

HOSPITAL
ADMINISTRATION
ORAL HISTORY
COLLECTION

Lewis E. Weeks Series

Chaiker Abbis

CHAIKER ABBIS

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

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Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298



Chaiker Abbis

CHRONOLOGY

- 1911 Born Beirut, Lebanon November 24
- 1911 Moved to Canada
- 1931 Seminaire de Quebec graduate
- 1935 St. Francis Xavier University, B.A.
- 1935 - 1945 Edmundston (N.B.) high school teacher
- 1939 - 1943 Canadian Army Reserve
- 1948 McGill University, B.C.L.
- 1948 Called to Bar of New Brunswick
- 1948 - 1973 Practiced law, Edmundston, N.B.
- 1968 Queen's Counsel
- 1973 - 1982 A justice of the court of the Queen's Bench of
New Brunswick

MEMBERSHIPS & AFFILIATIONS

Advisory Council to the New Brunswick Minister of Health, Vice-Chairman and Chairman, 1960-1966

American Hospital Association
Life Member
Delegate at Large, 1966-1979

Barristers' Society of New Brunswick,
Member

Canadian Bar Association, New Brunswick Branch, Municipal
Section, Chairman

Canadian Hospital Association
Director, 1961-1963
Second Vice President, 1963-1965
President-Elect, 1965-1966
President, 1966-1968

Hotel Dieu, Edmundston, N.B.
Advisory Board: Member, 1950;
Chairman, 1955-1969; Member, 1969-1973;
Chairman, 1973-1984

Kidney Foundation of Canada
President, Edmundston Chapter, 1971-1973
President, New Brunswick Branch, 1973-1974
National Secretary, 1974

Maritime Hospital Association
Vice President, 1957-1963

Maritime Hospital Service Association (BC/BS)
Director, 1958-1961

New Brunswick Hospital Association
Member, Board of Directors, and Founder
President 1958-1963

New Brunswick Study Committee on Nursing Education
Chairman, 1970-1971

AWARDS

American Hospital Association

Citation for Meritorious Service, 1976

Canadian Hospital Association

George Findlay Stephens Award. 1971

Kidney Foundation of Canada

Award for Selfless Devotion and Continued Devotion to the
Foundation, 1975

New Brunswick Hospital Association

Established "Judge Chaiker Abbis Award," 1977

Queen's Silver Jubilee Medal Recipient, 1977

American College of Hospital Administrators

Fellow (Honorary), 1985

WEEKS:

Justice Abbis, I note that you were born in Beirut.

ABBIS:

I was born of Canadian parents. My father came over with my mother in 1893, to Canada. Around 1911, Mother was lonesome to see her father and mother so Dad decided to take a trip. They took a trip from New York to LeHavre, then to Marseilles and Alexandria and Beirut. It was winter time. She found in the lobby of the hotel one of the neighbors of the village way up in the mountains where the Maronites live. She found out that her father had died inspecting one of his warehouses after a snowstorm. So they had to stay over to settle the estate and everybody renouncing in favor of her brother who was left there. So I say, I was conceived somewhere and born in Lebanon. We came right back and have been in Edmundston ever since.

WEEKS:

I noted two different dates. The date in the Canadian Who's Who is November 11, 1911.

ABBIS:

That is what I understand, because in 1975 I was on tour with Alan Hay, who was with the Ontario Hospital Association. We were to spend a week in Dubrovnik. I said, "I'll see you later. I think I'll hop on the plane and go to Beirut and try to search for my birth certificate."

In these days the churches kept all the vital statistics. I couldn't get it. So we figure that I was born in November of 1911.

WEEKS:

I had another date of 1915 and I tried to...

ABBIS:

Years ago somebody must have asked me...When I was appointed a judge, they wanted to know because you can only serve so many years. So Ottawa asked my age and my secretary answered with 1915. You know we get old age pension in Canada and we get the CPP, a kind of pension plan that we contribute in. So the manager of the office of the CPP* in my home town said, "Listen, we owe you money."

I said, "What do you mean you owe me money?"

He said, "You are over sixty-five and are entitled to the CPP and old age pension."

I said, "I can't prove what year I was born." So then we figured out -- I went to school in Edmundston, a convent school run by nuns, then Father sent me to Quebec City to learn French. From there I went to college at St. Francis Xavier University, a Scottish university. The first time I realized that there were some Scottish Catholics. Then from there I taught school for ten years and then I decided to take up law. I always wanted to become a lawyer. I went to McGill then. Then I came back home, and this is it.

WEEKS:

I noticed that you were a graduate of St. Francis Xavier and that you had taught school. How did you happen to become a schoolteacher?

ABBIS:

In the Depression, Father really took it badly playing the market. So I decided that it was a burden on him. I had two brothers. (One died, I was in

*CPP is the Canada Pension Plan.

Florida in 1985 and had to rush back.) We both had to wait. Then the army came along. My brother went to McGill and became a chemical engineer and I went to McGill and became a lawyer. It was the Depression days.

WEEKS:

What did you teach in high school?

ABBIS:

I taught in the vocational department. I taught them economics and anything but mathematics, because I was zero in mathematics.

WEEKS:

I don't like mathematics either.

Was there any particular reason why you chose law?

ABBIS:

I was young and my ambition was always...I think I was eight years old when one of the nuns at the convent school...in these days you paid tuition if you went to the private school but it was a dollar a month. They usually asked you what you wanted to become. Naturally, they probably expected me to become a priest or a missionary or a lay brother.

I said, "I want to become a lawyer."

The answer they gave then was, "Ah, no, you are going to become a blacksmith." That's one incident I remember of these first years, grade one through six.

WEEKS:

You practiced law for about twenty-five years.

ABBIS:

Yes.

WEEKS:

General practice?

ABBIS:

No. No criminal law, civil law. I always felt that that prostituted my profession and I wouldn't take a criminal case.

WEEKS:

I can understand that.

I notice you were created Queen's Counsel in 1968.

ABBIS:

Queen's Counsel, the gown is different. Have you ever read QB, the novel? It gives you a good description of what the Queen's Bench is...inner bar and outer bar. So when I argued in court I was in the inner bar. If you weren't a QC you were in the outer bar. It originated in England, the QC, as the Queen's Counsel. It is mostly honorary today. The only thing is that you have got to buy a new gown and you are entitled to go where the red velvet is. You sat there while the others had to sit behind you where there is only green stuff.

WEEKS:

It's nice...like an honorary degree, only more so.

ABBIS:

And it is chosen by the Supreme Court judges. Every two or three years they will suggest to the government two or three attorneys in my province. It is done by the Appeal Court in each province. Then the government usually says okay.

WEEKS:

Is there a limit to the number?

ABBIS:

It all depends. Some years they don't appoint any. Usually it is one or two. This year there haven't been any appointments. They reach a certain stage after twenty or twenty-five years. You have to have not only a private practice, you have to be heard and you have to try cases before the Supreme Court Appeal division.

WEEKS:

So you are a pretty well-rounded attorney before you qualify for that.

ABBIS:

Well, it is not a matter of qualifications, it is a matter that five justices on the Appeal Court decided to consider me.

WEEKS:

Sort of a peer review.

Then your appointment as federal judge. Of course in the United States we don't have a uniform system of judges either, except the federal judges.

ABBIS:

The Queen's Bench is something like your federal judgeship. In Ontario they call it the high court, in New Brunswick, it is the Queen's Bench. In Quebec, naturally, they go under the French civil law and they call it superior court.

WEEKS:

Is this an appeal court?

ABBIS:

We are an appellate court for the lower court. But for civil matters we are the top trial court. And in criminal matters, only indictable offenses. We have no grand jury. The provincial judges who decide whether there is

enough evidence to commit the accused to be tried before the Queen's bench.

WEEKS:

Even though we are close neighbors sometimes we don't understand the form of some of these things that we should. Is this an appointment for life?

ABBIS:

It used to be but then it was an appointment that you had to put in ten years. So in 1982 I resigned. I had high blood pressure. I came back -- I was sitting in St. John, New Brunswick -- came back home and felt tired. So I met my doctor and he said he wanted to see me right away. I had high blood pressure and I didn't realize it then. It is in the family because my brother died the first of February -- his heart.

So he said, "You've got to take a sabbatical."

So the clerk of the court phoned the Chief Justice and told him about it.

So he phoned back and said, "I'm going to come up to see you." He came up to see me and said, "Why don't you quit?"

I said, "What do you mean, quit?"

He said, "Why don't you resign?" He wanted to see my doctor, so I made an appointment for him to see my doctor. The doctor dictated a letter.

He (the Chief Justice) said, "Put in that it is very serious, that he shouldn't work any more."

That's not for publication what I am going to say to you. It's for your explanation, you'll get a kick out of it.

Trudeau was in power then. We knew he was going to be defeated. They thought if they could get Ottawa to appoint two or three fellows...by my resigning it opened a vacancy. They did the same thing with another one.

They said, "Why don't you become supernumerary?" I could have been supernumerary, mind you, but a federal judgeship in Canada, you get the same amount as you are paid as a judge, even if you are retired. So, why should I spend three or more years?

To tell you the truth, I didn't enjoy my seven years on the bench. Because the younger crowd coming in would litigate for...I had pity for the clients they were representing. They had no case -- just to have their day in court. Sometimes I think that raised my blood pressure just to see these poor clients being taken for a ride by these young solicitors who didn't know a darn thing. It seems to me today, the younger generation, they want to go to court instead of doing some really good business.

WEEKS:

Instead of trying to settle it out of court. I think we are guilty of that in this country too -- maybe even more so.

ABBIS:

Yes. I think you are.

WEEKS:

As far back as 1950, you have been connected with hospitals, haven't you?

ABBIS:

Yes. I was on the advisory board of what was a religious hospital then. Then when the government took over....

WEEKS:

Was this a Catholic run hospital?

ABBIS:

A Catholic institution.

WEEKS:

And when you said advisory board...

ABBIS:

They didn't have a board of trustees, it was just advisory then.

WEEKS:

It is a little bit different from a board of trustees, isn't it? The powers -- it is more advice.

ABBIS:

...and they consent.

WEEKS:

Weren't you chairman of that advisory board?

ABBIS:

I was chairman for a while, yes, and then I gave it up. I became a member only. Then when the government took over, under our system of health, and more particularly in my province, the Catholic hospitals gave up. They sold the property to the government and became government owned.

WEEKS:

Was that provincial or federal government?

ABBIS:

Provincial government. Because health is a provincial matter in Canada. Then we became board of trustees. But it is a misnomer because we had to submit a budget to the government and they decide how much we can spend. We were more or less board of management. I think it is a misnomer to call ourselves trustees in these hospitals in New Brunswick today unless it is a civic hospital that retained its charter. But legislation in New Brunswick spells out who can sit on the board -- representation from labor, perhaps,

civic and regional. But the board cannot appoint its chairman. He is appointed by the provincial government.

WEEKS:

Who selects the board?

ABBIS:

When we were under the religious control, they would find local citizens to sit on the board and they would elect their own chairman. But now they have a regulation under the health act, an establishment regulation, whereby the Minister of Health appoints. The act spells out who are to be on the board of a hospital and the minister appoints the chairman for a one year term. The board is staggered for three years.

We have no fiscal responsibility. We should have it but the government decides. You can't have a new program. You can't have anything until you ask for it. They will tell you that last year the budget was, let's say, ten million dollars and this year because of inflation and so forth we will allow you three or four percent more than last year. If you want some new equipment, we have to go to the Department of Supplies and Services and they buy for us. We only can buy pens and pencils and stationery and that sort of stuff.

WEEKS:

If you go to the Department of Supply, do you have to have it approved by somebody before?

ABBIS:

The board approves. The executive officer comes before the board and says we should do this and we need something in the operating section of the hospital or the emergency or so forth. We have committees that look over. We

say okay, if you can get the money from the government, go ahead.

WEEKS:

But the Department of Supply can deny your request.

ABBIS:

Oh, yes. They give you a budget also. We have two budgets to submit -- operations and maintenance.

WEEKS:

I think in the United States trustees are beginning to realize that they are more responsible for what goes on in the hospital -- legally -- than they realized before. I think for a long time in the United States, being a trustee on a board was sort of a civic honor that was bestowed upon you.

ABBIS:

I called it letter head.

WEEKS:

But the real boss was the administrator. He would come before the board and make suggestions and, if he were real clever he would try to make the board think it was their idea. Then they would rubber-stamp him. But now, I think they are beginning to realize that they have more responsibility than that.

ABBIS:

Well, the AHA has done wonderful work in the last fifteen years. Because there was a time, when I was delegate-at-large here representing Canada and would come to the meetings, people would look at me and say, "Are you a doctor?"

I would say, "No."

"Are you an administrator?"

I would say, "No."

"What do you do?"

I would say, "I'm in law," and they would look at me as to say what the hell are you doing here?

I was on that committee on governance, you know, and I was in Region 5 which took in the Midwest -- Michigan, Illinois, Wisconsin, and Indiana. We had to present the report of the committee on governance, since I was a member of that committee, and I had to explain what was going on. Here were all the administrators, you know, and it took a few years before they could digest. They thought it was intrusion on the part of the trustees into the management.

