Hospital Insurance

The Secretary's Page in the November issue of the Bulletin referred to the Advisory Committee on Health Insurance of The Medical Society of Nova Scotia and the plans which had been carried out to have the medical profession informed about Bill 320. Much has transpired since that time. The Valley Medical Society, the Cape Breton Medical, the Halifax Medical, the Cumberland Medical and the Antigonish-Guysborough Societies have had meetings to discuss Bill 320, and have appointed study committees to report to their respective Branches and to keep in touch with developments. A member of the Advisory Committee has been present at these meetings. Our Advisory Committee has held nine meetings of which two have been with the Hospital Services Planning Commission, one with chairman of special groups and six of the nucleus committee itself of which two were attended by the corresponding members. These activities are all desirable and necessary, since the developmental plan is still active and nothing has as yet been finalized. One major problem has been to obtain a correct interpretation of the wording of several parts of Bill 320. Representatives from the H.S.P.C. of Nova Scotia are proceeding to a meeting in Ottawa December 11-13 inclusive. This meeting is at the "technical level" and it is expected that clarification of several parts in Bill 320 may be forthcoming. Our nucleus committee expects to meet the Chairman of the H.S.P.C. on Monday, December 16 to obtain information stemming from the Ottawa meeting following which are full Committee meets with the Commission on Friday, December 20 for further discussion.

The plan for Insured Hospital Services and aids in diagnosis is of such major importance that this issue has been largely devoted to publishing material pertinent to the subject.

Hospital Services Planning Commission

Press Release
December 2, 1957

THE following pages contain, in outline, introductory material on a Plan of Hospital Insurance, which is now under consideration by the Hospital Services Planning Commission and its Advisory Committee. This material has been prepared for distribution to various public information media.

The Hospital Services Planning Commission was set up on July 15, 1957 under the authority of the Hospital Services Planning Commission Act passed at the 1957 session of the Legislature of Nova Scotia (Bill 55).

The establishment of this Commission stemmed from the Federal Government's action in offering to share with the Provinces the cost of publicly operated hospital care insurance plans. The function of the commission, as defined in the Act, is to inquire into (1) the adequacy of existing hospital facilities in Nova Scotia and the provision of needed additional facilities both for care of patients and for the training of personnel; (2) the present cost of hospital care and the means by which these costs are now being met; and (3) any plan proposed by the Government of Canada relating to a Hospital Care Insurance

Plan. The Commission's report to the Minister of Public Health, which will be based on the results of their inquiries, is to present "A plan or plans for prepaid publicly operated hospital care insurance, including specified laboratory and radiological services; for persons resident in the Province related to a plan or plans proposed by the Government of Canada," together with an estimate of the initial and future costs of the Plan and recommendations regarding methods of operating and financing it.

Objectives of a Plan

It is not the Commission's function to decide on the desirability of Hospital Care Insurance for the people of Nova Scotia. It is the prerogative of the Provincial Legislature to decide whether to accept the Federal offer to share costs of such a Plan, as set forth in the Hospital Insurance and Diagnostic Services Act (Bill 320) passed by the Federal Parliament in April 1957.

It may be interesting, however, to point out the objectives of the proposed plan and to indicate some of the advantages that will accrue to the people of Nova Scotia if a plan is instituted in this Province.

The main objectives of the plan are:

1. To relieve the patient of the burden of the cost of hospital care at the time of hospitalization. Such costs can be catastrophic, especially for persons in the low and medium income brackets, and existing Blue Cross and commercial hospital insurance plans are inadequate to meet the need by reason of limitations placed on the services provided and on the classes of persons accepted for coverage.
2. To relieve the hospitals of financial problems. It is becoming more and more difficult for hospitals to meet their operating costs, which are increasing at the rate of 8-10% per year, from rates charged to patients.
3. To improve the quality of hospital care. Any provincial plan related to the Federal proposal will remove the financial barrier to the acceptance of hospital care by all who need it. At the same time it will enable hospitals to provide a quality of care sometimes made impossible by the stringency of their financial situation.

Nature of the Plan

The Federal legislation provided for assistance to Provinces in meeting the cost of certain specified hospital services. Mandatory services are set forth in the Federal Act, Section 2 (f) as follows:

"In-patient services" means all of the following services to in-patients, namely

(i) accommodation and meals at the standard or public ward level,
(ii) necessary nursing service,
(iii) laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability,
(iv) drugs, biologicals and related preparations as provided in an agreement,
(v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
(vi) routine surgical supplies,
(viii) use of radio therapy facilities where available,
(viii) use of physiotherapy facilities where available,

(ix) services rendered by persons who receive remuneration therefor from the hospital, and

(x) such other services as are specified in an agreement."

It is optional with the Provinces to include the provision of out-patient services in their plan or to leave them out entirely. "Out-patient services" as defined in the Act, "means all or any of the services set out in paragraph (f), except subparagraphs (i) and (iv) thereof, to out-patients as specified in an agreement."

Whatever services are included in the plan must be furnished by hospitals that provide them on uniform terms and conditions to residents of the Province.

There are certain hospital costs that the Federal Government will not share. The most important of these are:

1. Any amount expended (by a hospital) on the capital cost of land, buildings or physical plant.
2. Any amount expended for the payment of any capital debt or interest thereon.
3. Any amount expended for the payment of any debt incurred prior to the coming into force of an agreement or interest thereon.
4. Any provision for depreciation on the value of land, buildings or physical plant.

Also excluded from the Federal plan are hospitals and institutions for the care of the tuberculous and the mentally ill, and nursing homes, homes for the aged, infirmaries and other institutions, the purpose of which is the provision of custodial care. The Federal Government will share only in the cost of operating general hospitals giving active treatment to acutely or chronically ill patients.

It should further be emphasized that this plan is for hospital care only. It does not cover doctors' bills in home, office or hospital, except in some special instances — sometimes referred to as the "traditional medical services in hospitals," such as laboratory and X-ray services. Also outside the scope of the place are spectacles, dentures, wigs and such items. This is not an all-inclusive plan for health care.

To sum up from the patient's point of view, this is a very comprehensive coverage of in-hospital care at the standard ward level. There is no limit on length of stay, no exclusion from benefits for pre-existing conditions or an account of age, and all facilities of the hospital will be placed at the patient's disposal. Naturally, if the patient wants a private or semi-private room there will be an additional charge for which the patient himself must pay, but services of the hospital other than the preferred ward accommodation itself will be available to all.

Areas Requiring Clarification

Comprehensive as this Federal offer seems to be, it still leaves a few points on which the Nova Scotia Commission and also the corresponding bodies in other Provinces, seek changes and/or clarification.

1. The exclusion of mental and tuberculosis hospitals from the shared cost of the Plan. It is the opinion in most Provinces that hospitals for the treatment of these two types of illness should receive the benefit of Federal participation in meeting their operating expenses.
2. The exclusion of all participation in costs related to capital. The situation, as now proposed, will leave the hospitals responsible for finding funds for capital construction or for repayment of funds

already borrowed. There is a suggestion that hospitals may be permitted to retain a certain part of their income from the differential charges for private and semi-private accommodation, but this small concession will fall far short of meeting the need.

3. The low level of assistance provided for construction or expansion of hospitals through the National Health Grants. The present Federal contribution is $1000 per bed for acute treatment and $1500 per bed for chronic treatment, as well as $1000 per each 300 square feet of space devoted to nurses' residences, out-patient, X-ray and laboratory departments and certain other adjunct services. These grants are matched by equal amounts paid by the Province. But Federal and Provincial payments together will meet only about one-sixth of the total cost, which today amounts to $12,000 - $15,000 per bed in active treatment general hospitals.
4. The transfer to the Provinces of responsibility for the care of certain groups formerly cared for at Federal expense. Among these are sick mariners, Indians and Eskimos.

