Da housie had requested a grant of $2,000 per student or a total of $106,000, a level of support comparable to that of Newfoundland.

In the autumn of 1964 it was obvious that Dalhousie Medical School would have a fairly large group of students who could not be accommodated in the following September. We considered that it would be unfair to the Governments of Newfoundland, Prince Edward Island and Nova Scotia to reject their students when, in fact, they had provided support in the amounts requested by Dalhousie. The Premier of New Brunswick was told that there would have to be a decrease in the number of students admitted in the following year unless the grant was increased. The amount requested was $194,000, calculated on the proportionate enrolment. The Government of New Brunswick agreed in February, 1965, to increase the grant from $60,000 to $100,000, but stated that it would stay at the same level for the following academic year 1965-66. This increase brought the New Brunswick grant to a level approximately one-half of that paid per student by Newfoundland and less than three-quarters of the Prince Edward Island rate. Negotiations had already been carried beyond the date when the 1965 class was being selected and the University could not delay action on its selection of students any longer. Notification was then sent to New Brunswick applicants that there would be a limitation in enrolment of New Brunswick students in view of the inadequate financial support. However, the number admitted would equal the number graduating that year, so there would be no decrease in the total enrolment.

This resulted in a very unpleasant argument and a great deal of newspaper publicity. Eventually, the Government of New Brunswick agreed to increase its grant to $150,000 and Dalhousie University accepted New Brunswick students on exactly the same basis of academic standing as those from all other provinces.

It is emphasized that the same criteria had been employed in selecting students every year and New Brunswick students have received the full share of places in the medical class in competition with students from the other Atlantic Provinces. There had never been a limitation on the number of New Brunswick students, although this was threatened, and, in fact, would have been carried out in 1965 if New Brunswick had not increased its grant to a more adequate level and agreed to consider further increments the following year. It is once more reiterated, however, that qualified students have of necessity been rejected during the past three years but in the same proportion from all provinces, not just from New Brunswick.

This review indicates several problems which still require solution. The first is that the Faculties of Medicine and Dentistry at Dalhousie University have not in fact been recognized as regional educational institutions by the governments of the four Atlantic Provinces, as recommended by the Deutsch Commission. The University must make an individual approach to each of the four governments every year. The information as to the governments' decision is often not available until after the budgets for the Medical and Dental Schools have to be submitted to the Board of Governors. It is impossible to plan even for the next year, let alone indulge in any long-range planning on a sound financial basis. There is also no formal agreement among the governments as to the sharing of the cost of these schools. Dalhousie has requested support on the basis of the percentage of students from each province, but there has always been a larger grant from Nova Scotia, although the formula for calculating the extent of this increased support has not been worked out on any sound basis.

Dalhousie University would be quite prepared to accept a system based upon the same grant per student from each of the three provinces, but would expect to obtain a higher grant from Nova Scotia. There are advantages to this province in the location of the school and in the service given to the hospitals by the staff of the Medical School.

It is emphasized that Dalhousie University is prepared to have its Faculties of Medicine and Dentistry continue to serve New Brunswick provided that reasonable financial support is assured for the annual budget, preferably based on a firm commitment for a period of not less than three years and with a formal system for review of the requirements at least one year prior to the completion of each three-year term. The establishment of a grant-per-student for each year would be acceptable, but it is obvious that this would result in a

fluctuation from year to year in the provinces' commitment.

We would prefer to have our Admission Committee free to select students from all four provinces wholly on the basis of their academic and other qualifications. On the basis of past experience, we know that this would produce relatively little fluctuation from year to year in the proportion from each province. It would be preferable not to establish quotas for each province, since New Brunswick might have a larger number of qualified students one year than another. However, subject to Faculty approval, the University would consider introducing a minimum quota for each province provided that the total involved no more than 75 per cent of the Atlantic Provinces students in the Faculty. Each province would then be assured that its enrolment would not fall below a certain fixed figure each year if there were qualified candidates. The University would select the additional 25 per cent on the basis of the relative academic standing of the students from the whole region.

The University would wish to keep 10 per cent of places for non-residents each year. Of the remaining places for Atlantic Province students, three-quarters would be filled by the Admission Committee with the best students from each province up to its full quota, if enough qualified students were available from each province. The remaining 25 per cent (and any unfilled places from the 10 per cent for non-residents) would be selected from the pool of Atlantic Province applicants without regard to provincial residence, provided such applicants also met the standards of acceptability of the Admission Committee.

This system would, in fact, result in the same enrolment pattern as at present. The University will not under any circumstances accept unqualified students in order to fill any provincial quota.

The requirements of the Faculty of Medicine were carefully reviewed and a five-year plan for the expansion of the annual budget presented to the Premiers of the four Atlantic Provinces in June, 1965. A further submission was made in September, 1966, with a request for an increase in the provincial grants for 1967-68.