WEEKS:

Yes, I know they are very jealous of it because Jim Hague or Maurice Norby told me that when they started Trustee magazine, some of the administrators wanted the magazine sent to the hospital office so that the administrator could pass them out. They didn't want them sent directly to the trustee. They didn't want anybody going to the trustee directly for anything. They wanted to protect their own turf. It has been a hard situation for these administrators to accept the fact that the trustees should know what is going on and they should set policy. They should be responsible for that side of the operation of the hospital. The administrator is the operating officer. If you look at it carefully, he should be carrying out the policy set by the trustees. But I am sure there are many hospitals that are not run that way.

ABBIS:

There has been progress in your country in trusteeship. It started with the political action committees, and Lee Gehrig when he was vice president

stationed in Washington got -- what was it called -- partnership in action or something. That's when they started having their business meeting in Washington in mid-winter. Well, it was just a big lobby.

Then it opened the eyes of trustees. If we've got something to say to our senators or congressmen, we should be more alert within our fold and our community.

One thing -- it is very interesting what you said about Jim Hague -- one thing I noticed at the ---- meetings was that they resented very much the advertisements in Trustee magazine from these for-profit hospitals. And one of these trustees would say, well, that's all advertising.

WEEKS:

I haven't seen a Trustee magazine recently and I really didn't realize that investor-owned hospitals were advertising in it.

ABBIS:

They were. They were against mergers and these private hospitals because their jobs were at stake.

WEEKS:

But investor-owned hospitals are a fact of life and we can't deny it. They are here for better or for worse.

ABBIS:

I am very pessimistic about this system of privately owned. They are going to get investors waiting for dividends rather than give good health care.

WEEKS:

I talked with Dr. Frist, the elder Dr. Frist, who is one of the founders of the Hospital Corporation of America. He could show me figures where they

could operate more cheaply, they could borrow money more cheaply, they could build faster. They have their own architectural department and they could build faster, build a hospital in fifteen months instead of three years. He showed me much evidence that financially they could do better in many cases than the community hospital. This is going to be hard to deny. Especially now that we are getting into tighter and tighter controls on hospitals in the sense of going to them and getting them to contract services at a lower and lower price. There are going to be some of those hospitals that are going to fail or close up anyway. So the investor-owned hospitals are going to come in and take over some of those hospitals and if they can operate them more efficiently it is going to be very difficult to deny that they are there.

ABBIS:

My fear is that if it becomes big business, you are approaching national health in your country. The people will clamor for it -- they know politicians.

WEEKS:

There is no question that we are in for a lot of changes in the next ten years, both in your country and our country.

I have another note here. You first became interested in hospitals shortly after the Canadian federal government began to show some interest. What were those first grants-in-aid before the hospital act was passed?

ABBIS:

Fifty cents per patient day. That was the only grant.

WEEKS:

That was just paid on the basis of per patient day?

ABBIS:

Actually, you could get then a private room for five dollars a day, now it is around \$350 to \$400 per day. It is all-inclusive naturally. Our system is all-inclusive -- drugs, operating room and so forth.

WEEKS:

Drugs in hospital?

ABBIS:

In hospital. Everything you get. We are paid a ward rate only. If you get a semi-private or private, you have got to pay. Naturally, they go through Blue Cross/Blue Shield.

WEEKS:

So this fifty cents a day was the first step that they took. But that wasn't enough.

ABBIS:

Well, I remember then I asked in a talk that I gave at a convention in New Brunswick that if they gave us a dollar or two we wouldn't need national health. Because, let's face it, in these days -- twenty-five years, thirty years ago -- religious hospitals had the manpower. They haven't got it any more. So they gave up. There is only one -- St. Joseph in St. John -- which is operating still under an order. But next to it is St. John Regional General, twelve hundred bed hospital.

WEEKS:

I noticed somewhere that Newfoundland was supposed to have some kind of provincial plan back as early as 1934.

ABBIS:

I am not too familiar with Newfoundland's system. If they are under the

Canada....

WEEKS:

This would be before the hospital act.

ABBIS:

Yes, that's right. They had a lot of hospitals run by religious orders. There is a big Irish population in Newfoundland.

WEEKS:

I have only been there once but I did attend their hospital association meeting one year and the president was a nun* who was running a hospital there.

ABBIS:

She sat on the national board when I was president of the Canadian Hospital Association. I understand she left the order.

WEEKS:

I was there the year she was president of the association in 1972.

ABBIS:

I wasn't there.

WEEKS:

I was very much impressed with her as a person.

ABBIS:

She's got personality. You get a sister out of the cloister and expose her to the public, you know, and she gets a taste of something and she can't go back to the nunnery.

*Lucie Powers

WEEKS:

In our state we have a Catholic sister who is the head of the welfare department and doing a very good job.

ABBIS:

She made headlines.

WEEKS:

Because she won't speak out against abortion as long as it is legal in Michigan. That must have been a very difficult thing for her to do.

Do you know Ed Connors of the Sisters of Mercy?

ABBIS:

I have met him, yes.

WEEKS:

Can you tell me of the Saskatchewan incident and what was going on in Alberta and Saskatchewan during the Depression?

ABBIS:

Economically, they were depressed. Canada is a mosaic. The west resents Ontario. They don't resent the east because they said we are have-not provinces. We have the have and have-nots. Then the Depression came along and crops failed for years and so forth. A Reverend T.C. Douglas, a Baptist minister, and another one, J.S. Wordsworth in Winnipeg and M.J. Coldwell met together. They had as a member of their group a brain, he taught me law at McGill, who was named Frank Scott. He died recently. He was a poet besides being a lawyer. They issued what they called the Winnipeg Manifesto. That started the C.C.F. party -- Cooperative Commonwealth Federation, which turned into what we have today, the NDP -- New Democratic Party.

These men were working for the establishment in Canada of a social order

in which the basic principle regulating production, distribution, and service will be for the common good, rather than for private profit.*

They swept the west. In Alberta, they went with a chap by the name of Aberhart, who espoused from C.H. Douglas of England, the social credit theory. They were elected and elected and elected. Alberta's a province where, if a party wins they win all the seats or lose everything. So now they've got a Tory government. They have been there for a long time but they were lucky, they found oil. Saskatchewan was socialistic until the last election about two years ago -- a Tory government. There was a tide against Trudeau over Canada.

That wave started socialization in welfare, pensions and all of that. It started out west through Douglas, who became leader of the party and who was succeeded then by ...well, Coldwell, Douglas and now Broadbent. Now they are more or less left of center. They were very extremist in these days and they started the system.

Out west you've got British Columbia and they've got a social credit government which is really mostly conservatives. Then you've got the conservatives now in Alberta. Now you come to Saskatchewan and you've got a conservative government and Winnipeg has a EP government, a socialistic government. They always resented Ontario being the powerhouse, industries in Ontario. When I was traveling out west giving talks to the provincial

*The C.C.F. in power in Saskatchewan introduced in 1946 the continent's first government-sponsored insurance plan. Medical insurance plan put into operation by the Saskatchewan government in 1962. The date of the national hospital plan is 1961; the national medical plan is 1968.

associations and they would meet and say where are you from and when I would say I am from the east -- they looked at me and would say -- Toronto? I would say no, maritime provinces. You are okay.

That wave didn't spread beyond Winnipeg but they started all the socialization that they've got in Canada today. They had a chap by the name of Taylor -- I wonder if you've ever read his book? -- from the University of Saskatchewan or Alberta, who wrote the book and explained the first Medicare/Medicaid system that started in Saskatchewan. Naturally, then it followed until the government in 1958 passed the bill we called Bill 320.

WEEKS:

That was the Hospital Act, yes. But before that, back in the '30s and '40s, they had sort of a community deal didn't they?

ABBIS:

They had cottage hospitals in the west.

WEEKS:

How were they supported?

ABBIS:

By local taxation.

WEEKS:

Did the patients have to pay something when they went there?

ABBIS:

If they could afford it, but if you had a certificate or something you didn't. Do you know some of these cottage hospitals were two beds, three beds. When they decided to build regional hospitals, they tried to abolish these cottage hospitals and the public wouldn't allow them to.

WEEKS:

There was a great distance to travel in many cases to get there. It is pretty sparsely populated, isn't it?

ABBIS:

Very much so.

WEEKS:

This doctor trouble they had in Saskatchewan, wasn't that when Saskatchewan was trying to set up some fee schedules? After we get into the Medicare Act, which came twenty years after this Saskatchewan trouble, can we connect the experience in Saskatchewan and attribute some of the thinking about setting up fee schedules to their trouble. As I remember, the doctors went on strike because they didn't want to accept money from the government -- a fee schedule -- even though the fee schedule was agreeable to them -- they thought it was fair at least -- they didn't want to accept any money from the federal government or the provincial government -- any government.

ABBIS:

It was mostly professional pride.

WEEKS:

Weren't they given some options? That either they could accept it from the government or they could accept it through an intermediary, like a medical association?

ABBIS:

I am not too sure, but, as I understand it, you could join the plan or stay out of it. If I'm out of it and I have a patient, he pays me. I give him a receipt and he collects from the government. That is the system that prevailed and still prevails, even under medicare. Now in my province, all

doctors chose to belong. In Quebec and Ontario, some doctors are free-lancing. They say, we don't want to belong, but if you went to see them and they charge you anything they give you a bill and you can collect. It is because the government will not give them -- let's say the consultation fee is \$100 but under the medicare act it is only \$50. That's what they call the extra billing.

WEEKS:

In Massachusetts they call it balance billing where the doctor charges beyond what the insurance company or government will pay him. This isn't very popular with the people, is it?

ABBIS:

Well, no. Because Mr. Mulroney, in his campaign mentioned that -- he was walking a tightrope -- and when his Minister of Finance came out with the idea they ought to do some cutting here and there, well in Parliament in Ottawa they solidly said it should remain as it is -- same as your people here, they don't want to cut anything from Social Security. So the problem we are getting in Canada under the national health system is not with the board of trustees or board of management...it should be management. You know what a trustee is in law, he's got responsibilities. Now the Act in our province says that the responsibility is to see that the fiscal needs are met, that we supervise the expenditures, and then subsection C says that the minister may request certain things be done and we've got to do it.

WEEKS:

And you probably say, "With what?"

ABBIS:

I resigned last fall, you know, because I thought there was too much

interference by the local representative in our legislature.

WEEKS:

Is that from your local hospital?

ABBIS:

Yes. I resigned because I told the Minister of Health, when your member of the legislature comes along and because the medical staff decides one doctor should be suspended from certain privileges he has as a surgeon, I'm not going to go because he is a friend of yours and see that the board reinstates him and go against the medical staff. Then they used to phone the administrator -- he's got a few friends, they want jobs and so forth. That's a problem in Canada today -- the interference of government, not the government as a body but the local representative.

WEEKS:

The bureaucracy is too hard to fight.

This Saskatchewan incident was settled and it turned out pretty well for the doctors, didn't it?

ABBIS:

Quite a few left. Dr. Barootes was the leader of that. He was quite a fighter.

WEEKS:

The CCF, do you think that their actions influenced the other provinces?

ABBIS:

Oh, yes. Definitely, yes. Our social system in Canada started out west and they were the pioneers. No problem, it's a fact of life. Because Quebec was the last to join the national health plan. They still influence the thinking of the two parties in Canada, the NDP do. The liberals stole some of

their platforms and the conservatives stole some of their platforms. They've got a big influence today.

WEEKS:

So even though they are not in office they have to be considered whenever anything comes up.

ABBIS:

They are populists. On the other hand you've got to give them credit that they think of the working man and I suppose that's their job.

WEEKS:

I've been wondering about Blue Cross. You mentioned that the hospitals furnish ward accommodations. Now some people carry Blue Cross or other insurance?

ABBIS:

No other insurance in Canada but Blue Cross -- no commercial insurance. I can buy accident insurance when I travel out of the country. Remember we used to have health and accident coverage, that you have, I suppose. No more in Canada. Everything is paid for you, rich or poor.

WEEKS:

Did they just wither up and blow away?

ABBIS:

Well, they were out of business. Why should I buy insurance in Canada when I can go to any hospital and get every medical care I want and I don't have to pay anything, except if I want a private room I have to pay \$15 or \$20. Then I can get it from Blue Cross/Blue Shield. Then Blue Cross/Blue Shield went into group insurance for dentistry in some provinces and eye glasses, which is not covered you know.

WEEKS:

At one time, before the hospital act of 1958, Blue Cross and other insurance covered about forty percent of the people. And I think there were Blue Cross plans in every province except one possibly.

ABBIS:

Well, we had what we called the Maritime Hospital Plan which covered the three Atlantic provinces -- maritime provinces -- Newfoundland didn't belong then. Quebec has its own, Ontario, its own. I think every province.

WEEKS:

Blue Cross lists only five plans. As you say the one plan may cover all the maritimes.

ABBIS:

Yes. That's the Maritime Hospital Plan.

WEEKS:

That may make the difference.

ABBIS:

Five, six, seven, eight. Newfoundland has it now -- unless the Maritime covers Newfoundland. I was the Director of the Blue Cross/Blue Shield for two or three years and can't recall having any representation from Newfoundland. So if Newfoundland is included today that makes it four under one system and there are five other provinces, so that's six. Unless you've skipped Quebec because they have another name.

WEEKS:

That could be.