Problem Factors

As the Commission has sought to work out the details of the services to be recommended for our Provincial Plan in accordance with the terms of the Federal Act, certain aspects of hospital care have presented peculiar problems. Among these are the following:

1. The definition of "diagnostic procedures." The Federal Act states that in-patient services include "laboratory, radiological and other diagnostic procedures." The difficulty arises in deciding what services should be included in addition to the two named.
2. The establishing of a definite line of division between hospital services and medical (doctors') services. The Federal authorities have made it clear that their offer is limited to the sharing of hospital costs only. The fact is, however, that interpretation of diagnostic procedures is the function of a doctor, who is usually a certified specialist in his field. It is a question not yet answered whether the doctor who provided the interpretation must receive his remuneration from the hospital, or whether he can be paid for his services directly by the administrators of the Plan.
3. The determination of what constitutes "necessary nursing service." The question arises as to whether a special duty nurse devoting all her time to the care of a seriously ill patient is included in the term. The question is further complicated if the patient is in a private or semi-private room. Who should have the authority to decide whether such nursing care is "necessary"?
4. The scope of out-patient services to be included in the Plan. As mentioned above, the Federal Act allows the province to decide what services are to be included.
5. What drugs, if any, should be excluded from benefits.

Method of Administration

There are two agencies by which such a Plan as is here visualized might be administered.

1. A Commission more or less independent of detailed Government control. Such a body would have approximately the same measure of auto-

nomy as the Public Utilities Board, Nova Scotia Power Commission and similar bodies.

2. A division of the Department of Public Health.

Each of these methods has points in its favor. Among the most powerful arguments for a Commission are independence of judgment and action, and the opportunity it affords for representation from interested groups in the controlling body. Operation from within the Department of Public Health, on the other hand, would provide for closer coordination with other health services and for increased control of the program by the Government.

Financing the Plan

The Federal proposal is for a separate insurance plan in each Province, operated and controlled by the Province, but conforming to certain conditions specified by the Federal Government. The Province will pay the operating costs of hospitals, and the Federal Government will reimburse the Province for a portion of these costs.

The formula on which Federal contributions are to be made is, briefly, 25 per cent of the national per capita cost of hospital services plus 25 per cent of the per capita cost in the Province concerned, multiplied by the number of persons in the Province who are eligible for benefits. Since costs in Nova Scotia are lower than the national average, the Federal contribution will be somewhat more than half of the total Provincial payments to hospitals. On the basis of 1955 figures the proportion would be 57.4 per cent.

It should be noted that this Federal contribution will constitute new money coming into this Province at the rate of several millions of dollars per year. At present levels it would represent a return to this Province of over 5 per cent of the Federal taxes collected in Nova Scotia.

But this still leaves several millions of dollars to be provided by the Provincial Government. How should this money be raised? Several sources of revenue are under consideration.

1. Premiums payable by individuals and heads of families.
2. A special hospital tax.
3. Deterrents.

The premium gives the person who pays a sense of having paid his own way on a straight forward insurance principle. The experience in other provinces, however, indicates several weaknesses, among which are, collection difficulties, high cost of administration, and the problem of payment for those who cannot or will not pay the premium themselves. At reasonable premium rates the revenue would be insufficient to meet the total Provincial costs, and would have to be supplemented from other sources.

A Hospital tax, like any other tax, would probably be unpopular, especially with the merchants who would have to collect it. A system based on Hospital tax, however, would be much cheaper and simpler to administer, and a rate could be set sufficient to yield all the required funds. It would have to be decided, of course, whether such a tax should be levied, at a comparatively low rate, on a broad range of commodities or whether it should be confined to a comparatively few so-called luxury items.

Another source, general revenue, is doubtless excluded because of the heavy financial obligations of the Province in other fields. Two possible sources of a part of the required funds are:

1. The patient, by means of a "deterrent" charge.
2. The municipalities.

Deterrent fees are not designed primarily to produce revenue, but to provide some control over use of services. The income would be relatively little.

Municipalities, through grants to hospitals, underwriting of operating deficits and payment of the costs of treatment of indigents, are bearing a considerable share of the costs of hospital operation in Nova Scotia. They should probably be relieved of part or all of this burden. How much should they continue to pay, and in what way should their contribution be made?

Costs of Education

The Federal Government will share in the cost of hospitals providing education for medical students, nurses, X-ray and laboratory technicians and other hospital personnel.

Control of Overutilization

One of the complicating factors in the operation of the plan is the probable increased use of hospitals. When the prospective patient is relieved of worry about his hospital bill, both he and his doctor are going to be considerably more willing to use the hospital. In principle this is a good thing, for there are undoubtedly many people needing hospital care who are not getting it because they cannot afford it.

In some parts of the Province, however, there is a serious shortage of hospital beds, and, in common with the rest of Canada, we need more nurses, physiotherapists, occupational therapists, social workers, X-ray and laboratory technicians — not to mention medical specialists in radiology, pathology, physical medicine and other fields. It is therefore important that only those who need hospital care should be admitted to hospitals.

Deterrent fees may help to control the number of admissions and the length of stay. There are some to whom even a small charge of $1.00 or $2.00 per day will give pause. On the other hand, hospitals may have difficulty in collecting these charges, and there is always the possibility that some of those to whom this small amount acts as a deterrent are the very people who should be receiving hospital care. The burden could become quite heavy in the case of a long term illness. Also of importance is the fact that deterrents are not shareable with the Federal Government.

In the final analysis the doctor is the chief agency of control. He alone has the authority to apply for the person's admission as a patient, and he alone is qualified to determine when the patient may safely be discharged.

Comparison with Existing Plans in Other Provinces

Saskatchewan has had a hospital insurance plan in operation since 1947, and British Columbia since 1949. Both have been very successful. Ontario has publicized details of a plan to be inaugurated in 1959 as part of the Federal plan. It is instructive to note some of the main features of these three schemes.

Saskatchewan, with a population of about 880,000, has about 94 per cent of their people covered. Individual premiums are $20 per year, with a maximum of $45 for families of three or more. Premiums are compulsory for those eligible for enrolment. One-third of a 3 per cent sales tax is also used for this purpose, and the remaining deficit is met from consolidated revenue. Premiums are collected by officers of the municipalities. Benefits consist of standard ward care in acute general hospitals and approved nursing homes. There is no coverage of out-patient services. Total cost in 1956 was over $22 million.

administration cost about $730,000. Administration is under the Provincial Department of Health.

British Columbia has about 92 per cent coverage of its population of 1,398,000. The remaining 8 per cent are not eligible for benefits because they have not fulfilled the residence requiremnt or are entitled to care from other agencies (armed forces, etc.). A 2 per cent sales tax, plus statutory provincial and municipal grants, and a deterrent charge of $1 per day cover the cost, amounting in 1956 to over $29 million. Administration cost was about $358,000. Benefits are standard ward care in general hospitals, and emergency out-patient treatment within 24 hours after an accident.

The proposed Ontario plan is expected to cover, at its inception, 80-85 per cent of the Province's 5,405,000 people. Premiums are to be compulsory for employees in establishments employing 15 or more persons, but for the rest of the population enrolment is to be voluntary. Amount of premiums is to be $25.20 per year for single persons and $50.40 per year for families of two or more. The deficit will be paid by the Province out of consolidated revenue. Benefits will include standard ward care in general and chronic hospitals, and also care in mental and tuberculosis hospitals. The Province, of course, will have to meet the full cost of care of mental disease and tuberculosis. Total cost the first year is expected to be about $210 million of which one-third will come from each of the Federal Government, the Provincial Government, and personal premiums.

Effect on Existing Plans

Ontario has passed legislation forbidding any agency to write insurance covering standard ward hospital care. While this may not be done in Nova Scotia, it seems probable that there will be little reason for anyone to wish to continue a Blue Cross contract or a sickness insurance policy at the standard ward level, when the Provincial plan will provide fuller coverage at lower direct cost. Industrial check off systems for health care will probably have to be revised to eliminate the portion to hospital care.

There will remain to Blue Cross and other insuring agencies the factors in health insurance not covered by the Provincial plan — such matters as the difference between standard ward and premium accommodation, physicians' services, etc.

Persons Assisting the Commission in Its Work

The Commission itself consists of five members, of whom one, Dr. C. G. Simms, is devoting his full time to this task.

In addition, there is an Advisory Committee to the Commission. This Committee, consisting of 11 members, is representative of various groups in the Province who have a particular interest in details of the Plan and are especially qualified to bring to the Commission expert advice and an interpretation of the opinions and needs of the various segments of our population.

Valuable assistance and co-operation has also been given by personnel in several departments of the Provincial Government, especially those of Health, Municipal Affairs, the Attorney General, and the Provincial Treasurer.