The June, 1965, projection for Medicine and Dentistry is shown in Table VI:

TABLE VI

ESTIMATED TOTAL PROVINCIAL GRANTS REQUIRED FOR MEDICINE AND DENTISTRY

	Medicine	Dentistry	Total
1965-66	698,280	313,720	1,012,000
1966-67	1,166,280	423,720	1,590,000
1967-68	1,568,980	533,720	2,102,700
1968-69	1,955,780	643,720	2,599,500
1969-70	2,247,680	753,720	3,001,400
1970-71	2,493,580	863,720	3,357,300

The request presented to the governments this year is for increments to bring the provincial grants to $2,102,700 for 1967-68. The increments to be expected from the Province of New Brunswick in the following years would be approximately 22 per cent of the new grants, assuming that the enrolment from that province remains relatively constant.

It is requested that the Government of New Brunswick give assurance to Dalhousie of these increases in order that the staff may be built up to take care of the larger enrolment from 1967-70. In addition, some arrangement will have to be made for larger increments from New Brunswick and Prince Edward Island if the Province of Newfoundland establishes its own medical school. At the same time, there would be a corresponding increase in enrolment from these provinces replacing the Newfoundland students.

The financing of building programs must also be considered. To date, all governmental support for the Sir Charles Tupper Building, the remodelling of the Clinical Research Center and the teaching hospitals has come from Nova Scotia. Dalhousie University requests assistance from the Health Resources Fund for the completion of the first two projects without which an increase in enrolment will be impossible. The most up-to-date cost estimate for the Tupper Building (which does not yet include a firm estimate of the cost of furnishings) is $11,600,000. The remodelling and equipping of the Clinical Research Center will cost $840,000. Research equipment will bring the total to $15,000.000. Expenditures before January 1st, 1966, and the Centennial Grant reduce this figure to $10,500,000. New Brunswick's share of this from the per capita grant would be approximately $1,500,000, if based on the English-speaking population of the province.

In conclusion, we would reiterate our opinion that there is not a sufficient number of students entering medicine in the Atlantic Region to warrant the establishment of two additional medical schools as well as the enlargement of the Dalhousie Faculty.

* * *

This document, published in three parts, was submitted in November, 1966, to the Committee appointed by the Government of New Brunswick to report on the feasibility and desirability of establishing a medical school in that province. This Committee has not yet reported. Meanwhile, however, the Government of New Brunswick has agreed to allocate $1,500,000 of its per capita share of the Health Resources Fund to the Sir Charles Tupper Medical Building, and has agreed with the other three provinces to an additional allocation of approximately 2.5 million from the Atlantic Provinces' grant from the same fund. The Government estimates also include a larger grant toward the annual operating costs of the Medical School for 1967-68 in the amount requested. □

Medical-Legal Inquiries

MEDICAL EXPENSES IN CASES INVOLVING LITIGATION

Q: In suits for damages resulting from an accident, it seems that the plaintiff usually assumes that all his medical expenses will be paid by his medical insurance agency, which is not the case. In addition to this he usually assumes that money he receives if he wins his case is clear money. Is there no way the courts can withold money to pay outstanding bills?

A: Medical expenses arising out of an accident are paid by medical insurance agencies in the same manner as are any other medical expenses and the doctor can submit his bill for payment in the usual way. If the accident necessitates an unusual degree of specialist care the specialist can, of course, submit his account to the patient for this but a bill of this type is no different from any other medical account and payment is the responsibility of the patient, not his lawyer nor any third party.

On the other hand most patient contracts carry a clause indicating that if there is subsequent litigation involving a third party and damages are afforded to the injured person, he must reimburse the insuring agency for monies paid out on his behalf. Should the case come to litigation it will be part of the plaintiff's suit to show that he has been put to considerable expense by virtue of the accident. The monies paid out by him for specialist services and by his medical insurance on his behalf will, together with other expenses, be submitted to the Court for the assessment of special, damages, and should he win his case, he will be entitled to reimbursement for the sum granted by the Court. This will be itemized only insofar as it will be divided into general damages (loss of time, inconvenience, hardship and the like) and special damages for all out of pocket expenses. Specific judgment regarding the bill of the doctor or the medical insurance agency is not an issue before the Court.

Medical - Legal expenses arising from the suit such as review of the medical record, re-examination and witness fees are not covered by medical insurance but are included in the costs of the case which may or may not be granted to the plaintiff.

The last portion of the question raises a fundamental point of misunderstanding. The Courts cannot be considered collection agencies and if the plaintiff fails to pay his bills it is in no way germaine to the primary litigation; nor is it the responsibility of the lawyer to insure that his client pays his bills, though he will always instruct him to do so. □

I.M.