ABBIS:

Or it could be that some of the western provinces are combined. That's a

good question. We'll have to look into it.

WEEKS:

Blue Cross and Blue Shield before 1958 -- there was Blue Shield also -- so you had hospital and medical coverage as a service.

ABBIS:

Blue Shield came after Blue Cross.

WEEKS:

It did in the United States too, a few years behind.

I think I'm talking to the right person to ask -- I'm not quite sure about the division of powers between a province and the federal government.

ABBIS:

The federal government is the opposite of your congress. Health, education is under provincial jurisdiction. Customs, defense, residuary power is in Ottawa.

WEEKS:

Residual powers are in federal?

ABBIS:

Yes. Because the provinces are very strong in Canada, very strong. When we started with the plan, Bill 320, the government was paying fifty percent of our costs. Then they changed it because the provinces were saying, you feds get out of it, this is a provincial matter. So the federal said okay we'll give you tax credits and we will give you \$20 for preventive medicine and so forth. But the problem today is that it was based on the economic factor but since the feds vacated the field you know we ran into inflation every year and so forth. So we were better off, in the have-not provinces, under the old system because we were getting more than fifty percent...we were getting

fifty-two percent. Because we weren't as rich as Ontario.

WEEKS:

This action after Saskatchewan and after Alberta and after the prairie provinces started their own little health systems, wasn't there a federal advisory committee on health insurance? Isn't that before, several years before, the Act of 1958 was passed?

ABBIS:

Oh, yes.

WEEKS:

The grants-in-aid that you were talking about, the fifty cents a day, that was one of the first steps they took.

ABBIS:

This was before the introduction of national health in my province.

What happened was we had what was called social welfare in each county of each province. There was a municipal council and they would vote monies to help the distressed, the ill — it was social welfare -- but it was run by the parish or county council. They would vote so much and it was administered by the Commissioner of the Poor, that was his title. This was for anybody who needed help, had to go to a hospital or so forth. When I was on the advisory board of my hospital, we used to meet the county council and ask them...here are people who were hospitalized and they were too poor to pay. They are your responsibility now. And they would vote us a grant to cover these things. We would meet with each commissioner of the poor in each parish.

WEEKS:

So that was how your responsibilities differed from what we had in the United States...well, I guess counties in the past were somewhat responsible

for the poor, but in recent years -- the last fifty years -- we have looked to the federal government for Medicaid or some other form of help (Kerr-Mills before that) to try to take care of the poor.

ABBIS:

It was local in Canada.

WEEKS:

So that would be the big difference between Canada and the United States in the approach.

In 1958 when the hospital law was passed, you were Vice President of the Maritime Hospital Association.

ABBIS:

Yes. That's Blue Cross and Blue Shield.

WEEKS:

Weren't you also in the hospital association?

ABBIS:

We had one association for the three provinces called the Maritime Hospital Association. We had the New Brunswick division, the Nova Scotia division, Prince Edward Island division. I was vice president and then I told them that I would not accept the presidency the next year. They asked me why. I said I don't want to break up the association but we are going into Bill 320 and we are going to need the government. And I am from New Brunswick talking to the Premier or the Minister of Health from Nova Scotia and say you stay in your bailiwick. So that's when I founded the N.B. Hospital Association. I spent five years as the president.

WEEKS:

What is the population of New Brunswick, about?

ABBIS:

Smaller than Maine. We are about 750,000.

WEEKS:

Is it a large geographic area?

ABBIS:

No. I would say from north to south it is about 200 miles and across it is 150. It is smaller than Maine but similar because the interior is all wooded, forestry.

WEEKS:

The National Hospital and Diagnostic Service Act.

ABBIS:

That's Bill 320. That's the federal act.

WEEKS:

The general statement is that the federal government paid fifty percent of the cost of hospital care. Somewhere I read that the fifty percent was figured on the basis of -- half of it was figured on the basis of national average and the other half was figured on provincial.

ABBIS:

Presently. When the feds vacated the field and told the provinces, you run your own. Before that it was fifty percent of the expenses.

I was asked by the Minister of Health -- we had the schools of nursing then, hospital-based, and if you recall the national nurses' association were always clamoring to get out of the hospitals and get separate schools of nursing. So the Minister appointed me Chairman of the Study Committee. We decided, and the government accepted, to give the nurses the two year course outside of the hospital. At the time we were still under the old federal act

and the government decided to accept the report but put it under the Department of Health expenditures because they were getting fifty percent or more from the feds...instead of putting it under the Department of Education. That was the scheme the provinces were playing...they put everything under the Ministry of Health because they could bill the government. So nursing education was being paid fifty-two percent. Now that it's out, they are thinking of taking it away from the Department of Health and putting under the Department of Education, like they have in Saskatchewan. Technical schools where the plumbers and the millwrights are being taught, well the nurses are being taught under the same roof.

WEEKS:

How many levels of registered nurse are there in Canada?

ABBIS:

There is the R.N....

WEEKS:

Is that a two year course?

ABBIS:

Now it is a two year course. Two year only. If you want a baccalaureate you go to the university. It is another two or three years.

WEEKS:

But if you get a baccalaureate you still end up with an R.N.

ABBIS:

Yes, a B.Sc. in Nursing. There is a tendency now for a lot of these young girls, if they can afford it, they will become an R.N., become a registered nurse and then go two more years to the university and get a baccalaureate. Because they get more pay.

WEEKS:

And then they can get into administration and that kind of thing more easily.

ABBIS:

We also have nursing aides. They are trained in the trade schools.

WEEKS:

Are they like licensed practical nurses?

ABBIS:

Not exactly. They are below that.

WEEKS:

How long a course is it?

ABBIS:

It is about one year.

WEEKS:

In Michigan we have licensed practical nurse one year and the schools are regulated by the state but they do many of the things that registered nurses do.

ABBIS:

The only thing is you have to be careful. There is one thing about our system. Malpractice hasn't crept into our society yet in Canada.

WEEKS:

I understand you don't allow cases on a contingency basis.

ABBIS:

Some provinces do but you've got to file a certificate and present it to the Department of Justice and then they will okay it. You just can't tell your client I'm going to take fifty or sixty or seventy percent of it. I

think if they can get thirty, that's about the top. That's in New Brunswick, mind you. I don't think contingency fee is fair.

WEEKS:

It creates a lot of ambulance chasers.

ABBIS:

But let's make a distinction here. Civil matters in Canada, there is no jury. I am master of the facts of law in a civil case -- no jury. In your system there is a jury who decides and they know that a solicitor or attorney is going to get fifty percent of it so they say we'll allow him \$100,000 but since he'll only get \$50,000 because his lawyer is going to keep half of it...we'll give him \$200,000. That doesn't exist here because I decide how much the victim's going to get and the bill of cost of the lawyer has to be signed by me.

WEEKS:

This affects the malpractice awards and probably the number of malpractice suits too, doesn't it?

ABBIS:

In my seven years in court in New Brunswick, I don't think we had a malpractice case in the last seven years.

WEEKS:

Is that right?

ABBIS:

One.

WEEKS:

But it is decided by the judge -- the award.

On the way over this morning on the plane I was reading in the newspaper

about Wayne County, the county where Detroit is, having one of the highest or second highest records of awards by juries -- somebody gets hurt and they give them ten million dollars -- extreme awards. Especially if they think an insurance company is paying for it. But here in this country we have areas where it is almost impossible for a doctor to buy malpractice insurance, especially if he is a surgeon or orthopedic surgeon, one of the specialties. He is likely to find it very difficult. I have also read that you could look at New York City and at the rate that the doctor has to pay there, if he can get insurance, and look fifty miles away in some smaller New York city and the rate is a third or half of what it is in Manhattan.

ABBIS:

It is a deterrence for the poor doctor who has to refer, get a second opinion. I blame the system -- the jury trials and civil matters. I think in a criminal case you should be judged by your peers. But in civil matters...I think the British system, not bragging about our system being better than yours. I argued that with McMahon once on the Orient Express and we couldn't agree. I was telling him that our system is better than your system. After four or five Scotches I think we went to bed -- no decision.

WEEKS:

What standards does a province have to have...how do they qualify for this fifty percent aid?

ABBIS:

Universality is one of them.

WEEKS:

Is that a certain percentage of the people...

ABBIS:

No, no. It means that everybody is covered.

WEEKS:

You don't have to go and register, you are covered automatically.

ABBIS:

They give you a little card so that when you go in the hospital they can take your number so they can bill the government.

WEEKS:

But if you are a resident there, you're covered.

ABBIS:

And portable means that if I am in one province and I am treated in another province, I am covered too. If I fall sick today in Illinois, I am covered. But not for the rate I will be charged in the state. So that's why I have to carry insurance when I leave the country.

WEEKS:

Whatever it is in New Brunswick you are covered for...

ABBIS:

They'll pay whatever I would get in New Brunswick.

WEEKS:

...but Illinois will come up with the balance.

ABBIS:

If they charge me \$1,000 a day and I can only get \$300 from my province...

WEEKS:

This is supplemental insurance that you carry.

ABBIS:

I take the phone and call Global Assess through American Express and tell them I'm leaving the country and I'll be gone for 10 days....

WEEKS:

It's like buying travel insurance.

ABBIS:

Yes.

WEEKS:

That's good to know. I didn't know how you handled that. That has been a problem in our Blue Cross plans here in this country. You travel just within the country -- if you have Blue Cross -- you might not find that San Francisco pays the same rate as Detroit does or vice versa. It complicates matters.

I think that we have mentioned the fact that this rate that's paid to the hospital is an inclusive rate. How is that determined?

ABBIS:

The drugs, there is a pharmacist and his staff -- the operating room is included -- it's inclusive. In the old days we used to send a bill so much per day for the room, then drugs, operating room and so forth. There is nothing of it now. The rate, let's say \$350 a day, is inclusive.

WEEKS:

What I meant about asking about inclusive rate -- I was wondering how the inclusive rate is set. Do they figure the cost of the hospital or do they figure it on charges?

ABBIS:

Depreciation is not allowed. Capital cost is not allowed because that is

a different budget. The controller of the hospital will come along and figure out he has so many rooms that will be occupied during the year, based on the last year, and if we go over our budget we have to go and plead with them -- couldn't help it, there was an emergency. If we make a profit, we have to give it back to the government.

WEEKS:

What I meant to ask you about the inclusive rate is how it is determined for each hospital. Say your local hospital may have 200 or 300 beds, a hospital in Toronto may have 500 beds or more...is this based on past experience of costs and you project a budget?

ABBIS:

We project a budget.

WEEKS:

Say they will allow you \$300 a day and if at the end of the year you can prove that it really cost you more than \$300 a day then you are likely to be recompensed for it?

ABBIS:

Yes, but you've got to be able to prove it. Once the budget is approved we can't establish a new program, establish new equipment without getting permission during the year. You've got it right, it's based on the experience of the previous year.

WEEKS:

How are these hospitals inspected or controlled? -- quality control, for instance.

ABBIS:

We are supposed to submit six months before the fiscal year is over a

budget for the next fiscal year. Then it goes to the department and then they'll take a good look at it and check everything. Then if they are not too satisfied they will send somebody to meet with the board or the administrator and say...We usually ask for more than we are going to get -- and they want us to justify the action. But we get along.

WEEKS:

Are there government teams that come in like the Joint Commission and look at your operation?

ABBIS:

No. Oh, they send consultants. For example, if they find that the nursing has too many sick leaves, too many vacations without or with pay, then they will send a nurse, an employee of the government -- a consultant. She comes along and studies the system and what went wrong. In finance they will do the same thing. They will send a CPA.

WEEKS:

What about things like housekeeping? If you run a dirty hospital, as an example. Is there any way of checking on that?

ABBIS:

The public. The public will start screaming and the board will hear about it and at the board level we always allow...if you have anything to say in other business, that comes in. For example, too long waiting in admission and that sort of stuff. We are not computerized yet.

WEEKS:

How about the physicians themselves. Do they have tissue committees and all this sort of thing to check up on the physician?

ABBIS:

Yes.

WEEKS:

How about granting privileges?

ABBIS:

It is done by the credentials committee and then is submitted to the board. We ask the administrator have you checked these credentials, and, if he hasn't, we usually ask him why don't you go where he comes from and find out if he's a bum or that sort of stuff. Because it happens sometimes, you know.

WEEKS:

It has happened. Unfortunately in the United States it has happened where doctors have done things beyond their ability and patients have died and yet they have gone to another place and done the same thing.

ABBIS:

That's the responsibility of the board.

WEEKS:

But the board realizes this?

ABBIS:

Oh, yes.

WEEKS:

Have you had any cases in your province or any of the other provinces that you know about where the hospital board has tried to dismiss a physician from having privileges in the hospital?

ABBIS:

Once, and he went to the human rights. It was a question of certain of

his privileges were curtailed and he wasn't satisfied. The medical staff went against him. The board agreed with the medical staff, so he went to the human rights people in the province. They didn't do anything. No, we haven't got these problems.

WEEKS:

Now if this came up in court might it come up before you if it happened in New Brunswick?

ABBIS:

Now the human rights -- I remember once I wrote the board that they had a grievance from somebody and so forth and present your views. I can't recall any case that came before the courts in New Brunswick. Naturally, we always keep in touch with the different decisions throughout Canada. It happened, but very little.