Briefs have been submitted from many groups and some individuals. A public hearing has been held in Yarmouth, and others are planned for Halifax and Sydney. The information and opinions provided through these two media give much valuable guidance to the Commission in its planning.

The material in this release is in the nature of an introduction to the work of the Hospital Insurance Planning Commission and its Advisory Committee, members of which are now considering a plan of hospital care insurance which might be suitable in the Province of Nova Scotia. It is hoped that this release will afford an opportunity to those concerned with public information services to familiarize themselves with the background and issues involved in such a Plan.

Members of Hospital Services Planning Commission

R. McD. Black, Barrister, Halifax, Nova Scotia, Chairman.

Dr. G. G. Simms, Assistant Deputy Minister of Public Health, Halifax, Nova Scotia.

Reverend Mother M. Ignatius, Mother General, Sisters of St. Martha, Antigonish, Nova Scotia.

Dr. H. F. McKay, Superintendent, Aberdeen Hospital, New Glasgow, Nova Scotia.

M. R. Chappell, President, Chappells Limited, Sydney, Nova Scotia.

Members of Advisory Committee to Commission

Dr. J. S. Robertson, Deputy Minister of Public Health, Halifax, Nova Scotia.

Mr. Henry Muggah, Legislative Counsel, Department of the Attorney General, Halifax, Nova Scotia.

Dr. O. C. MacIntosh, Director of Laboratory and Radiological Services, Department of Public Health, Antigonish, Nova Scotia.

Dr. C. B. Stewart, Dean of Medicine, Dalhousie University, Halifax, Nova Scotia

Dr. D. M. MacRae, Medical Society of Nova Scotia, Halifax, Nova Scotia.

Mrs. John MacLean, N. S. Federation of Agriculture, Eureka, Nova Scotia.

Sister Catherine Gerard, Nova Scotia Section, Maritime Hospital Association, Halifax, Nova Scotia.

Miss Florence Gass, Registered Nurses' Association of Nova Scotia, Halifax, Nova Scotia.

Mr. John Lynks, Nova Scotia Federation of Labor, Dominion, Nova Scotia.

Mr. Tom MacLachlan, United Mine Workers District 26, Glace Bay, Nova Scotia.

Mayor Dan A. MacDonald, Union of Nova Scotia Municipalities, Glace Bay. Nova Scotia.

The following letter has been received since the press release issued on December 2, 1957.

Hospital Services Planning Commission
R. MacD. Black, Chairman — H. F. McKay, M.D.,
G. G. Simms, M.D., — M. R. Chappell, Esq.
Reverend Mother M. Ignatius

Box 488, Halifax, Nova Scotia
December 5, 1957.

Doctor C. J. W. Beckwith,
Executive Secretary,
Medical Society of Nova Scotia,
Dalhousie Public Health Clinic,
Halifax, Nova Scotia.

Dear Dr. Beckwith:

Since providing you with a copy of the Commission's background information release to the press, we have learned that my verbal remarks concerning the participation of your profession in planning was not included in the text. I did however, devote considerable time during my remarks to the press to indicate the great help we have received.

May I therefore now take the opportunity to thank the Society through you for the co-operation we have received.

The Commission went on record from the very first to the effect that no successful plan for hospitalization could be implemented without participation in planning by the profession.

The Commission has already had two full scale meetings with your Medical Advisory Committee on Health Insurance. Two more are planned in the immediate future.

In addition, substantial help and counsel has been provided by individuals on that Committee who have met frequently with the Commission and who have made splendid contributions by use of research and statistics reports.

It is our feeling that the progress made by the Commission to date has not only been materially assisted by your co-operation, but perhaps might have been impossible without it.

May I therefore once more express our gratitude and thanks not only to the individuals who have been participating but also to the Society as a whole for selecting them.

Yours very truly,
(Sgd.) R. MacD. Black,
Chairman

5th Session, 22nd Parliament, 5-6 Elizabeth II, 1957

THE HOUSE OF COMMONS OF CANADA

BILL 320

An Act to Authorize Contributions by Canada in respect of Programmes Administered by the Provinces, Providing Hospital Insurance and Laboratory and Other Services in Aid of Diagnosis. Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

Short Title

Short Title

1. This Act may be cited as the Hospital Insurance and Diagnostic Services Act.

Interpretation

Definitions;

2. In this Act,

"Agreement" (a) "agreement" means an agreement made under Section 3;

"Authorized charges" (b) "authorized charges" means charges, authorized by an agreement, to be made directly to patients for insured services, but does not include charges by way of premium or other amount not related to a specific service;

"Conbributions" (c) "contributions" means contributions by Canada pursuant to an agreement;

"Cost" (d) "cost" means the cost, to be determined as prescribed in the regulations, or providing services in hospitals, but does not include

(i) any amount expended on the capital cost of land, buildings or physical plant,

(ii) any amount expended for the payment of any capital debt or interest thereon,

(iii) any amount expended for the payment of any debt incurred prior to the coming into force of an agreement or interest thereon, or

(iv) any provision for depreciation on the value of land, buildings or physical plant;

"Hospital" (e) "hospital" means a hospital or other facility, prescribed by the regulations, providing in-patient or out-patient services, but does not include

(i) a tuberculosis hospital or sanatorium,

(ii) a hospital or institution for the mentally ill, or

(iii) a nursing home, a home for the aged, an infirmary or other institution the purpose of which is the provision of custodial care;

"In-patient services" (f) "in-patient services" means all of the following services to in-patients, namely,

(i) accommodation and meals at the standard or public ward level,

(ii) necessary nursing service,

(iii) laboratory, radiological and other diagnostic procedures together with the necessary interpretations

for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability,

(iv) drugs, biologicals and related preparations as provided in an agreement,

(v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(vi) routine surgical supplies,

(vii) use of radiotherapy facilities where available,

(viii) use of physiotherapy facilities where available,

(ix) services rendered by persons who receive remuneration therefor from the hospital, and

(x) such other services as are specified in an agreement;

"Insured Services" (g) "insured services" means the in-patient services and out-patient services to which residents of a province are entitled under provincial law wthout charge except a general charge by way of premium or other amount not related to a specific service and except authorized charges, but does not include services any person is entitled to and eligible for under any Act of the Parliament of Canada or a provincial legislature specified in an agreement;

"Minister" (h) "Minister" means the Minister of National Health and Welfare;

"Out-patient Services" (i) "out-patient services" means all or any of the services set out in paragraph (f), except subparagraphs (i) and (iv) thereof, to out-patients as specified in an agreement; and

Participating Province" (j) "participating province" means a province that is a party to an agreement.

Agreements Authorized

Agreements authorized 3. (1) Subject to this Act, the Minister may, with the approval of the Governor in Council, enter into an agreement with any province to provide for the payment by Canada to the province of contributions in respect of the cost of insured services incurred by the province pursuant to provincial law.

Provincial law described (2) The provincial law referred to in this Act in relation to a province is a law of the province that

(a) makes provision for the furnishing by hospitals of insured services upon uniform term and conditions to residents of the province under the conditions specified in this Act and the regulations;

(b) makes provision for the payment of amounts to hospitals in respect of the cost of insured services, and the payment of such amounts as may be specified in an agreement when insured services are provided to residents of the province, who are eligible therefor and entitled thereto, by hospitals that are owned or operated by Canada or are situated outside the province; and

(c) authorizes the province to enter into an agreement.

Contributions

Amount of Contributions

4. The contribution payable to a province under an agreement shall be paid in respect of each year, and shall be the total of

(a) the aggregate in that year of

(i) twenty-five per cent of the per capita cost of in-patient services in Canada, and

(ii) twenty-five per cent of per capita cost of in-patient services in the province less the per capita amount of authorized charges in respect thereof,

multiplied by the average for the year of the number of persons in the province who were eligible for and entitled to insured services at the end of each month in that year; and

(b) an amount that is in the same proportion to the cost of out-patient services in the province, less the amount of authorized charges in respect thereof, as the amount payable by Canada under paragraph (a) is to the cost of in-patient services in the province less the amount of authorized charges in respect thereof.

Terms of Agreement

Provisions to be included in agreements

5. (1) An agreement shall

(a) specify the insured services to be provided;

(b) specify the amount of authorized charges;

(c) include a schedule of hospitals in the province; and

(d) set out the scheme for the administration of the provincial law.