NOVA SCOTIA MEDICAL BULLETIN
Editorial Office

THE BULLETIN is planning a regular Medical-Legal section devoted to **Medical Legal Enquiries.** You are invited to contribute questions.

Q.....

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Please send completed form to: - Ian Maxwell, M.D.
Medical-Legal Liaison Committee
Department of Pathology
Halifax Infirmary
Queen Street
HALIFAX, Nova Scotia

FORTY YEARS AGO

From the Nova Scotia Medical *Bulletin* April, 1927

I was first called to see her Feb. 2nd of this year, on account of a severe pain in left side, lower abdomen, which took her suddenly, that morning, on attempting to get out of bed. She was a thin spare woman, pulse varying from 120 to 130, normal temperature, much bothered with a cough. Abdominal enlargement very pronounced, abdomen very tender not permitting much palpation. Vaginal examination revealed an enlarged uterus and ballottment the presence of some intra uterine body. Breasts very small and flabby and not suggestive of pregnancy. She was in poor shape and that afternoon was removed to Soldiers Memorial Hospital, Middleton.

On the following afternoon, the abdominal tenderness having subsided, in company with Dr. L. R. Morse, a further examination was made. Among the possibilities we had to consider, were abdominal ascites, an abdominal tumor,—either ovarian or of some other variety—a cystic kidney, a pregnancy of an abnormal character, as for instance hydramnios, or a normal pregnancy plus an abdominal tumor. By careful manipulation we thought we could make out a slight sulcus about half way between the Symphsis Pubes and Umbilicus, and that an enlarged uterus, separate and apart from the other mass, could be delineated. It was decided to observe her for a time and endeavor to get her into better shape for any future surgical measures.

After a few days to relieve distress from distension a trocar was introduced and about three quarts of dark green viscid fluid was aspirated,—apparently from an ovarian cyst. This opinion was confirmed by Dr. Nicholls to whom a specimen was sent, although he suggested the possibility of it being due to exudation from a gelatinous intraperitoneal malignant tumor. On Feb. 16th, a laparotomy was done, Dr. L. R. Morse assisting and Dr. Messenger being the Anaesthetist. A median line incision was made, mostly above umbilicus revealing a large ovarian cyst, the pedicle being attached to the right fimbriated body of the uterus. In order to deliver it, it was necessary to use the trocar and an unmeasured amount of fluid obtained. There were some adhesions, upper left quadrant. Pedicle tied off with stout silk and incision closed in the usual way, peritoneum, fascia and skin, with a small cigarette drain which was removed in 24 hours. The solid part of the tumor which was a multi-locular cyst, weighed 8 pounds. Patient made a good and uneventful recovery and left hospital after operation in 14 days.

On May 25th was again admitted to hospital and was delivered of a fine boy, apparently full term, with no complications. Since then has been in good health doing the work that usually falls to the lot of a woman on a large farm. □

Summer Meeting, The Pines, Digby, N. S.

July 1st, 2nd, 3rd, & 4th, 1967

You are invited to complete and return the Housing application form on this page.

Dr. G. McK. Saunders and his Committee Chairmen are developing the program which starts on Friday **evening** June 30. The detailed program will be outlined in an early Issue.

You can be assured of an interesting program which will include time for relaxation to enjoy the surroundings and pleasures associated with The Pines at Digby.

HOUSING APPLICATION FORM
The Medical Society of Nova Scotia
The Pines Hotel, Digby, N. S.
July 1, 2, 3. 4, 1967

Executive Secretary
The Medical Society of Nova Scotia
Dalhousie Research Centre
Halifax, N. S.

Please have reserved for me the following: -

Please check
IN HOTEL

1. ( ) Double room with bath - twin beds - including meals $17.00 per person per day. (accommodates 2 persons)

2. ( )*Single occupancy $20.00 per person per day. If attending alone please indicate with whom you wish to share accommodation.

IN COTTAGE

3. ( )Cottage $5.00 per day with sitting-room and two twin bedded bedrooms - including meals $17.00 per person per day. (accommodates 4 persons)

4. ( )Cottage $5.00 per day with sitting-room and three twin bedded bedrooms - including meals $17.00 per person per day. (accommodates 6 persons)

5. ( )CHILDREN under 14: Rate $9.50 per day per child. Please give ages of children accompanying you.

	Day	Date	Time
Date for arrival	.....	..... AM ..... PM	
Date for departure	.....	.....	

Name of persons who will occupy above accommodations:

NAME (please print) ADDRESS

.....

.....

.....

*In view of the attendance expected, single occupancy of rooms cannot be guaranteed. If coming alone, and you are willing to share a room in the hotel, please check here.....

N.B.—Space will definitely be available at "The Pines" for applications received up to June 10, 1967. Accommodations at the Pines *or* a motel can be provided for applications received after June 10.