WEEKS:

This human rights, is this a federal department?

ABBIS:

There is a federal human rights commissioner and also each province has their own department. They investigate for example. A matter like Indians' privileges and so forth. For example, -- I don't know what it is in your country -- if an Indian marries a white girl, she is not a member of the band. She has no privileges under the reservation and so forth. But there is very little of that. You may find that especially in Toronto, for example. I read recently where a woman came out with a study she did for the government about equal rights. Today, that's the problem.

WEEKS:

What is this human rights commission?

ABBIS:

It is usually a chairman and two or more members appointed and paid by the provincial government.

WEEKS:

Do they have any powers of enforcing the change in any respect?

ABBIS:

Yes. If they find that the human rights have been...

WEEKS:

If in their opinion something is wrong then they have the power to change it.

This money, the fifty percent that the federal government has been giving up until recently and the fifty percent that the province raises...is it up to the separate governments to determine what kind of taxes they want to levy or how they want to raise the money?

ABBIS:

In some provinces they have a premium. Each citizen pays a premium for his family or if you are single you pay a certain premium. Now Ontario has a premium and some other provinces out west have a premium. In the east, everything comes from the general fund, provincial budget. When they vote on a budget, they say health will cost us so much this year. That's a total of all health expenditures. In Ontario you have a premium which you have to pay monthly or pay for the year.

WEEKS:

Otherwise the province would have to raise money by sales tax or -- do they have provincial property tax?

ABBIS:

Yes.

WEEKS:

In Michigan we have abandoned that.

ABBIS:

We have property tax, school taxes, and we've got a sales tax -- eleven percent, except on clothes. They took that off.

WEEKS:

On food?

ABBIS:

No, not on food or clothing. Where they get their money is they will tell you we are not going to raise taxes but on your property, they will raise the evaluation of it.

WEEKS:

Raise the assessment so you have to pay it anyway. We've been through all of that also. I guess it is a common fault of most governments to try to fool you but you know you pay in the end.

ABBIS:

Another manner where we get financing is the have-not provinces. Ontario pays so much federal taxes that the have-not provinces get subsidies -- grants per capita. In my province we would go broke if we didn't get that subsidy from the federal government.

WEEKS:

Is this subsidy from the federal government sort of a blanket subsidy of so much per capita?

ABBIS:

Per capita...not with health. That's another matter, health.

WEEKS:

Health is different.

ABBIS:

The other one is to help out the provincial government meet its disbursement and expenditures.

WEEKS:

The province can use it as it sees fit or needs -- but the health is separate?

ABBIS:

That's right. Because when that came out I was giving my valedictory speech at the Canadian Hospital Association and the Minister of Finance then, Mr. Sharp, I think, had said that we're going to vacate the field. And I mentioned in my speech saying now the hospital should be very careful because that money coming from the feds is going to go to the general fund of the province and they can build roads and do anything with it. Instead of if the feds had said to the provinces we are going to give you so much money but that is going to go for health expenditures. But it isn't so. It's supposed to be so but is isn't. That's why some provinces a year or two ago, you must have read about discontent from certain provincial governments that the monies -- they were assessing us. For example, in my province they charge you now six dollars if you go to outpatient.* Now the feds said if you do that we are going to take it away from your health subsidy. Now in my province they are

*Social welfare patients are exempt from this payment.

still charging it. But the feds said that if you change it within three years we will give you retroactively what we held.

So what the governments do now, that's a ploy isn't it, they might have an election next year and they'll say we'll abolish the six dollars. Then the feds will come on with a nice bundle.

Our system is a wonderful system but the public doesn't realize what is going on politically in the management and the financing of health.

WEEKS:

Now, all the provincial plans are not the same, are they?

ABBIS:

You asked me how they raise revenue. In my province we are not taxed directly, no premium, Ontario has a premium and a few other provinces out west have a premium you pay.

WEEKS:

But in your province you take it out of the general fund.

ABBIS:

I suppose in Ontario the money goes in general fund but you can say we are getting millions of dollars from that premium.

WEEKS:

That's easier, it's like people say let's have dog race betting and give the money to the schools. Everybody knows it's for the schools, so it's good. We are going through that in Michigan right now. They are going to take Belle Isle -- are you familiar with Belle Isle -- and turn that into a gambling casino.

After 1958, as a member of the board of a hospital, did you notice any great changes? Did it affect the hospital in any way? Did it fill up the

hospital?

ABBIS:

Yes, it filled up. It held its fee so people are making good use of it. But our stay -- I think Canadians can say that the length of stay has gone down.

WEEKS:

It was rather high wasn't it?

ABBIS:

Ten days.

WEEKS:

I think that the last Blue Cross figures I saw showed that Blue Cross enrollees in Canada had a higher length of stay than they did in the states. Your admissions are fairly high too, but length of stay in Canada as a whole considering the prairie states and the large expanse of thinly populated territory that you have it would seem to me that you can't send people home as quickly as you could if you are in the city and you can just come with the car and take them home -- or an ambulance -- if you have to go 150 or 200 miles through the wilderness.

ABBIS:

That would apply to the western provinces not to the central provinces nor in the east. There is a hospital in Edmundston, my home town, then about 175 miles down the river there are two hospitals forty-five miles separate. Then you go to Woodstock, Fredericton, St. John, Moncton, Kent, they are all around us. They are building three hospitals, renovating them. We are getting a new hospital two years from now. And they are building one on the north shore. They just finished building the regional hospital in St. John,

1200 beds. We are spending lots of money and the government pays.

WEEKS:

Is this the provincial government?

ABBIS:

Yes.

WEEKS:

Who makes those decisions as to whether you need a hospital or not?

ABBIS:

We go to Toronto and get consultants to study the situation. We paid at least \$55,000 to Agnew, Peckham.

WEEKS:

You say the provincial government decides whether you should build a new hospital after you have...

ABBIS:

Usually the government will say we'll allow you so much money, make a study of the need of a new hospital or renovation or so forth. When that is done, they've got their own staff and we've got our consultants and we'll meet and...we were supposed to get a new hospital and they started building it and now they've been at it for five years. But they wait each year to see how much they are going to vote in the budget and when they've spent it then they close down the operation. It will take seven years. That is the advantage that you mentioned earlier about the privately owned hospitals doing it pretty fast because they can raise the money and don't have to depend on the budget next year.

WEEKS:

You mentioned before that there are no depreciation funds. Hospitals

don't have depreciation funds.

ABBIS:

It is not allowed under the federal act. Because that would be manna from heaven, wouldn't it?

WEEKS:

Sure it would. That's what it amounts to in this country.

ABBIS:

It is a bookkeeping entry that's all.

WEEKS:

But if you don't have any fund for depreciation then you have to go to the government to get the money and this is sort of a certificate of need from them.

ABBIS:

For example, now we needed, let's say a new...change all the windows in the hospital, well, you went...that's a separate budget...maintenance, repairs; that's a separate budget. It is not on the health budget.

WEEKS:

I see.

ABBIS:

The feds don't contribute to the structure, to the building.

WEEKS:

This has to all be provincial. They don't share the cost.

Are any of the provinces using any co-payments outside of this three dollar fee in Ontario? Are there any other kinds of co-payments?

ABBIS:

They did, that three dollars, but it was withdrawn by quite a few of the

provinces except my province, they kept it.

WEEKS:

But there is no one who says you have to pay the first hundred dollars...nothing of that sort?

ABBIS:

No.

WEEKS:

What are the governments or the governing boards doing in the way of asking for second opinions on whether surgery should be done?

ABBIS:

Not by the board -- by the medical staff and the medical director in each hospital.

WEEKS:

Do they do this because of a matter of quality or need for care, I mean, to prevent overuse, too much surgery? Quite often you read an article that says 50% of the surgery was not necessary. Do the hospital medical staff or a particular committee that might oversee, do they do this to maintain the quality of care in their hospitals? Not so much to prevent people getting in. For instance, in this country now, if you have Blue Cross insurance -- this would be Blue Shield -- if you are going in the hospital for surgery and your doctor says you need your gallbladder removed, maybe under the insurance plan you would have to get a second opinion before they would agree to pay for that service. You don't have that?

ABBIS:

The only thing that happens is if a surgeon does things beyond what he was...well, the medical staff will report it to him and he can appeal to the

board and if he is not satisfied with the appeal to the board, he can appeal to the Minister of Health.

WEEKS:

What I was thinking about was cost control. Here you have your hospital in Edmundston and you have a budget you have to live under and it's getting a little bit tight and you don't know whether you are going to be able to make it go or not and you don't know whether you are going to be able to get more money out of the government -- would that hospital do anything to...

ABBIS:

Let's make it clear. We don't budget doctors' fees, you see, they are paid by the government. They send their charges, fees, to the government every month and they get their check for time.

WEEKS:

Is this on an agreed schedule of payment?

ABBIS:

Yes. The medical society negotiates with the provincial government the fees of their membership. Now, in regard to surgery, for example, what you are saying could be possible in big centers when you've got too many surgeons -- too many specialists. But mostly in Canada, outside of Toronto and Montreal, we've got a lot of GPs. But it is hard sometimes to get an internist or a surgeon because they want to stick where the universities are. If we had a medical school in the province we would get more doctors. We've only got one medical school for three provinces in Halifax. So our problem in New Brunswick is that we lack surgeons. We've got two or three, they are very busy. We've got three internists but we've got about twenty-five or thirty GPs. The population has a lot to do with it. If it is a dense population,

there might be a lot of abuses.

WEEKS:

In the smaller provinces, the doctors pretty much...

ABBIS:

They are doing well, mind you.

Last year I was invited to the Kentucky Derby. The chap who invited me was Wade Mountz who used to be chairman of the board of AHA. He invites usually two every year...and a chap from Arkansas, named Murphy. Naturally, Kentucky Derby day is something like Christmas in my country -- parties and so forth. We were invited -- two or three doctors. They were around thirty-five years of age or less, I'd say. The homes they had in the suburbs, the swimming pools, hot tubs and so forth -- I couldn't help but wonder, darn it, they must be making a hell of a lot of money.

WEEKS:

I'm sure a lot of them do.

ABBIS:

They must, because they live.

WEEKS:

And they can't help but be influenced by the fact that they can make money. It seems to me a very difficult position to put a person in to decide when you want to be an idealist and do good for humanity and on the other hand you look at all the money you can make if you do certain operations that won't hurt them.

ABBIS:

You know what they say. They spend so many years, and I agree with them, they spend so many years before they can practice medicine.

WEEKS:

Yes, but, you couldn't begin practicing law much sooner than a physician can start practicing medicine.

ABBIS:

Well, a law course is three years after you get an arts degree. But they've got to finish four or five years of medical school and then they've got to go through an internship before they can be licensed.

WEEKS:

Yes, but it isn't quite as bad as they make it look.

ABBIS:

Oh, I know. But that is the argument they always give you.

WEEKS:

They don't tell you, in our country -- and I'm sure it's true in your country -- the federal government subsidizes that education a great deal too.

ABBIS:

They don't mention that. Oh, no.

WEEKS:

It's as though they are giving up their life and their wife has had to work to get them through school. Every profession -- I went to school like you did, the extra years, but I've never felt that because I did it that I sacrificed a great deal. I feel that I benefited. I happened to pay my own way through but I don't feel that I have been misused or that I should make \$200,000 a year or more.

ABBIS:

When you were in school you weren't driving a car.

WEEKS:

Anyway...

I suppose you go back to this supply department when you want to buy a CAT scanner or...

ABBIS:

Yes. We've got to ask them and we submit the price and then we wait -- we wait -- we wait. We've only got two in the whole province now, out of thirty-two hospitals.

WEEKS:

Maybe that's enough. I think they are overused in this country. Are there any standards or requirements about what these new technological wonders can be used for? For instance, in this country we have had complaints that people with simple headaches have had a CAT scan which is, what, five or six hundred dollars? Are there any requirements in your country?

ABBIS:

Because if a CAT scan is in the hospital it is owned by the hospital and the radiologist is there and he is being paid for the time he spends. But I understand here that some radiologists can open shop next door to a hospital and advertise that they've got a CAT scan and x-ray and so forth. They can't do that at home.

I notice in Florida they've got these walk-in doctors all over the place.

WEEKS:

We have walk-in clinics all over the place. I don't know whether they have CAT scans. They would have x-ray.

ABBIS:

In Maine there is one company that has one that is fixed to one of these

big semis -- trucks -- and they service four or five hospitals up in northern Maine. I think this is a good idea.

WEEKS:

We have one in northern Michigan too.

ABBIS:

It's a good idea. I suggested once to the Minister of Health. I said the northern part of the province they have to travel 200 miles to go to St. John or where there is a CAT scan. I said why don't you buy one and service the North. Well they just put it off.

WEEKS:

Who decides...

ABBIS:

We've got to go to the Minister of Health and present our case. You see we can't lobby in Canada. Our system is against lobbying. The only lobby I can have any effect on is to see the Minister of Health but he or she cannot make a decision. It has to go to the cabinet and they vote on the party line. In Ottawa or in my province, New Brunswick, or in Ontario -- here Congress will vote. You see Republicans and Democrats voting against Republicans and Democrats. We can't do that in Canada under the British parliamentary system -- so you've got to tow the party line. To tow the party line...you can make a request to one person...the minister in charge. Then the minister might agree with you but he will go to the Cabinet and say, well, the Cabinet says we can't afford it this year. It is a matter of financing.