Covenants by provinces

(2) In every agreement, the province shall covenant and agree

(a) to make insured services available to all residents of the province upon uniform terms and conditions;

(b) to make such arrangements as are necessary to ensure that adequate standards are maintained in hospitals, including the supervision, licensing and inspection thereof;

(c) to maintain adequate records and accounts in form satisfactory to the Minister respecting the provision of insured services and the cost of in-patient and out-patient services and at any resonable time to permit access thereto and audit thereof by the Minister or any person designated by him; and

(d) to make provision for the recovery of the cost of insured services furnished to a person in respect of an injury or disability where such person is legally entitled to recover the cost of such services from some other person by way of damages for negligence or other wrongful act, and to make provision for the recovery from such other person by subrogation or otherwise, and to take all proper and reasonable steps to effect such recovery.

Covenants by Canada

(3) An agreement shall contain covenants by Canada

(a) to pay the province in accordance with the provisions thereof the amounts that Canada is authorized to pay to the province under this Act and the regulations, and

(b) to make available to the province reports and records of the calculation of costs.

Deduction of premiums from wages

(4) Where the provincial law contains provisions requiring employers to deduct from the wages, salary or other remuneration payable to their employees any premium or other amount not related to a specific service, the Governor in Council may make regulations for giving effect to such provisions in relation to persons who are paid wages, salary or other remuneration out of the Consolidated Revenue Fund, or to persons who are employed by Her Majesty in right of Canada or any agent of Her Majesty.

Payment of Contributions

Payment of contributions

6. (1) Contributions or advances on account thereof shall be paid by the Minister of Finance out of the Consolidated Revenue Fund upon the certificate of the Minister at such times and in such manner as may be prescribed in the regulations or in an agreement, but all payments of contributions are subject to the conditions specified in this Act and the regulations and to the observance of the covenants, agreements and undertakings contained in an agreement.

Condition

(2) No contributions shall be paid under this Act until at least six provinces, containing at least one-half the population of Canada, have entered into an agreement, and the provincial law in relation to those provinces is in force.

Operation of Agreements

Duration of Agreements

7. (1) Subject to subsection (2), every agreement shall continue in force so long as the provincial law remains in operation and the province continues to give full effect to the agreement or until the expiration of five years from the day on which notice of intention to terminate the agreement is given by the Minister, with the approval of the Governor in Council, to the province with which the agreement was made; but notice of intention to terminate an agreement may not be given until after the expiration of five years from the day the agreement came into force.

Amendments

(2) An agreement may be amended or terminated by mutual consent of the parties thereto

(a) with the approval of the Governor in Council, or

(b) with the approval of the Minister, in respect of any matter referred to in subparagraph (iv) or (x) of paragraph (f) or paragraph (i) of section 2, paragraph (c) or (d) of subsection (1) of section 5 or the Acts referred to in paragraph (g) of section 2.

Regulations

Regulations

8. (1) The Governor in Council may make regulations for the administration of this Act and of agreements and for carrying their purposes and provisions into effect and, without restricting the generality of the foregoing, may make regulations.

(a) defining "residents of a province" for the purpose of this Act, but no specified period of residence shall be required as a condition precedent to the establishment of residence in a province.
(b) for calculating costs for the purposes of this Act; and
(c) prescribing the matters to be included in the scheme for the administration of the provincial law.

Alteration of regulations

(2) No regulation, by reference to which an agreement with a province has been made, shall be altered except with the consent of the province or in accordance with the regulations to which it has agreed.

Report to Parliament

Report

9. The Minister shall, as soon as possible after the termination of each fiscal year, submit a report to Parliament respecting the operation for that year of the agreements made under this Act and the payments made to the provinces under each of the agreements.

Commencement

Commencement

10. This Act shall come into force on a day to be fixed by proclamation of the Governor in Council.

As Passed by The House of Commons 10th April, 1957.

Obituary

Dr. Marion Robertson O'Brien, age 51, passed away suddenly on the evening of November 29. She had been in good health, and the fatal heart attack was both sudden and tragic.

A native of Buctouche, N. B., Marion O'Brien graduated from the Dalhousie Medical School in 1927. She specialized in radiology and pathology in Charlottetown, P.E.I., until 1933 when she retired from active practice. Dr. O'Brien was interested and active in many things in the community and was a member of the I.O.D.E. During the second World War she did voluntary work in the Navy League canteens.

Mrs. O'Brien leaves to mourn her loss her husband, Dr. Harry D. O'Brien, one son, John, a student at Kings Collegiate School in Windsor, a brother, K. C. Irving of Saint John, N. B., and two sisters, Dorothy, (Mrs. George D. Watt) of New York, and Mrs. A. R. Rettie of Halifax.

Dr. Ferguson Robert Little, age 66, passed away on Sunday, December 1, while a patient in the Halifax Infirmary. In poor health for some years his fatal illness occurred on November 26.

Dr. Little had practised medicine in Halifax for 38 years. He was born in Halifax and was educated at Halifax County Academy. He graduated from the Dalhousie University with his M.D., C.M. in 1914. In his youth he had been a great athlete, was captain of the Dalhousie football team, played inter-collegiate hockey, and was a star performer with the old Wanderers' English rugby team. He was a noted oarsman and fisherman, and until a few years ago enjoyed hunting. Dr. Little was always interested in community affairs and politics and was a past president of the Nova Scotia Progressive Conservative Association.

He is survived by one son, Hugh R. Little, Halifax, one daughter, Marion, (Mrs. James Sutherland, Vancouver), and four grandchildren.

Brief from The Medical Society of Nova Scotia to Hospital Services Planning Commission. Hospital Insurance and Laboratory and Other Services In Aid of Diagnosis

The Medical of Nova Scotia is pleased to submit this Brief as representing the thinking of the medical profession of this Province.

We wish to record our appreciation of membership on the Advisory Committee to the Commission and more particularly the direct access of our Advisory Committee on Health Insurance to the Hospital Services Planning Commission. Since the proposed plan for insured services includes some medical services, it is of vital importance to the success of the plan that adequate consultation be held with the medical profession to assure the best services to the people of Nova Scotia.

The Medical Society of Nova Scotia will present its views under three headings: (A) Administration, (B) Diagnostic Services, (C) Hospitalization Insurance.

(A) Administration

(1) The Medical Society of Nova Scotia endorses the principle of The Canadian Medical Association that all health insurance programmes which are subsidized by government funds should be administered under the authority of an independent commission, representative of those giving and those receiving the services, responsible to government.

(2) The number of commissioners should be not less than three and not more than five and should include one from nominations made by The Medical Society of Nova Scotia.

(3) Since the commission will be largely concerned with the provision and utilization of both hospital care and diagnostic medical services, The Medical Society of Nova Scotia feels the commission should employ as managing director, a medical doctor preferably with the following qualifications: (a) a graduate of at least ten years; (b) have adequate experience in clinical practice and medical administration; (c) be in good standing with The Medical Society of Nova Scotia.

(4) The executive officer should supervise the administration of the programme on behalf of the commission.

(5) Careful consideration should be given to making use of existing non-profit organizations. It is specifically recommended that the agency for medical services should be Maritime Medical Care, Incorporated.

(6) The Medical Society of Nova Scotia would offer its services in an advisory and consultative capacity to the commission.

(B) Laboratory, Radiological and Other Services in Aid of Diagnoses

The Medical Society of Nova Scotia would emphasize that laboratory, radiological and other services in aid of diagnoses are medical services, which have professional and technical components, whether performed in or out of hospital. Radiology and clinical pathology are specialties in medicine and have the same academic standing with The Royal College of Physicians and Surgeons of Canada as any other specialty in Medicine and Surgery.

The following paragraphs present some view of this Society on these services.

(1) It is the aim of the radiologists and clinical pathologists of Nova Scotia to provide all residents of the province with as complete and as high a standard of service as possible. To accomplish this will require an adequate number of well trained professional and technical personnel and the provision of a budget related directly to the volume of such services, and separate from the budget for hospital services.

(2) These services should be available to patients out of hospital. This should receive careful consideration and not be instituted until there is sufficient trained personnel to provide the desired standard of service.

(3) The Medical Society of Nova Scotia recommends that payment for professional services be on a fee-for-service basis, except when under special circumstances a physician may choose arrangements for remuneration other than this preferred method; that the tariff of The Medical Society of Nova Scotia be the basis for fee-for-service payment and that the physician be paid directly for all professional services by the agency employed by the commission. There may be special circumstances such as sparsely settled areas, etc., where it will be necessary to consider remuneration in addition to the fee for service.

(4) Since some of the proposed services are now performed by physicians in private radiological and clinical pathological practice and in offices of other medical practitioners, these services should be included in any insurance plan, provided these are up to accepted standards.

(5) The Nova Scotia Association of Radiologists through The Medical Society of Nova Scotia is willing to assume responsibility for setting up standards to ensure the quality and accuracy of diagnostic radiology as practised in Nova Scotia.

(6) The Medical Society of Nova Scoia is willing to assist in any way possible in designing measures to control the utilization of the insured services.

(7) The administration should be by an insurance commission as mentioned under "Administration" paragraph 1. We do not believe that medical services should be administered by a hospital commission. Nevertheless, for practical purposes and as a temporary measure only, the above may be necessary during the transition period. The "medical" as distinct from the "hospital" nature of the services must, however, be kept in mind and the budget for each type of service should be kept separate.

(C) Hospitalization Insurance

The medical profession is interested in hospitalization because doctors are responsible for the care of their patients while in hospital as well as out, and the profession also shares the responsibility with the administrators and the superintendents of nurses for the day by day operation of the hospital. Accordingly, The Medical Society of Nova Scotia recommends:

(1) That hospitalization insurance be available to all residents of Nova Scotia for general ward care. The latter to include nursing care as required, meals, and special diets, the use of operating and case rooms, including anaesthetic supplies and equipment, blood and plasma, surgical dressings and casts, formulary drugs, etc.

(2) That such insurance be applicable to semi-private and private wards, with additional payment for such accommodation.

(3) That persons receiving the benefits of such insurance co-operate in the clinical training of medical students, nurses, technicians, etc.
(4) That medical functions of the hospital be delegated to the medical staff.
(5) That the medical staff be organized so that, in so far as possible, it will fulfil the requirements of Hospital Accreditation.
(6) That there be a joint conference committee for liaison between the governing board of the hospital and the medical staff.
(7) That part of the duties of the medical staff be to assist in the control of admissions and length of stay in hospital.
(8) That physician services are not part of hospital services and shall not be treated as such.
(9) That adequate financial provisions are made initially to permit high quality hospital services, and that the budget be adjusted periodically according to need.
(10) That any subsidized scheme ensure that the patient will receive the increasing benefits associated with the advancement of medical science by providing for administration, research, teaching, adequate physical facilities and properly qualified personnel. A specified portion of the budget should be set aside for these purposes.

D. M. MacRAE, M.D.
Chairman, Advisory Committee on Health Insurance

C. J. W. BECKWITH, M.D., D.P.H.
Executive Secretary
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F. J. Barton, M.D.
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Letters to the Editor

8 Birchdale Avenue,
Halifax
Dec. 10th, 1957

The Editor,
The Bulletin,
Medical Society of Nova Scotia.

RE HEALTH INSURANCE

So we are to have a further extension of Government Health Insurance! And because it begins to have its first real impact upon the practice of Medicine, we are all in a flurry about it. Why are we so excited? (From the committees galore, all the meetings, and all the hours of talk that are going on just now we obviously are excited). Why? Is it because it "all came so suddenly"?

Organized Medicine in Canada has seen it coming for many years and has said so. Provinces have been affected one after another on an individual basis. Others, knowing that sooner or later they would be involved, had kept up discussions of the possibilities and had established patterns of action against the time when they would be required. We, in Nova Scotia, have, in general, been sceptical and those who might have kept us interested and active would probably, by now, have been stoned as Jeremiahs had they done so. Do you say "impossible"? How many of us remember the meeting at Keltic Lodge when some of our more vocal members provided a Roman holiday for those present by scoffing our suggestions out of court as we tried to advance a realistic appraisal of the possibilities for us for Health Insurance in this province?

This is not being written now with any idea of saying "I told you so" or of rubbing anyone's nose in anything. It is salutary at times, however, to be reminded of our folly. Why do I say folly? Because, like the foolish virgins of scripture, failure to prepare ourselves finds us with no light. In so many cases we are so terribly uninformed. There are, of course, many who know a great deal of the score, and are anxious. Still others do not know too much, but are concerned. I know that, from the interminable questions that are directed to me—questions which, as far as possible, I am always happy and indeed anxious to answer. It is largely because of that, that I now offer this contribution to your pages. I believe that many other members of our Nova Scotia Society are concerned—as they indeed should be—and would like to see some views presented in our Bulletin.

Our appreciation of what was likely to happen in Health Insurance goes back well beyond the time of the Saskatoon Declaration. That, however, is a good time to look at, because that Declaration (which has been amplified and reaffirmed several times since) is the Magna Charta of Canadian Medicine.

I. Its first principle on which I am finding most lack of knowledge is that then adopted, later confirmed on the national level, and formally adopted on the provincial level, which says in effect: We recognize the right of every citizen of Canada to be insured against the cost of sickness. This was carried further and it was intimated that we would very much prefer to see it under a

system of voluntary prepaid insurance; but we could in no sense see ourselves denying this insurance to our people if the cost of the premium were picked up by Government. Sometimes indirectly, but for the most part directly, we agreed at all major levels of medical organization, that we were in favour of Health Insurance.

II. Our second principle was that any form of Governmental Health Insurance "should come in stages, beginning with Hospitalization." The enunciation of that principle appeared to throw consternation into the camp of some of those who had been working hard for a completely comprehensive measure—hospital and all forms of medical care insurance—all at once.

It is my view that — despite the very recent demand of the Honourable Leader of the C.C.F. party that we should at the current session of Parliament, introduce the total measure — Canada should thank organized Medicine for adopting and promulgating this principle. We shall now almost certainly have the Hospital stage first.

III. The third principle was, in effect, that the operation of any measure of Health Insurance should be by a Commission — non-political in nature, and composed of representatives both of those giving and of those receiving the insured services. Implicit in this has always been the idea that this must apply to the operation of *any* commission and at every phase of a commission's activities — planning or administrative, because, of the two, planning *could* be the more important.

IV. There were many other principles laid down having to do with the preservation of the doctor-patient relationship and the position of the doctor in the scheme, all at the same time being for the preservation of the high quality of Medicine in Canada. This is the phase of thinking at which we should have arrived. We are not ready for it, however, until the preceding ones are firmly established. It is therefore not pertinent to this writing.

"Bill 320" — The measure of Health Insurance covered by "Bill 320" is Hospital Care and certain diagnostic services, to be defined, in both their technical and professional (medical) components. It specifically names radiological and laboratory services among them.

This Act, in virtually all its phases, makes important impact upon the practice of Medicine, and when it becomes effective, we shall have serious new responsibilities because of it. This is, more or less, generally accepted, but the interesting question is how are we reacting to the knowledge?

There are of course a goodly number, no doubt the majority, who say, "We have consistently professed our desire and intention to co-operate with Governments in the application of such measures provided that our principles receive proper respect." On the other hand, as the details are discussed, we find some seriously contending that *no* part of the Medical side of diagnostic services should be covered by Government insurance and that we should strongly recommend that the Act be amended to exclude it. Very occasionally, we find the opposite of that with others suggesting that *all* diagnostic services, whether they have "hospital" or "technical" components or are entirely Medical Diagnostic Services, should be included. The Government of Canada has made provision for the covering of certain things, though there may be some modification made in the Federal-Provincial agreements when they are made. We shall not seek any extension of Medical Diagnostic Services under the Act, but are we in Medicine to suggest that certain insurance benefits offered to the people of Canada are to be denied? Sir! I take the position that when and if our profession makes demands on Government, it should be on behalf of fair-

ness and justice in administration and because fairness and justice as *we* see those qualities, will also be for the best interests of health in our country. If we take Britain as an example, obviously Governments cannot be trusted to do what is best for those interests.

It will also be seen that any effort on our part to deny insurance to our people, contravenes our first principle as listed above, to which the vast majority of Canadian doctors have subscribed. This contention would therefore not get far, except against our efforts in the realm of public relations, in which, in our own province, it would be of incalculable harm. Frankly, one is more than surprised that the suggestion could be born at all, for in conceding this, right we need not surrender those traditional practices which we shall continue to regard as essential.