Our system is very, very government related.

WEEKS:

There is not much you can do.

ABBIS:

No. We can't go to see a member from my town or parish or county and say -- there is no such thing as PAC. If you want to support a party, you support the party.

WEEKS:

There are probably advantages to that.

ABBIS:

Well, it is less expensive. Can you imagine -- I made that remark to Mr. Lanigan who brought me down -- they've got this AHA building here and the Illinois Hospital Association now have their own building. The expenses traveling, staffing.

It seems to me that the administrators are always traveling all over the place. How can they run the hospitals when they attend all kinds of conventions and meetings: urban, rural, councils, city matters, Tri-State, and so on?

WEEKS:

Persons with whom I have talked previously have said that the administrator who goes through the different offices and gets to be president of AHA often finds that he is in trouble back home. The hospital board may say that something happened at the hospital while John the administrator was away somewhere on AHA business. The board wonders who he is working for.

ABBIS:

A smart man who is to become president of AHA talks it over with his board first.

WEEKS:

I think that would be a smart thing to do if he values his job.

ABBIS:

Quite a few have lost their jobs who didn't clear it with the board.

WEEKS:

I guess we have answered this question already. I was just wondering how when you were Chairman of the hospital in Edmundston, what was the reaction on the board about this new national hospital act? Were you concerned that you couldn't make it work?

ABBIS:

No, we weren't concerned because we had a hard time financing the hospital.

WEEKS:

We mentioned a little bit that after this 1958 law went into effect that the occupancy rates went up.

ABBIS:

Yes. They had long waiting lists.

WEEKS:

Like it was in the United States when we put in Medicaid and Medicare.

ABBIS:

And that was the beef we board members had to put up with -- public clamoring -- can't get in, can't get in, got to wait too long.

WEEKS:

Did you find that after the act went into effect and these people started rushing in, did it make any difference in the cost to the hospital? One of the arguments today about the practice in this country of HMOs and PPOs going to a hospital and saying, here, we want to make a contract with you but we don't want to pay your regular rates. We want twenty-five off or whatever.

And the hospital then says, if we allow that, we will fill up the hospital and we'll be able to operate in the black. Where now we are going along at sixty percent occupancy what if we get eighty-five or ninety percent occupancy and it won't cost us much more to take care of that many people than it does sixty percent. Was that your experience?

ABBIS:

Well, to a certain extent an empty bed affected our budget but our occupancy was pretty high except in the summer months. It is usually 100%. Because people are making use of the hospital.

WEEKS:

They put them out in the halls sometimes.

ABBIS:

This winter I don't know what happened. I was told there were five or six beds on each floor in the hallway. I suppose we had a mild winter and are not used to it out east -- northeast.

I think that the public, the Canadian population, wouldn't go back to the old system. I think they are happy with the system as is. The headache is with the board members -- trying to make both ends meet -- satisfy the public and satisfy the staff. Unions are in now.

WEEKS:

But if a hospital is paid say \$300 a day for each patient, you get paid \$300 a day whether you have sixty percent occupancy or whether you have eighty-five percent occupancy?

ABBIS:

Only on the occupied beds.

WEEKS:

But you get paid \$300 per bed that's occupied whether you have sixty percent occupancy or eighty percent occupancy.

ABBIS:

That's right. They figure that we will get an occupancy in 1986, for example, of so many patient days. So I suppose they take 365 days and put in the 200 beds and so forth and that's your budget. That's what I said previously is that if you miss the target and you are given so much every month -- they give it monthly -- and at the end of the month we got too much because the beds weren't occupied. Well, we have to reimburse the government. They say we'll take it off the next check of yours. It happens often.

WEEKS:

The argument I was thinking was if you have ninety-five percent occupancy, for example, you don't have any more fixed costs for the ninety-five than you would for the sixty.

ABBIS:

That's right.

WEEKS:

So if you could fill it up to ninety-five percent you should make a little money.

ABBIS:

But you can't keep it.

WEEKS:

So there isn't any incentive to save money.

ABBIS:

No. The only thing is that the board has to make sure that we are

fiscally responsible for what is entrusted to the hospital.

WEEKS:

So then you have to get somebody who is smart on budgets.

ABBIS:

Yes. We have a controller and a finance committee and usually we try to get an accountant from one of the companies and say will you chair the committee. Then they report monthly to the board and the administrator has to answer a few questions that are asked.

WEEKS:

How often are the hospitals paid by the provincial government?

ABBIS:

Monthly. And the controller, usually, when he gets the check will not pay the suppliers but will invest the money in CDs. So the hospital can make a few dollars that way. Money earned by the auxiliaries now would be offset revenue to the hospital. So we say why don't you organize yourselves and we will rent you space, one dollar a year. If we had a house for the medical director, for example, or sometimes a physician needs something and we charge rent, that would be taken off our budget.

WEEKS:

Or if you had office space that you rented...

ABBIS:

That's offset.

WEEKS:

So there is no objective in having it.

ABBIS:

That's the thing, there is no incentive to save money unless you throw it

out of the window foolishly. People are making use of it, especially the outpatient. If you are in a mill town -- they come in around midnight because they work from four to twelve -- they come in and they want a doctor. So we've got to keep doctors working and pay them extra to be in attendance in the outpatient department and in emergency.

WEEKS:

They probably work on a salary, don't they?

ABBIS:

No. They are given a stipend. They are paid a regular fee per visit and then the government gives them so much -- they sleep in the hospital in a little room, instead of calling them at home and waking them up. So the GPs do that type of work. The government looks after that.

No, there is no incentive at all to save money. I recall when the sisters were running the hospital, in the operating room -- sutures -- sometimes there would be about six inches of a suture left and the nun would keep it and use it. Now what they do...they throw it in the wastepaper basket. They overdo with x-rays. Everything, you've got to go to x-ray -- especially for a chest x-ray. You have been in the hospital three or four times a year and you've got to go and have a chest x-ray.

WEEKS:

On admission.

ABBIS:

On admission.

WEEKS:

We are finally getting rid of that in this country but it was, up until a short time ago, standard procedure to have an x-ray every time you were

admitted to the hospital.

Is there any control? Is there any way you can control -- assume you have a physician who orders x-rays five times as often as the average -- will that come through the medical staff again?

ABBIS:

It would come through the administrator to the board. Heavy expenditures. When the budget is set at x amount of dollars, for certain matters, let's say for x-ray films, the finance committee and the controller comes before the board and say now we have exceeded it by twenty percent. We usually ask. We will need an explanation -- how come? Did you underbudget or not?

WEEKS:

We talked about construction costs, we talked about new technology and about no depreciation funds. Have you any idea of what percentage of the people have some insurance coverage besides the hospital plan? It probably isn't very great any more, is it?

ABBIS:

There is no insurance to be bought anyway. There is only insurance for the private room or semi-private since the government pays ward rate. The budget is based on ward care.

WEEKS:

What do you consider a ward -- four beds?

ABBIS:

Four, yes. Some are five but generally speaking they are four. Semi-private is two.

WEEKS:

The medical plan came in in 1968. I think in what we talked about before that that works on a fee schedule settled by the medical association.

ABBIS:

For the doctors. And the hospital staff submits its needs to the board and then we approve it and send it to the government for their approval. They never approve 100%.

WEEKS:

Do you have any salaried people or doctors?

ABBIS:

The medical director.

WEEKS:

How about radiology?

ABBIS:

No. They all come under the medical plan.

WEEKS:

They work on a fee schedule also in the hospital?

ABBIS:

Yes. They are not allowed to do any private. If they are taking private in their offices -- they have an x-ray machine -- they can't get paid for it.

WEEKS:

I see. But they get paid on a fee basis.

ABBIS:

Same as a GP or a surgeon. They allow so much -- the same system you've got now from Washington, isn't it? They get a set fee for a certain surgical intervention or operation and so forth.

WEEKS:

Yes...the DRG you mean. I was going to ask you about that.

ABBIS:

They have that. For example, when I see my internist to take my blood pressure. He asks me to go every sixty days. Now if he were to ask me to go every thirty days, the second visit wouldn't give him as much as he gets from the sixty. If he's got a patient that stays too long in the hospital, he's using a bed and if he visits that patient, let's say for twenty days, the twentieth day he gets a pittance. He doesn't get the same fee for each visit. It's fee de-escalation.

WEEKS:

Is there any committee in the hospital that would look at length of stay?

ABBIS:

Yes. Usually the administrator reports to the board. The only thing is that only a doctor can admit and discharge. You've got some of these doctors that are kindhearted. We had an example once, which I think is very common elsewhere. For example, a woman is admitted to the hospital and she gets well, but she got flowers, she got get-well cards, but somebody hasn't come to see her yet. So she begged the doctor, can I stay an extra day or two? We have some of these doctors who are kindhearted and we have to tell the administrator to tell the medical director -- tell Dr. so-and-so now that he has too many patients -- long stays.

Our problem in some parts of Canada -- in our part -- is you get a heart attack, anything that what was a long stay and we have no convalescent homes. It would cost less for the government. That would be, I would say, the next step. It is cheaper to keep a person in a convalescent home than to keep them

in the hospital.

WEEKS:

No question about that.

ABBIS:

What we are starting in New Brunswick is a system that they started in New Zealand -- extramural hospitals. That is, they will go into a town and have a building and retain doctors on a fee-for-service and a nurse. Then they have their offices there, no beds, but they will treat you in your home. It's the New Zealand system. They call it extramural.

That is helping quite a bit where it is established but it only got started about three years ago. That is paid by the government with no help from the feds, except the \$20 per capita for preventive health care.

WEEKS:

Can this be any kind of patient?

ABBIS:

Say I have a stroke and the doctors says well you've got to lie in bed for three or four months. After I am not in acute care any more in the hospital, then I can go home. Then the nurse will visit me and the doctor will visit me in my home.

WEEKS:

Is this similar to what we call home care in this country? Where the nurse visits at regular intervals and keeps a chart for the physician.

ABBIS:

It would be the same. We call it extramural. And the physician, is he paid by the state, or is he on a fee? Who pays for his care? The patient in his home who is visited by the nurse.

WEEKS:

Here, Blue Cross might do it, if you have Blue Cross insurance.

ABBIS:

How about the physician?

WEEKS:

He gets something from Blue Shield but I am not sure just how he is paid. Because the physician himself doesn't make many calls in the home, only if the visiting nurse reports to the doctor and says I think you might want to look at this man because of this and this and this. Then the physician might go out. But in home care the visiting nurse really does most of the work. She may also have a physical therapist come out and help exercise that limb that is immobile. They might even have a dietitian come out and instruct the family on how to prepare the right kind of special diet for this person. But as you say it saves a lot of money. It is cheaper than paying three or four hundred dollars.

ABBIS:

And he's at home and has that good environment.

WEEKS:

And it is better for the patient, too, because he feels I am getting better, I am at home. And the family's around. We all feel better. I haven't been in the hospital many times but I can remember each time that I have I was eager to get home. I think that is half the battle -- getting home -- you get better faster.

I am going to repeat this but I think I've got it straight. Under this national medical plan or medicare you call it, don't you?

ABBIS:

No, we don't call it Medicare/Medicaid. We use it because we borrowed it from you people.

WEEKS:

Somewhere I saw an author use it and call it medicare, with a small M. Anyway, the fee schedules are set up but the physicians are not allowed to charge more.

ABBIS:

If he opts out he can. But if he is a participant, no, he can't.

WEEKS:

We talked about the effects on utilization.

What about this act that you mentioned before but didn't call it by name, I don't think. In the 1970s the government decided it was too much money being spent and they...

ABBIS:

No, it's the provinces. They said education and health is a provincial matter under the constitution, the British North America Act of 1867. The government said, okay, you don't want us to interfere in your jurisdiction, you handle health, it's your responsibility. The provinces said, okay, but we need money -- we haven't got enough money. They said okay we'll give you money but we will give you per capita two percent. Then the provinces -- that's the time I said to the hospitals in Canada, be careful, the provincial government is going to get grants for the health from the feds instead of that straight fifty percent, which is based on hospital costs. Now, they are going to give it based on per capita and the income policy and so forth. Is the provincial government going to use this for health or are they going to use it

build bridges and roads and other things or spend it traveling. If it were earmarked. But you can't have it earmarked because the provinces said health and education is our jurisdiction. So naturally the feds could not tag that amount and say you are going to use it for health because that would be intruding on the jurisdiction of the province.

WEEKS:

You have talked about the nursing education. Would you like to talk about the medical education. What do you have, about sixteen medical schools in Canada?

ABBIS:

There is Quebec, Sherbrooke, Montreal in Quebec. That's three. In Ontario, you've got Ottawa, Toronto, Queen's in Kingston and London, Ontario. Then we have one in each other province. In the maritimes...Newfoundland has a school now, at Memorial University. But for three Atlantic provinces, it is housed in Halifax.

WEEKS:

You really have more medical schools in number in ratio to your population than we do. Your population is about ten percent of ours and we have less than 100 schools.

ABBIS:

Let's say in Detroit, how many schools have you?

WEEKS:

Just Wayne University, I think...Wayne State University. Then we have the University of Michigan and Michigan State University. We have three in Michigan.