On the matter of Health Insurance coming in stages: again we should, I am sure, be thankful that that principle of ours is being respected. I say that, both as a citizen and as a doctor. We would prefer very much to have seen any and all forms of health insurance paid for on the basis of individual or family premiums — paid directly by the insured person or group where possible and by the Government in the case of persons not able to pay. I say that because, in the final analysis, it is economically sound for the people who can pay, to pay for what they get *and to know they are paying.* This does not seem, however, to be in keeping with current political philosophy, except in Ontario, and so we may not see it done that way. Instead, we may have to accept a compromise. The introduction of Hospital insurance at this time will, however, give opportunity to study and appreciate the cost of one phase before going on to the next, unless the C.C.F. gets the chance soon to try to impose upon Canada the British system of Health Insurance, which is its current threat.

Doctor's concern as regards "Bill 320" takes several directions. When we think of the present relations of doctors with hospitals in our province, generally we are quite happy. The required standards for the accreditation of Hospitals, established by the International Joint Commission, keep hospital authority and Medical Staff authority in balance, and our good relations are preserved. It has not always been so, however, especially in other places on this continent, and I have no doubt but that in a large measure the rules and regulations for Accreditation were written as they were, as a corrective to a trend towards hospital domination which was then very much in evidence. While that trend was never as great in Canada as elsewhere, nevertheless our doctors do not want to see the present state of affairs disturbed, and so they are troubled by a provision of the Act which makes this possible.

The Act indicates that the provinces must produce a plan which Ottawa may accept, but it requires "*the provision by hospitals*" of certain diagnostic services which include interpretation by doctors. Insofar as doctors now have contractual relations with hospitals, or may in future have such relations, no one is or will be concerned. The Commission may and probably will ask the hospitals to carry on just as they are doing. The objection is not that they may do just that, but that *the hospital and only the hospital — not the province — not the commission — is given this power by law to furnish those doctors' services.*

It was the desire to preserve the present balance that led the Halifax Medical Society a week or two ago to express, in a resolution, their strongest recommendation that the two words "by hospitals" in this context, be deleted from Act. If the Act is not so amended, hospital staffs will be watching their Accreditation rules much more closely.

Another, indeed our greatest concern, is the matter of Commissions. In III above, I have cited the position and principle of organized Medicine in Canada with respect to them. While our advisory committee to the provincial government has worked assiduously on our behalf in connection with the whole business of "Bill 320" under their terms of reference from the Medical Society of Nova Scotia, and while, as indicated in the November Bulletin, they have received "concessions" which allow our committee to go directly to the planning Commission if, as and when required, it is clear that this province has not yet seen fit to pay the respect to this principle which we regard as an essential tenet of our faith. We have no representative on the Commission.

The Nova Scotia Medical Society, at its last annual meeting, expressed its displeasure at the attitude of government with respect to our relationship to this matter which affects us so closely. I am credibly informed that reaction to this complaint was of the nature of this: "We don't see why the Medical Association should be dissatisfied—we appointed two members of their Society to the Commission." A few days ago I met Dr. MacKay, one of our medical members of the Commission, by sheer accident, and in the course of discussion I mentioned the matter of this discontent — that we had no representative of our Society on the Commission. He informed me that there was no representative of anything on it. I intimated my appreciation of the joke by asking him whether Dr. Simms represented anything, or whether Mother Ignatius of St. Martha's Hospital, or he of Aberdeen Hospital were just appointed by accident. I also asked him if he thought that the Nova Scotia Medical Society, given opportunity to nominate a man, as was done in Ontario, would elect either of the government-selected men to represent us no matter how highly we regarded them both as doctors? We have no kick about either of those men being on the Commission. We do regard them both very highly indeed, but to say that they represent the organized profession of this province is just not so. We simply are not represented on a Commission to plan legislation which will very definitely affect our profession. On the other hand, it is everywhere admitted that, to a very great degree, the plan must have our interest and close co-operation to ensure for it any reasonable measure of success.

. . . . . .

Sir, the citing of those principles of Canadian Medicine — formally adopted by our own Medical Society — indicates a pattern for us to follow, but one which unfortunately we have not followed. This may suggest that I am offering criticism of our own Nova Scotia Advisory Committee. That is not so. Direction was given to that committee by our Society in the belief that it was the right direction, and in the unfortunate understanding that they were doing so on authoritative advice. I would make it clear, therefore, that if there is any criticism involved, it is upon us all as members of our Society. We had not studied sufficiently thoroughly what time, experience and our best minds have regarded as essential principles in the maintenance of the high standards and traditions of Canadian Medicine. If we had, we could simply have picked them up when we needed them, dusted them off, and applied them to the good of all concerned. However, I think that after all our fumbling of the ball, it is not too late to recover it now. It is only necessary for our Nova Scotia Medical Society to undertake a reappraisal of where we are and what we are sacrificing and then to change our direction and establish the pattern that we believe is the correct one.

I have mentioned Ontario. It is only a couple of months since the advisory committee of our sister division there, through its Advisory Committee, was able to convince the Commission — *to which they always had had direct access* — that the O.M.A. should be represented on the Commission. The Commission in turn recommended to the Department of Health that in addition to any other Medical men on the Commission, such a representative be appointed. I don't know what changes were necessary to make the appointment possible, but the O.M.A. nominated their man and he was appointed, their Advisory Committee being kept as active in reflecting Medical opinion as ever.

Sir, I have written at this length for two other reasons:

(1) I have the same complaint that you have — "no letters to the Editor" (November Bulletin) — that at this most important time in the history of Medicine in our province so little is going into our records to indicate that there are some men among us with very strong views on the general subject of this letter. I am happy to be able to testify now that there are many such men among us, and happy too to see that many of them are of our younger brighter minds who have concern for the future of Medicine in Nova Scotia. This of course is fitting, since it naturally affects them and not persons of my age who will soon have outlived their usefulness. Yet even for older men there is the obligation to posterity to see that as far as we can, we shall work to maintain those principles in time of war to which we gave lip service in time of peace, and to see that our views and our methods are recorded.

(II) The second reason is more personal. I have been misquoted — no doubt on misunderstanding — in answers that I have given to questions asked of me. It is important that that does not occur. I believe that the principles adopted by Canadian Medicine are good for us, and that in full respect for them, lies safety for the future — (a) in the manner in which the doctors of the future shall conduct their practices, (b) in the degree to which scientific medicine will or will not continue to progress, and, most important of all, (c) in the quality of medical care that the Canadian people will receive. (Remember Mr. Coldwell's threat to give Canada the British system). There is nothing equivocal in my respect for those principles, though details within their compass may vary widely, and so herein would I nail my colours to the mast.

Finally I would agree with the view now so frequently expressed, that since nothing more important has faced our Medical Society in its history, the Society should, regardless of cost or inconvenience, meet as often as may be required, either in its Executive or in extraordinary meeting of the membership, until our principles are recognized. It should see that the air is fully cleared of any misconceptions which may now be entertained by any of us, and in unanimity as near to the absolute as possible, should determine the course of our future conduct by such principles as may then be adopted or reaffirmed. Experience elsewhere has shown that principles, once sacrificed, are just about impossible to revive, great medical skill to the contrary notwithstanding.

Norman H. Gosse, M.D.

Prepaid Medical and Hospital Care by the Check-off System in Cape Breton[1]

H. J. DEVEREUX, M.D.[2]

THE medical services for the miners and their dependents in the Cape Breton area are provided by five different hospitals and thirty-eight doctors. These services are supported by the check-off system whereby the Dominion Coal Company deducts from the wages of its employees fixed amounts for specified services. These wage deductions are a condition of employment; a miner going to work in any mine must check-off to a certain doctor and hospital before he can be employed.

The earliest information on the check-off system is found in the minutes of the Provincial Workers' Association, the miners' union prior to the organization of the United Mine Workers' Union, and these show that deductions were made for the services of doctors and support of schools prior to 1883. In 1903 the practice of holding back specified amounts from the payroll of the miner was approved by the provincial legislature and in 1918 a bill was passed in the provincial legislature making it compulsory for all miners to have deductions made for both hospital and doctor. Since then, the check-off has been used to deduct money to pay for taxes, support of churches, relief societies and many other types of payments, and the miner today supports most of his charitable organizations as well as schools, doctors and hospitals through the check-off. This is one of the weaknesses of the check-off system because it relieves the miner of a sense of responsibility in these matters.

In 1926, a Royal Commission on the coal mining industry of Nova Scotia recommended that the check-off be abolished except for hospital services but nothing came of this recommendation and the check-off system is still in vogue in all the coal mining areas in Cape Breton.

Subscribers' Payments

Practitioners' services. The wage deductions for check-off have varied greatly over the past forty years. In 1914, men working in Company stores or railroads paid 30c a month if they were single and 40c a month if married. The miners at this time paid 40c a month if single and 50c a month if married, for which the doctor supplied all drugs, surgical, obstetrical and medical services. The only exception was that the subscriber was to pay $5.00 for confinements, but this was rarely done. In 1916, the rate was increased to 60c a month. In 1920, the rate was increased to 25c per week for all subscribers and this continued until 1925 when there was a strike that lasted six months. During that time, the doctors and hospitals supplied the same services but received no money and when the men did go back to work they did not pay back the check-off that should have been paid during this period. About 1927, the rate was increased to 40c per week, both to hospital and doctor, and this rate continued until 1947 when the doctors were refused a further raise and thereupon refused to dispense drugs. Over the next three or four years there was constant bargaining. One offer put forward by the doctors at this time was that for

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1Presented at the forty-fourth annual meeting, Canadian Public Health Association, Saint John, N. B., May 29-31, 1956.

2Chairman, Medical Economics Committee, Medical Society of Nova Scotia.

*Reprinted from the Canadian Journal of Public Health, May, 1957.

90c a week they would give complete care including specialists' care; this was brought before the various union locals and was turned down. Following this refusal, the doctors refused to supply drugs and the 40c a week covered only medical, surgical and obstetrical care. It was soon discovered that people did not buy drugs when the doctor did not supply them. After about a year, it was agreed that the miner would pay $1.00 a week to the doctor for which he would receive complete medical, surgical and obstetrical care, as well as ordinary drugs; such drugs as insulin, cortisone, expensive antibiotics, and some of the more expensive vitamins were not supplied. There was also a clause in this agreement that the subscriber would pay $10.00 for confinement cases but this is rarely ever paid and the doctors do not make any effort to collect it. Today, about 80% of the miners pay $1.00 a week and get the full services, the other 20% pay 40c a week and buy their own drugs. This $1.00 per week paid to the doctor does not carry any weekly indemnity; the subscribers pay an extra 25c a week to their relief society and in return may receive $14.00 per week for six months, after that the amount is gradually reduced until it expires at the end of two years. The Dominion Coal Company contributes from $8,000 to $10,000 a year to this relief society.

Specialists' care. Under this sytem, specialists' care is not provided, but there is an exception to this in Glace Bay where a clinic or group practice has been formed. Here the doctors, if necessary, will themselves pay an eye, ear, nose and throat specialist for treatment of injury or disease to the eyes or removal of a foreign body from the oesophagus, but refractions are not covered.

Hospital care. The subscriber also pays $1.25 a week for hospital care and this is the same for single or married men. Twenty-five years ago they paid 30c a week but it has gradually been increased up to the present rate. For this $1.25 a week, the subscribers and their dependents receive ward bed care which can go on indefinitely. They get free operating room services, free case room services and almost free laboratory and X-ray services. For laboratory services there is now a nominal charge which may vary from 50c to a maximum charge of $3.00 regardless of how much work has been done. There is also a nominal charge for X-ray work which ranges from $1.00 to $5.00 and $5.00 is the maximum, even though a man may have had a complete radiological survey while in hospital. The miners themselves, however, bitterly object to this so-called "extra billing." While in hospital, the subscriber receives, at no additional charge, the ordinary standard hospital mixtures such as cough mixtures, tonics, aspirins, penicillin and insulin, but such items as expensive antibiotics, cortisone and liver extract are charged for. All dressings are free. Men who have been pensioned off from the coal mine pay $1.00 a month and receive all the privileges mentioned. If the man or his dependent wishes to take a private room, he pays $1.50 a day and if it is for an obstetrical case, $2.00 a day extra. The hospitals paid by the check-off still run on a deficit though it is not as large as that of the privately owned hospitals in our area. Hospital authorities admit that if it were not for the shortage of beds, their deficit would be greater.

Under the check-off system, the Compensaton Board does not have to pay either the doctor or hospital for treating a man who has been injured in the mine, so the Company and the Compensation Board are not too anxious to have this system changed. In discussing this matter with the men active in the

local unions, they claim that this is their biggest hurdle to get over in trying to get the system changed.

Volume of Service. I would like to give a rough outline of the work done by one of the practitioners in the Glace Bay area. He has 500 subscribers or roughly 2,000 people to look after. He does about 200 confinements a year, about 130 major operations and 250 minor operations; these minor operations include tonsillectomy, teeth extractions, lacerations, etc. He sees about 40 patients in his office each day and besides this he makes 12 to 15 house calls a day. Ordinary procedure, such as pelvic examination, suturing of any extent, blood counts and urinalysis, are not done in his office but are done in the out-patient department in the hospital at a very minimal cost to the patient. This man would earn approximately $25,000 a year, out of which he pays an assistant about $7,500 and his drugs and supplies would cost him roughly $3,000, but in talking this over with the clinic group in Glace Bay, they state that their staff, drugs and supplies consume about 50% of their gross income.

Advantages of the Check-Off System

A. *As relating to the doctor.*

- There is very little bookkeeping to be done as most of the money comes in a monthly cheque.
- Office expense is much less for the individual doctor although in the group practice the office expense is fairly high.
- There is less competition than in private practice, because subscribers tend to stay with the practice they have been paying into, so that a new man coming into a practice recently vacated finds himself with a steady income of good proportions immediately.
- The conscientious doctor can give good surgical and obstetrical care but medical care, in my opinion, is not up to par for the simple reason that he does not have sufficient time to spend on the patients.
- Care can be given without too much worry about expense to the patient but the doctor works much harder than the man in private practice because the person who pays the $1.00 a week feels he must get his money's worth and there is a consequent demand for over-servicing.

B. *As relating to the hospitals.*

- They have ready money coming in all the time which, however, is usually not enough.
- The patient in hospital demands less service than in the privately run hospital.

These are about the only advantages the administrators could tell me when I asked them.

C. *As relating to the patient.*

- Freedom from worry about most medical and hospital bills.
- There is a feeling that a doctor can be reached whenever he is needed.

Disadvantages of the Check-Off System

A. *As relating to the doctor.*

- He has not enough time to spend on the proper investigation of the patients in the office because he has too many patients to see. Most of the doctors stated that the majority of patients coming to their office do not want to be examined; they have a complaint and they want a bottle of medicine or a box of pills to cure them.

- The doctor-patient relationship is poor. People apparently have no concern as to when or for what reason they call a doctor. Calls that could be made quite easily in the daytime are often made late at night with the demand that the doctor come at once and this has created a feeling of hostility between many of the patients and the doctor.
- The doctor finds it difficult to weed out the incompatible patients.
- A conscientious doctor becomes a slave to his practice.
- The doctor gets $1.00 a week from each subscriber but if the subscriber is off work for any reason such as illness, strike, injury or holidays the doctor does not get paid. A very good example of this was during the 1925 strike which lasted six months. The doctors did not receive any money during that time, but they still had to give all the usual services. For example, one doctor had a weekly pay check of $3.00 during this time.
- There is a lack of respect for the doctor and his family.
- If a man pays a doctor for three months, then the doctor must look after him as long as he lives even though the man no longer pays him any money.
- There is too much time spent in dispensing drugs.
- The subscriber feels that he must get his money's worth and there is a consequent demand for over-servicing.
- All the relatives of the subscriber are looked after free.

B. *As relating to the hospital.*

- The patient stays much too long in hospital. In 1955, the average stay for medical cases in one of the Glace Bay hospitals was 30.3 days.
- The hospital still runs at a deficit.
- The patients are more demanding to get into the hospital. Each one feels that he should not have to wait when he needs to go to hospital and with the shortage of hospital beds the patient cannot always be admitted when he wants to go.
- The subscriber who is away sick, on strike, or on his holidays does not pay his $1.25 to the hospital. An effort is made to collect this when the man returns to work but this is difficult to do and gives rise to much ill-feeling.
- The pensioners of the Dominion Coal Company are not paying enough, only $1.00 a month, and this is one of the big causes for the hospital deficit.