ABBIS:

Here they've got quite a few haven't they...in Chicago?

WEEKS:

I don't know just exactly how many they have but they have quite a few.

ABBIS:

But when you go through a hospital zone here, they are all over.

WEEKS:

Yes. This is pretty heavily health around here isn't it?

ABBIS:

You know the problem we have in Canada is the language situation. There are two universities in the province of Quebec -- no, there are three in Quebec now -- Laval in Quebec city, University of Montreal and Sherbrooke -- but they give it in French.

WEEKS:

How about the other schools? Are they in English, or bilingual?

ABBIS:

The other schools are English, not bilingual, English.

WEEKS:

You don't have as many foreign medical graduates as you used to, do you?

ABBIS:

We've got some. Especially in the poorer provinces, the have-not provinces. It's difficult to get people from big cities to come to small towns.

WEEKS:

We have the same trouble.

ABBIS:

Remember Phil Bonnet? I remember we had a cocktail...the past presidents and he invited me over and I said, "Phil, what is the problem? We've got a problem that we need more surgeons at home. How do you get surgeons?"

He said, "Cherchez la femme."

He's right. They get married young now. When they are students, they get married. And they've got all the facilities in the big city, the culture, the shopping and everything. Why do they want to leave and go in the far-flung areas.

WEEKS:

I used to live in a small city that was not over thirty-five miles from several cities but this was a town of 5,000. We were trying to get doctors to come on our staff but the only thing we had to say was we had lakes and we have recreation and we are only thirty-five miles from the University of Michigan, we're only thirty-five miles from Michigan State University, we are only fifty miles from Detroit. This is the way we were trying to attract them. But we ended up having a lot of osteopaths.

ABBIS:

That's right you have osteopaths, we don't.

WEEKS:

You don't have any licensed in Canada?

ABBIS:

Osteopaths, no. We have chiropractors, that's all. I think if a physician refers you to a chiropractor, the government will pay the chiropractor. But to be treated by a chiropractor...

WEEKS:

But not as a primary source.

ABBIS:

No.

WEEKS:

In this country, I think some of the contracts from the insurance companies will allow a patient to go to a chiropractor as a primary source.

There has been some talk -- maybe you have gone farther than talk about community health centers, where you have a team of professionals working together -- doctors, nurses, therapists and so forth. That hasn't really developed?

ABBIS:

There are doctors banding together to give you twenty-four hour service and I think some of the GPs are getting together and they call it medical centers. But they do it on their own.

WEEKS:

It is nothing that is supported by the government?

ABBIS:

Just that if I go there on a visit they will take my number and charge it to the government. It is covered under the health plan.

WEEKS:

But it is just more for convenience. I think some of those are taking place in England, too, aren't they under the national health service there. There are a few of these centers that are being built by physicians.

ABBIS:

But most of them are opting out -- these physicians in England, aren't

they? You see the British system is so different from the Canadian system. I'm free to choose the doctor I want and I can go to the hospital I want. I am not a number whereby I am told that in this zone you've got to see Dr. Jones or Dr. Smith and so forth.

WEEKS:

Their freedom of choice is you choose a man and you stay with him but with you you could go see one man today and next week go see another man if you wanted to, without going through any registration.

ABBIS:

Unless, like the GP will refer a lot of patients to an internist. The same thing, the internist -- if you needed a surgical intervention -- he would refer you. But you can choose your doctor. They can't tell you you are going to be operated on by so-and-so -- you choose. That is one problem we have with the surgeon sometimes, the poor surgeon is always bitching to the board that he is not getting too many referrals for surgery. Well, the GPs feel that he is not as competent as the other surgeon.

WEEKS:

So if he doesn't get referrals, it is his own fault.

ABBIS:

It's his own fault. We can't do anything. He comes along and he bitches to the board that the medical director should see to it. Well, that's proficiency and competency.

WEEKS:

We talked about foreign medical graduates. Do they have to take an examination when they come to the country?

ABBIS:

They've got to be licensed by the province...the provincial medical council.

WEEKS:

If they are already a doctor somewhere else and come to Canada, they have to take some kind of examination even though they are licensed somewhere else.

ABBIS:

That doesn't count. They've got to be licensed here. As I said before, in some of these remote areas, New Brunswick is an example, every hospital has foreign doctors.

WEEKS:

Now the government doesn't pay a doctor in a remote area any more of a fee?

ABBIS:

They used to do it out west. If you went to a university and they paid your expenses and they told you you've got to serve for two or three years up in the northwest. I think that still exists, I don't know.

WEEKS:

I think in Britain, you can only go where you are allowed to go to open up a practice, but if somebody way up in the highlands somewhere wants a doctor and they send a young man up there they may pay him an extra fee because it is so remote and he won't have a very big capitation.

ABBIS:

You've got the same system that they call the "flying doctors" in Australia. They must be paid a little more because you've got to fly.

WEEKS:

That's the only way they are going to take care of remote areas. We have remote areas in our country where people can't get a doctor to come and settle because, as you say, he wants to be near the lively things that are going on and he doesn't want to be in a remote area.

ABBIS:

And let's not forget that you in Michigan, and me in the northeast of Canada, the weather has a lot to do. That's why they are overpopulated down south. I understand that they have very strict licensing laws in the state of Florida today.

WEEKS:

Yes. They have for quite a while.

ABBIS:

Yes, because everybody was -- all the Canadians went to Texas.

WEEKS:

California used to have very difficult laws about reciprocating your license. The same in pharmacy. I think they have the same thing in Florida and Canada.

ABBIS:

You see, in Canada if you graduate from medical school you pass the Dominion licensing board. That gives you the right to practice throughout Canada, except Quebec. Quebec licenses their own. But if you got a license in Quebec you couldn't come and practice in New Brunswick.

WEEKS:

You couldn't?

ABBIS:

No. Because he didn't get what they call the Dominion license. See we could get doctors from Maine sometimes and they thought -- we had applications once for surgeons and somebody from the Carolinas, but the problem is he would have to come to New Brunswick and undergo examination. But after you have been practicing fifteen or twenty years, to go back to the books! Because there is no reciprocity between the United States and Canada.

WEEKS:

That seems strange because the medical schools on both sides of the border, aren't they examined by the same examining board? I think there is a joint board...

ABBIS:

I think you are right that certainly if a chap graduates from Harvard in medicine and he wants to practice in Canada, the licensing board in any province will just issue him his license. But if they are foreign graduates, they have to know which university they've been to, was it in Granada for example?

WEEKS:

Then too, some of these foreign schools like Granada the students might be mostly American, maybe some Canadians too, I don't know. They can't get into an American school -- all filled up -- so they have to go to some other school. We used to think that people would then go to Scotland.

ABBIS:

They used to go to Edinburgh.

WEEKS:

The United States and Canada seem to work closely together on some of

these things such as the approval of schools and I think that graduates of the medical schools of the two countries have quite a lot in common.

ABBIS:

I know in nursing it is the same. For example, we got some American girls from the Maine border and if they take their course in Canada and they want to practice in Maine all they have to do is be licensed. There is reciprocity. They can't use the New Brunswick license to practice in Maine.

WEEKS:

I can understand that.

We just mentioned DRGs. Is there anything like that going on in Canada?

ABBIS:

Yes. For surgeons. Everybody, as I mentioned before, for an appendectomy they get so much and the same with visiting GPs. As I said, if you are in the hospital for ten days and he sees you every day, the first day he gets the full fee. But it goes down.

WEEKS:

We haven't gone quite as far in this country on physicians as you have. Our DRGs started out with the hospitals with Medicare patients. But I think we are going to end up having some kind of deal where the physicians are on a DRG...

ABBIS:

That is the AMA would negotiate for all the doctors?

WEEKS:

That's possible. I don't know as they have even talked about it yet. But the Department of Health and Human Services probably will set up a task force and work with maybe somebody from AMA...a group from there. But I think

it's coming. Physicians won't like it but I think it's probably coming. Especially as we are moving more toward -- they probably will start out with this in Medicare and maybe Medicaid. The general population, I don't know what they will do about them. The hospitals now are the ones who are getting this DRG -- some of the Blue Cross plans are beginning to pay benefits under a DRG type of -- so that, as you say, an appendectomy may be \$100 or \$150...

ABBIS:

It's a good deal for the hospitals, you know. That will force them to be more careful. If they make a profit they keep it, I understand, on the DRGs.

WEEKS:

Yes. So I think this has cut down occupancy, it's cut down admissions -- of course they go together. But the occupancy is sometimes cut off at the other end by length of stay. It has saved on length of stay and it has saved on admissions. So the health bill is rising less swiftly than it did a year or two ago.

ABBIS:

Is it true now that if you get an aspirin tablet in the hospital they may charge you two dollars for an aspirin tablet that cost them?

WEEKS:

I don't know. The last time I looked into anything like that they had certain standard stock drugs such as aspirin, milk of magnesia, or some kind of common things -- household type of drugs -- that they didn't charge for. But they used to charge enough for their other drugs that they made up for it I think.

I ran into a situation one time in a hospital where a lady came into the pharmacy to buy some medicine that the doctor had ordered that could be

administered at home by the visiting nurse. There was a 10cc vial, ten shots, and the hospital had been charging, we'll say, four dollars a shot when they administered it in the hospital. So the pharmacy charged them four dollars times ten or forty dollars for this little vial that she could buy at the drugstore for three dollars. But they couldn't understand it because they were thinking in terms of this is the price we charge -- so much per injection. That showed me that they were doing pretty well on their pharmacy. In fact that was the money-maker of the departments, kind of subsidized some of the others.

You talked a little bit about convalescent homes. What about the nursing home?

ABBIS:

We've got plenty of nursing homes for senior citizens. One floor is devoted for nursing, besides being a senior citizens' home, they'll have a floor with nurses in attendance. What I meant to say is that outside of Montreal and Toronto, where you can send a patient to a convalescent home...

WEEKS:

I know that's a different degree of care.

ABBIS:

That's a different degree. That's what is lacking in some provinces. That causes the long stays -- the occupying of beds when people are waiting. But nursing homes -- they are all over the place now. Because senior citizens now -- that's all they are waiting for -- there is a long list. They want to get in, they want to sell their house. They are elderly and they want to go to a senior citizens' home. The province will -- they can bill the home through central mortgage, from Ottawa money. They can use the facility of the

senior citizens' home for a nursing home too. They will take one full floor, for example, they'll have people who are comatose perhaps or...

WEEKS:

Who need a lot of body care.

ABBIS:

Yes. That's all. And if they are sick they just ship them right away to a hospital, and then when they are well they go back to the nursing home.

WEEKS:

Don't you also have a combination for senior citizens, ambulatory people? The ambulatory senior citizens' home would be on another floor.

ABBIS:

They occupy three-quarters of the building. Let's say a four story building -- they have their little apartment, a little kitchenette and everything -- then one floor will be nursing. Now some are only nursing homes. Now they will send, for example, the invalids. There are four or five in the province. For example, I know a friend of mine who was controller of a company and he just went mentally. There is a home for them, they look after them. That's what we call a nursing home. But in different localities they have a combination. Let's say in the county where I am there is about a population of 30,000. Well, there is one place that used to be an old hospital run by the nuns about five miles from my home town. Half of it is occupied by sick people. They call it tertiary care or something like that.

WEEKS:

Tertiary care is usually the big hospital.

ABBIS:

Then the other is people who are looking, they applied to be cared for. They can eat there. They have a room but there is a common dining room. There is one in Edmundston. There is one in every darned village. They get grants from the government to build the building. They borrow money. Then if you are a social welfare case, if your earnings are not above a certain amount, the government takes over your old age pension and they will say it costs so much -- to the owners or the organization -- we'll pay you so much a month, you look after the person.

WEEKS:

But the government sets the rate.

ABBIS:

Yes. They figure out your income...some people cheat, you know, they will deed their homes to their children. But we've got plenty of that going on.

WEEKS:

There are enough of those.

ABBIS:

Oh, yes. But there are too many people, when they reach a certain age, they want to go to some of these senior citizens' homes. And they are not privately owned. Therefore the government has to come in and help them build and then they have a board to look after the management.

WEEKS:

These people who go to the senior citizens' home have to pay something?

ABBIS:

Yes, if they can afford, they have to pay the full fee. If you can't the

government will subsidize part of it. Let's say you've got enough to pay fifty percent and the government will pay the extra fifty.

WEEKS:

How about the families? In our country, especially in Michigan, today the children are not very responsible for the parents. If the parents need care the government doesn't go to the children and say, look,...

ABBIS:

No, they don't. Though in common law, they could. Under the old common law you were responsible for your father and mother. But it's just in the textbook, that's all.

WEEKS:

The excuse has been that it's like trying to get fathers who have left their wives to take care of the children. They say it costs too much to hunt them down and to force them to do it so the government sometimes looks the other way. I suppose this is true with the children.

ABBIS:

Social welfare people are artists. They'll do everything. They live very well. They live better than you and me. They don't get married so that they can get two social welfare checks, they shack-up. Then they have children and the children are looked after under the social welfare act. It's abused.

WEEKS:

I think all over the world it must be abused. Until I read of some place like Holland, the Netherlands, and I think that we are pretty strict here compared with what they are there. They seem to get away with everything in Holland.

ABBIS:

In Holland, yes. I was in Amsterdam three or four years ago and there was a beautiful park next to the hotel we were staying at. I said that's a beautiful park. They say, no, that's not. That's where the users -- every night the police corralled them, put them in the park and locked the iron gate. "Do what you want to do, but don't roam the streets."

It's terrible.

The problem the next generation will have to face, perhaps it won't happen in our life time, you and me, is the percentage of the GNP of each country -- the United States and Canada -- each of these countries are going for social welfare. And people don't want to work. They say, why, if I can get \$800 or \$900 a month, why should I work?

WEEKS:

This is true.

ABBIS:

And you've got the problem here of the blacks. Little girls are having children at the age of thirteen and fourteen.

WEEKS:

Yes. The percentage of illegitimate is terrific.

ABBIS:

I read in Newsweek or Time the latest figures. It's terrible, you know.

WEEKS:

What do you do about mental health?

ABBIS:

We've got mental hospitals, two in my province. That's looked after by the provinces, it doesn't come under the federal act.

WEEKS:

Here again it's the province. They don't get any money from the federal government?

ABBIS:

Because health is a provincial responsibility.

WEEKS:

Like the money that they get to help with the hospital costs...the mental hospitals are not figured in?

ABBIS:

They are not under the plan, the health plan, the Bill 320. We've got two of them and the doctors are paid by the government, provincial government, and the staff.

WEEKS:

They are salaried?

ABBIS:

Salaried, yes.

WEEKS:

What about admission there? Does the state charge a patient who goes there? In other words, do you have to pay your way if you can?

ABBIS:

No. If you need a treatment they are paid under...

WEEKS:

What if you are sent there by the court?

ABBIS:

By the court? You are there for free.

WEEKS:

In our state they are trying to collect money from the family if they can if somebody is committed. I don't know how successfully it is working out.

ABBIS:

Let's say that I become very depressed and the doctor says why don't you go and get a treatment. So I go to the mental hospital and see a psychiatrist there, that would be my responsibility. I can come under the medicare. But if you are committed, there for life... There is the mental incompetency act, each province has one.

WEEKS:

What about transplants? Are you doing much in the way of organ transplants?

ABBIS:

No -- except kidney.

WEEKS:

I was going to ask you about that a little later.

ABBIS:

They started a chapter in New Brunswick and our hospital was the first one, St. John. We still have two or three rooms devoted for kidney patients. They come in from all over the northern part of the province and those from the southern part go to the southern part of the province.

WEEKS:

When that became a part of our 1972 amendment to the Social Security Act -- free dialysis, they thought a million or two dollars in cost. It has grown to be a terrific... In fact I heard a statement the other day by a surgeon who said if it costs \$30,000 for a kidney transplant, it is cheaper over a

period of years, assuming a person survives for ten years, it would be cheaper for the government than keeping him on dialysis. It's getting so they work it out on a dollars and cents benefit now.

Your dental care, that's not under the provincial. Can you buy that?

ABBIS:

You can buy that if you are in the group but not individually.

WEEKS:

How about drug and alcohol abuse?

ABBIS:

We've got a commission that preaches prevention and so forth. We've got laws. They have a commission, with a doctor who is on salary. He is chairman of the commission. They've got places -- de-toxicating -- we've got one in Edmundston. They've got them in different places now. The law says that the police officer or anybody can have them committed there to be treated.

WEEKS:

Is it much of a problem in your province?

ABBIS:

No.

WEEKS:

It's mostly the big cities?

ABBIS:

The big cities -- the slums and the ghettos.

WEEKS:

You mentioned this doctor that tries to teach people about drug abuse. How about your health education generally? Do you try to teach the general public how to live and what not to drink and what not to eat?

ABBIS:

Well, we've got these societies like the Cancer Society, the Kidney Foundation and they do a lot of preventive. Clinics, like blood donors and so forth. And the hospital itself. We conduct at times classes for CPR. And the companies will get together against abuse or smoking, alcohol, and the public is invited to attend. That's voluntary work, done by volunteers. But alcoholism, the government takes charge. They've got a staff and a doctor in charge of it.

WEEKS:

That's the provincial responsibility but doesn't come under the hospital act.

I haven't been able to find out much about -- we talked a little bit about the twenty dollars per capita for extras...

ABBIS:

That's for preventive medicine, home care, ambulatory and so forth. That's given like extramural -- they'll get twenty dollars per capita.

WEEKS:

So the payments on both hospital and medical care are based on the incident, not on the number of people in the province or anything else. It's how many people use the service and there is a fee paid by the provincial government for the service either in the hospital or by the doctor.

ABBIS:

But the reimbursement from the feds is based on per capita, tax points and so forth. But the hospital gets its budget and gets its money as budgeted.

WEEKS:

You spoke a little bit about serving on the Maritime Hospital Association which is Blue Cross/Blue Shield. Do you want to talk about that?

ABBIS:

Well, it was very interesting. Naturally, in these days it was big because you insured the population for health.

WEEKS:

This was before 1958.

ABBIS:

Now it exists but only for surcharge for private and semi-private and they will underwrite groups, for example, for dental or eye and that sort of thing.

WEEKS:

Do most of the people use a two bed or private room facility?

ABBIS:

Everybody wants a private room.

WEEKS:

It isn't too much more?

ABBIS:

It's about twenty dollars more.

WEEKS:

That's cheap considering the rest of it may cost \$300.

ABBIS:

Well, we serve a lot of Americans on the other side of the river. Well, they've got to pay the full shot. And they've got to pay an extra. Because the government says we financed the building, we're financing the plan and

they are benefiting from it. So they pay more than the government pays the hospital for a bed.

WEEKS:

Every once in a while on our television when there is something being discussed about health someone will say I went to Canada and I had wonderful service and I paid much less than I would pay in this country.

ABBIS:

I think it's right. From what I know about people who spent their winters in Florida and got sick. They came in with bills and they were exorbitant.

WEEKS:

Oh, yes. There is no question about it. But most of the people who live in this country have some kind of insurance. I would say eighty or ninety percent of the people have some kind of insurance whether it's full coverage or not might not be true.

You have remarked that the big change came about after 1958 when the hospital law went into effect.

ABBIS:

The federal enacted the law and then the provinces had to accept it. The last one to accept it was Quebec in 1968 or later. It was the last province to come in.

WEEKS:

Even on hospital?

ABBIS:

Yes, on everything. Bill 320 was voted and each province came in one after the other because they had to enact...each legislature had to enact its

health act. I was asked to draw up the provincial health act for New Brunswick. I remember because we went to the administrator and there was a battery of all of these fellows checking what I was doing. Naturally, we copied from the Ontario act and other acts. We made it fit.

WEEKS:

Did you say that you founded the New Brunswick Hospital Association?

ABBIS:

Yes. And I was president for five years. I enjoyed it.

WEEKS:

How many hospitals?

ABBIS:

Thirty-two.

WEEKS:

The members of the hospital association, were they...

ABBIS:

The hospitals.

WEEKS:

The hospitals were the members and the administrators and the boards could attend.

ABBIS:

Yes. We had a section for trustees and a section for administrators. In Canada we always had a president of trustees and we alternate a lot...even the Canadian Hospital Association is made up of a federation. It is not the hospital membership in the Canadian Hospital Association. It's the provincial association that is a member of the Canadian Hospital Association.

WEEKS:

Does this affect voting then?

ABBIS:

Well there is not much now because the feds take care of the field. So now they are going to education seminars and...

WEEKS:

If, for instance, the Canadian Hospital Association or the New Brunswick Hospital wanted to set some new policy about education and so forth, the voting would be done by the members who would be the hospitals?

ABBIS:

Not the hospitals in respect to the CHA but the associations. It is just like if Illinois and Michigan are represented in the AHA, not by the hospitals but by the state association.

WEEKS:

I can see where that would apply on the Canadian Hospital Association but when you get down to provincial, like New Brunswick...

ABBIS:

The hospitals vote. There are differences between the two systems.

WEEKS:

Tell me something about your work at AHA as delegate-at-large.

ABBIS:

Oh, I enjoy very much of it. They ask me a lot of questions the same as you are asking me. They were very curious. Especially when Jack Kauffman put me on the committee on governance. That resulted with what they've got today -- the trustee organization. That was very interesting. Because, as we said earlier today, administrators didn't look favorably on the trustees meddling

into their affairs.

WEEKS:

You were a delegate to the House of Delegates?

ABBIS:

I was. I am no longer.

WEEKS:

How many delegates-at-large from Canada would there be?

ABBIS:

One...there were two, excuse me. The Canadian Hospital Association is a member now of the American Hospital Association so they are entitled to one. But the AHA is entitled to elect on its own, another Canadian. At first I was the nominee of the Canadian Hospital Association because I was president. Then later on the AHA voted me in.

WEEKS:

You have full voting rights as a delegate-at-large, do you?

ABBIS:

In the House, yes. There are like twenty or thirty delegates-at-large. The regions have delegates-at-large. They send somebody.

WEEKS:

Oh, yes. Because I've heard someone say that they didn't like the idea because it diluted the membership at the House of Delegates by bringing in people from all the regions. How many are there? About nine or ten regions?

ABBIS:

Yes. How many health regions are there in the states?

WEEKS:

Nine or ten.

ABBIS:

Now, under the new bylaws, there is a doctor and a trustee from each region.

WEEKS:

I see.

You mentioned the Kidney Foundation. You've held quite a few offices there too, haven't you?

ABBIS:

They came and asked me if I would look after one in the hospital at home. I said okay. From there I was provincial president and then I was the national honorary secretary. So it was a lot of fun. Meeting people, all volunteers.

WEEKS:

How do they raise their money?

ABBIS:

Campaigns. Once a year.

WEEKS:

This goes to...

ABBIS:

Goes to the national and part of it goes to the provincial and the other part goes to the national foundation. The national foundation did all the publicity and the broadcasts, testimonials from Hollywood stars or prominent people as well as subsidized research.

WEEKS:

Do the people who can afford to pay, do they pay for their dialysis or pay something?

ABBIS:

No. It comes under the health care act. It's free.

WEEKS:

So the kidney foundation is...

ABBIS:

Mostly education and helping those at home. A portable machine comes out. We are trying to get the government to help these fellows, instead of being hospitalized, some of them have to travel 200 miles to go to get the treatment that lasts some days.

WEEKS:

The treatments are paid for under the hospital act but how about the machines? Who buys those?

ABBIS:

They are part of the hospital equipment. They come under the supplies department. Only two hospitals have the equipment in our province. One at home and one down in St. John. Not every hospital can treat. It's just like the scanner you know.

WEEKS:

You said the indigent are taken care of...

ABBIS:

Well, travel expenses -- something that is not covered. If they have to travel, let's say 150 miles and they can't afford it.

WEEKS:

What about the handicapped generally? Is there a provision, is this a provincial thing or is this a federal thing?

ABBIS:

It is neither. It all depends how handicapped you are.

WEEKS:

As an example, in the United States if you are so-called totally disabled, at a certain age you can draw benefits from the federal Social Security — the state doesn't enter into it.

ABBIS:

That's where we come in with our nursing homes.

WEEKS:

I see. Your nursing homes take care of that.

ABBIS:

But I'll have to check on that.

WEEKS:

I'm probably asking a lot of silly questions.

ABBIS:

Oh, no. It's a good question, because I can't answer you.

WEEKS:

This life membership that you have in AHA...

ABBIS:

They do that once a year to one person. They have three awards to give every year -- Kimball Award, Meritorious Services, and the Trustee Award...they give it to one of their members. Jim Hague got an award, Mr. Lanigan had one.

WEEKS:

Mr. Lanigan?

ABBIS:

He used to be in charge of conventions, meetings and so forth.

WEEKS:

We talked about your nursing committee work, we talked about the RNs. Maybe we ought to say a little something about the awards you got. I have you down for this AHA citation for meritorious service.

ABBIS:

That's very nice.

WEEKS:

What is the George Findlay Stephens Award?

ABBIS:

That's the highest award that the Canadian Hospital Association gives. One of the founders of the Canadian Hospital Association.

WEEKS:

Then the New Brunswick Hospital Association honored you by setting up an award with your name on it.

ABBIS:

Yes, and they give it every year.

WEEKS:

What is the purpose, I mean...

ABBIS:

They give it to persons who dedicate themselves to the field of health, whether it's a trustee or an administrator. Two years ago they gave it to a physician from St. John. I understand this year they are giving it to a past president.

WEEKS:

Somebody they want to honor for work.

Could you tell me about the Queen's Silver Jubilee Medal?

ABBIS:

It's hers. When she was queen for twenty-five years the government gave her a list of those who received a medal to honor...

WEEKS:

As part of the ceremony?

ABBIS:

Well, let's say that each time the government says Mr. Weeks should get a something because of public affairs or in his field of work he did something. You see, we are not entitled to titles in Canada. Because if I were in England and I would quit the Queen's Bench, I would be a Sir. In court we were referred to as Your Lordship. Interior courts were 'your honor.' So when I became a member of the Queen's Bench somebody found out up in Canada we are referred to as Your Lord. Walter McNerney of Blue Cross came to me and said, "Are you a Lord?"

I said, "Hell, no, I'm still Chaiker Abbis." It's just the appellation in court.