C. *As relating to the subscriber.*

- Lack of specialists' care. This general statement is made even though the doctors in some cases do pay for the services of some specialists. It is true however, that when a subscriber needs the services of a cardiologist, neuro-surgeon or chest surgeon he will have to pay for him out of his own pocket.
- The subscriber has no hospital coverage or medical-surgical coverage when away from his own town.
- The doctor receiving the check-off may hire a young doctor just out of college and then he can go away for a year or two and still receive the amount of his check-off even though he pays a much smaller amount to the man that is replacing him.
- The subscribers complain bitterly that they still have to pay extra in hospital for X-ray and laboratory work and for the more expensive drugs, even though the charge is nominal.

- The subscriber feels it very unjust that he should receive a bill after being in hospital for a compensable injury. In other words, even though he is a compensation case he still has to pay for some drugs, for some of the laboratory work and for some of his X-ray work.

Generally speaking, the subscriber could be described as being unhappy with his set-up and many of them feel that they should have some change; this is particularly true in the higher levels of the union leadership..

This, then, is a resumé of one of the oldest prepaid hospital and medical plans on the continent and I hope that I have given some idea of its methods of financing, its short-comings, and its advantages.

THE NEW DENTAL BUILDING AT DALHOUSIE UNIVERSITY

A further development of the teaching facilities in the health field at Dalhousie University is the new building for the Faculty of Dentistry. Situated at the corner of Robie Street and University Avenue, the two storey tapestry brick and sandstone building of Georgian design makes a fine addition to that border of the Forrest Campus. It is expected that the first classes will be held in the new quarters early in 1958.

It was apparent that the present quarters of the Faculty in the Forrest Building had become outmoded and quite inadequate for even the present maximum size of classes. Further, local and national studies pointed to the acute shortage of dental personnel in Canada, and in the Atlantic region in particular. In designing the building, provision was made to double the present size of the classes so that about twenty-five students could be graduated each year. It was decided also that accommodation should be provided for the training of the auxiliary dental personnel known as Dental Hygienists. Consideration is being given to the establishment of the two year diploma course in which there would be about eight girls in each class.

The L-shaped building covers an area of about 12,000 square feet, with the main entrance on University Avenue and the entrance for the clinical patients on Robie Street. On the ground floor are two large pre-clinical laboratories with adjacent staff and service areas, four additional but somewhat smaller laboratories, storage and dressing rooms.

The clinical facilities occupy the entire first floor. The main clinic area, which is on the Robie Street side, is almost two storeys high and provides an exceptionally good working area with its thrity-three new dental units and specially designed cabinets. On the remainder of the floor area are four private operating rooms for demonstration and other special purposes, a two chair diagnostic department, a large clinical laboratory and two service rooms.

The main lecture room, seminar-museum room and staff offices occupy the second floor. The animal house, for experimental animals, is located on the roof.

It is proposed to continue the present fine arrangement for the teaching of the basic medical sciences conjointly with the students in the Faculty of Medicine. Space released in the Forrest Building following the movement of the Faculty of Dentistry, the planned enlargement of the Pathological Institute and some changes in the Medical Sciences Building will provide room for expansion in both the Faculties of Medicine and Dentistry.

The full-time staff in the Faculty of Dentistry is to be increased from two to six within the next year or two, and the addition of about $200,000 worth of new equipment will complete the million dollar project which will provide undergraduate facilities at least equal to most of the better dental schools in North America.

Secretary's Page

C.M.A. Retirement Savings Plan

The Canadian Medical Association Journal of December 1 carries the following information about The Canadian Medical Retirement Savings Plan.

"When comparing C.M.R.S.P. rates with those of any other plan, it is important that all features be on the same basis. We have compared the rates of many individual contracts and we found that in no case do the other companies come close to C.M.R.S.P. This is due to the fact that C.M.R.S.P. is a group plan and, as such, benefits from group economies.

Insured Annuity

In order to compare tables I and II of the C.M.R.S.P. booklet, you should obtain the *monthly* annuity guaranteed for 10 years, purchased by a *monthly* premium of $100.00, under which the death benefit before retirement is the return of premiums with 3% interest plus accumulated dividends. If the individual contract is participating, both the guaranteed and the estimated benefits should be compared. If the contract is non-participating it is quite difficult to compare it with C.M.R.S.P., but any comparison should take into account the fact that guaranteed benefits under the C.M.R.S.P. contract are minimum benefits and should be substantially increased by dividends.

Common Stock Fund

Some trust companies are offering individual pooled common stock funds under which the expense charge is 1% of the total fund, each year. Most mutual funds have an investment charge of 1% of the total fund, each year, plus acquisition or sales cost of 6 to 9% of contributions made. C.M.R.S.P.'s total expense charge is ½% of the value of the fund, each year. There is no acquisition or sales cost. C.M.R.S.P., like other funds, re-invests dividends without charge. This reduced expense rate could make an appreciable difference in the accumulated value of your savings at retirement.

The fund will be managed by The Royal Trust Company, Canada's largest trust company. Common stock management is an important phase of activity in The Royal Trust. The total value of common stocks under administration is in the order of hundreds of millions of dollars.

C.M.R.S.P. brings to you the lowest expense factors available and the manpower resources of Canada's largest financial institution. In addition C.M.R.S.P. guaranteed now, annuity rates applicable to a portion of each member's common stock accumulation, whereas individual trust and mutual funds must purchase annuities at market price at the time of your retirement. This is an important factor in view of the trend to improvement in mortality.

When comparing the offerings of other plans with C.M.R.S.P., you should determine the answers to these questions:

1. Does the plan provide a more advantageous interest rate which is guaranteed for your lifetime?
2. Does this interest rate apply to all future contributions as well as to those made in the current year or in the next three or five years?
3. Does the plan guarantee annuity rates which will be used at your retirement to translate your savings into retirement annuities?
4. Does the plan provide for a return of all contributions plus a realistic interest rate if death occurs prior to retirement?
5. Does the plan provide you with the option of varying the amount of your savings, year by year?

Compare the answers which you receive with the information set out in the C.M.R.S.P. brochure. Acting in your interest, the C.M.A. plan was devised to provide the best long-term guarantees available. The level of these guarantees is designed to assure reasonable earnings coupled with safety and satisfactory annuity rates.

All members are again reminded that to obtain tax-deferment on contributions relative to 1957 income, it is necessary that they be enrolled in a registered retirement savings plan before December 31, 1957. The prompt return of your application for enrolment in C.M.R.S.P. will protect your position in respect of deposits made before February 9, 1958."

College of General Practice

The advance programme of the Second Annual Scientific Assembly has been received. It will take place at Winnipeg in the Royal Alexandra Hotel, April 14-16, 1958 inclusive. The programme indicates there will be live demonstrations of special interest to general practitioners; medical films selected for interest will be shown in the film salon from 9 a.m. to 5 p.m. daily; 30 scientific exhibits will be shown and there will be more than 70 technical exhibits. Twenty-five speakers will give presentations to the scientific sessions. Health examinations for general practitioners will be available.

Further information will be published in a later issue.

The Editorial Board of the Bulletin, Mrs. Currie and the Executive Secretary extend to you greetings for the Christmas Season and best wishes for a Healthy and Happy New Year.

C.J.W.B.

Effect of Meprobamate on Cerebral Palsy*

Fifty-three cerebral-palsy patients received medication with meprobamate. Twenty-three were from pyramidal damage, 26 had extrapyramidal lesions, and two fitted into both categories.

Direct physical examinations were supplemented by electromyographic studies made during periods without medication and after treatment with the drug had been instituted.

It was apparent that meprobamate effected a change in some part of the central nervous system in a certain percentage of patients. This change was manifested clinically by improvement in function, as expressed by the development of new purposeful movements, increase in head control or grasp, or greater ease in bracing. In most cases, however, increase in function was moderate.

Gillette, H. E., Annals of the New York Academy of Sciences. 67: May, 1957.
*Medical Abstracts, August, 1957.

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Abbreviations used: — Ab. for abstract; anon; for anonymous; bilg. for biographical note; C. for correspondence; C.R. for case reports; diagr. for diagrams; Ed. for editorial; illus. for illustrations; Pers. for personal; item; port. for portrait; rev. for review.