WEEKS:

The last award I have is 1977. Have you had any awards since then?

ABBIS:

I understand you and I are being honored by the American College of Hospital Administrators.

WEEKS:

Are you going to be honored this year too?

ABBIS:

Yes. The two of us.

WEEKS:

I'll see you again in July then.

ABBIS:

Yes.

WEEKS:

That's wonderful.

ABBIS:

Stuart phoned me and said I would get the invitation officially soon and said, "By the way, Mr. Weeks is the other nominee."

WEEKS:

I talked with him a while ago when he called but he didn't say who the other nominee would be.

ABBIS:

Well he knew that I would be meeting you today.

WEEKS:

I haven't had any honors like you have had. I've had a few small ones, but...

ABBIS:

Well, you know I'm a bachelor -- never got married. I took an interest in health young and it became a hobby. I could get away from the law books and get away from the law circles. I enjoyed it. One of my friends in Montreal, Frank Common, who is the director of all the banks. He was on a committee of a hospital in Montreal. I said, "Frank, how come you are on it?"

He said, "Isn't it fascinating?"

That's the answer I usually give -- it's fascinating being involved in the health field.

WEEKS:

It is. There is no question about it. It's the one place you can do voluntary work and see results. So many places you can't.

What do you see for the future?

ABBIS:

In Canada the problem is financing the plan and it is the same problem you will have. Doctors want always more and hospitals want to rival one another. One hospital has something and the other one has to have it. We've got to be careful that we don't duplicate services. At the same time we should always remember that primary care, acute care should be looked into regardless of how much it is going to cost.

In your country I see a trend where, as I said earlier, that the merger of your hospitals, the not-for-profit hospitals, the community hospitals, there is a danger that the community or the local county hospitals will disappear. Then people will have that problem of geography, having to go to the big institution. Well, the big institution, is it there primarily for quality care or to make money? Take for example what is going on with these heart transplants. When you read the Wall Street Journal and you see how much profit Humana made last year and the dividends they are paying. Well, I may be calloused when I say it but I think hospitals should just meet their expenses. Hospitals shouldn't make any money. Let's pay them what they need to look after us but let's not use the hospital to make money. Like if I owned Beatrice Foods, for example, or Canadian International Paper -- they are in business to make money, a profit. I don't think the hospital is. The

institution of hospitals from centuries ago -- it started with the house of pestilence and for the poor and so forth. Religions took care of the poor and the sick. You've got an example here in your country. You've got the Baptist hospitals, the Presbyterian hospitals, Methodist hospitals, Catholic hospitals. These are all volunteers. Now today business is infringing on the volunteerism and they are going in it for profit. I think that's wrong.

WEEKS:

In this country the Catholic hospitals, as an example, are merging and forming chains.

ABBIS:

They've got to compete.

WEEKS:

My exposure to investor-owned is only one interview, as I told you, with Dr. Frist, Sr. But he would probably argue that if an investor-owned hospital can operate more efficiently than a regular community hospital and cost a community no more money, then the profit should be allowed.

ABBIS:

That's the difference between his argument and mine. My argument is that if there is any profit it goes back to the hospital. It doesn't go to investors. I agree with him that quality of care -- look at the competition you have between Pepsi-Cola and Coca Cola. That's good competition and hospitals should do the same thing in the health field. But there is a difference in selling coke and dispensing health. I don't think I should invest and buy stock in it.

WEEKS:

No. I have not bought any stock in those companies for that very reason.

ABBIS:

If I were a financier -- I own stocks in banks in Canada and trust companies and so forth. I dabble into it. And if I weren't involved in the health field I think I would, if I were an American citizen and reading the Wall Street Journal and saw how the Hospital Corporation of America and others in the northwest were doing, I think I would invest in their stock because the return and the yield is better than any industrial company.

WEEKS:

Yes, it's tremendous. At least in the beginning it was. I think it is leveling off now. What do you think about multihospital systems of community hospitals?

ABBIS:

I agree with that.

WEEKS:

Are they developing in Canada?

ABBIS:

We are talking about it. I gave a talk in St. John two weeks ago on that subject.

WEEKS:

What will be the inducement in Canada as long as you are being paid by the government?

ABBIS:

Purchasing. Sharing of expertise. For example, the good doctor in my hospital can serve as the expert instead of having another of the same specialty at forty, fifty, a hundred miles. He could serve the region.

WEEKS:

Who will foster this organization? Will the province...

ABBIS:

Well, the province is trying to discuss it with the association in New Brunswick -- what do you think about regionalization? The question I asked the Minister's representative, "Is it going to be cheaper? Are you trying to get that system implemented because it's going to cost less? I think it's going to cost more."

He didn't answer me. In the House last week somebody questioned him. (We have got the question person in our system.) Well, he says, as many hospitals as there are, as many systems as there are. That's the only answer he gave. Because we want to know.

WEEKS:

I can't see why the hospital would have any inducement to form multi-hospital systems.

ABBIS:

The inducement would be cost. If you've got an expert in cardiovascular, let's say, why should each hospital have one when the patient load is only twenty or thirty percent of your whole patient load. Then each hospital would be able to specialize in what they need most.

WEEKS:

I can see where there might be some attraction to the idea that -- here, your hospital in Edmundston -- if there is some way we can broaden our services...

ABBIS:

To the satellite hospitals.

WEEKS:

And through that extra service you can afford to have some specialist you don't have now or some services you don't have now, I can see where that would be a community advantage. You could say that as a hospital in our community we feel it's our duty to do what we can for our community and make better things possible. But from a standpoint of cost there is no inducement, as I see it.

ABBIS:

It will probably cost more.

WEEKS:

I'm sure it will.

ABBIS:

But the system we are talking about in Canada is whereby in a province we would have one regional hospital here but all the satellites would be served by that region. The problem I see facing these small communities is they will say big brother over there, the regional hospital, is going to dictate to us. We want to retain our community service. I think this is going to be the stumbling block.

WEEKS:

Walter McNerney wrote a book on that you know -- regionalization -- he and Don Riedel. Riedel used to be editor of Medical Care. He was at Michigan when McNerney was there. They got some support from Kellogg Foundation I believe it was and they tried to regionalize northern Michigan and set up some satellite system with the big hospital, the tertiary hospital, at Traverse City and one at Petoskey and Grand Rapids. The idea was for the smaller hospitals to feed into these bigger hospitals the more complex cases. But

after a while the little hospital said you haven't returned us any business.

ABBIS:

That's right. That's what is going to happen.

WEEKS:

We can take care of some of these people. We don't need to send them to you because you aren't returning us any referrals.

ABBIS:

That's happened at home. The Industry Regional Hospital in Edmundston -- there are two hospitals within a radius of fifty miles and they look at us and say the hell with you people, you aren't going to tell us how to run our hospital. That's a problem.

WEEKS:

I think there is a lot of local pride.

ABBIS:

I have told you about Saskatchewan, these cottage hospitals, they tried to do away with them by building a regional hospital and the population wanted to keep their little cottage hospital.

WEEKS:

It's just like a small town wants their own bank and their own newspaper and their own hospital. It's local pride.

Do you see any possibility of HMOs developing in Canada?

ABBIS:

No. I say no. There is no demand for it. The public is satisfied with the system as it is. The only criticism that we get is from the hospitals -- not enough money in their budgets and doctors not being paid enough. That's the only criticism the plan has in Canada.

WEEKS:

I can see where the provincial government might say if we could set up an HMO system of some kind we might be able to handle it for less cost.

ABBIS:

All the provinces would have to agree. Because a province can't act alone in Canada because of the money they are getting from the feds. You see you read your newspapers and you read the Canadian newspapers and you never hear anything about hospitals and suits and going to court because they didn't get this or that.

WEEKS:

We do have the advantage of Canadian television through Windsor.

ABBIS:

I read Trustee magazine and there is always an article by a lawyer saying they are suing somebody...they are suing the federal government, they are suing Blue Cross. That doesn't exist under our plan.

WEEKS:

It seems to work pretty well.

ABBIS:

It's working. It's working. As McMahon -- that article that was in Trustee magazine -- he wrote me and said I don't agree with all you said but sometime I'll read it more profoundly when I'll be riding long distance or something. I can appreciate...the American Hospital Association is always joining plaintiffs in each state, each hospital, gives work, does everything.

WEEKS:

Is there anything else you would like to add to our record here?

ABBIS:

No. I think you have asked -- there are a few things you asked me that I will check on.

WEEKS:

Is the address I have in Edmundston your home? I notice you have one in Maine too.

ABBIS:

It's because the mail is faster on the American side coming from the states. When we had a postal strike and Jim Hague wrote my certificate of meritorious service, he mentioned that, "he's a good member because as soon as he knew there was going to be a postal strike in Canada, he rented a box in Maine so he could get our mail."

WEEKS:

So the Maine address is a post box. I noticed on the map the towns are right across the border from each other.

ABBIS:

Yes. We just cross the river and we are there. We buy our milk it's cheaper there. I get the Wall Street Journal. I can get it the same day in Madawaska, Maine. If I were to get the Montreal paper I would get it two days late and it would be old news -- no longer news. I get all my magazines Time and Newsweek before I get the Canadian Time and Newsweek. I am an avid and voracious reader. That's my pastime.

WEEKS:

Thank you for the interview, it has been very interesting.

Interview in Chicago

May 20, 1985

In a letter dated June 18, 1985, Justice Abbis added the following information:

In regard to the comprehensive element of the health plan there can be no exclusion. For hospital care, all necessary inpatient care must be provided, but care in mental institutions and tuberculosis sanitariums was specifically excluded because it was felt that in those cases full protection was provided under individual provincial plans then in existence. Care in nursing homes and custodial care have also been excluded. For medicare [medical care], all medically required services rendered by physicians must be covered.

As for costs of these programs, I believe that the formulae discussed with you are self-explanatory. However, we do have three provinces and one territory that levy a premium. I was able to get the monthly premiums this day from Ottawa. They are as follows:

Ontario	\$29.75 single	\$59.50 family
Alberta	14.00 single	28.00 family
British Columbia	17.00 single	32.00 husband & wife 36.00 husband, wife & children
Yukon	19.00 single	26.59 family

In all other provinces costs are paid from the consolidated fund of the province.

The above-mentioned provinces do reduce the premiums for those over 65, or the indigent.

APPENDIX

Remarks excerpted from a speech

by Justice Chaiker Abbis

to a meeting of the South Shore Regional Council of the
Massachusetts Hospital Association

March 18, 1978

The Canadian system is a significant text book for all persons concerned with national health legislation. However, it would be a mistake to assume that the Canadian program is simply a later edition of the British National Health service, for it is quite different.

The Canadian program is unique because, although federal legislation activated the present nation-wide system of prepaid hospital care, and although the federal and the provincial governments share the costs of operating the program, the federal act leaves administration of the plans at the provincial level and the provincial statutes reserve ownership and control at the local level as heretofore.

The act authorized the federal government to make contributions towards the cost of provincial programs of hospital care under which insured hospital services are made available to all residents of the province "upon uniform terms and conditions." The federal contribution is one-quarter of the per capita cost of hospital care in the province plus one-quarter of the per capita cost of hospital care in Canada as a whole times the population in the province entitled to care. In other words, the federal contribution is roughly one-half, but provinces with a relatively low per capita cost of hospital care get somewhat more than one-half and those with above average per

capita cost of hospital care get less than one-half. Since the economically poorer provinces have, as a rule, a low per capita cost of hospital care, the formula provides, on the whole, a greater measure of aid to these provinces.

The act defines the cost of hospital care in which the federal government will share, as, in general, all net costs excluding depreciation on plant, interest and repayment of debt. The program applies only to general hospitals, not mental or tuberculosis hospitals. To obtain federal aid, a province must agree (1) to provide complete inpatient care in standard ward accommodations, including x-ray and laboratory services, without limit on stay; (2) to have arrangements to ensure that adequate standards are maintained in hospitals, including supervision, licensing and inspection, and (3) to maintain adequate records and accounts.

Aside from these main stipulations, the provinces are free to operate and finance their programs as they wish. They may, if they wish, provide outpatient services: if they do, the federal government will share in the cost on the same basis as for inpatient care. To obtain uniformity in plan development, however, the federal government requires any province which cares to participate to enact legislation similar to the federal bill and to sign an agreement of participation with the federal government.

The federal act can be summarized in terms of three general principles:

1. The Act has been designed to provide a basic standard of inpatient services available to everyone in all participating provinces and allows the provinces to provide outpatient services.
2. The Act has also been designed to permit a variety of provincial arrangements in the administration of programs which will meet the special circumstances of each province.

3. The Act does not in any way "freeze" hospital services, but permits their development to meet the changes and demands upon hospitals.

Although the various provinces have developed their individual plans, they are all within the framework of Bill 320, and therefore, they have certain things in common. For example, they tend to cover the whole population, and they cover this population at standard ward level. Under these governmental hospital insurance plans, each general hospital theoretically receives its full operating costs from the paying agency. This, in general, is based on an approved rate for standard (ward) care. The amount of the differential that can be charged to semi-private and private patients is fixed by the government agency. Almost all of the plans include the submission of a carefully prepared annual budget and these budgets are very carefully scrutinized. This probably means that the hospital will not get everything it asks for and it may lead to more government control over hospitals, particularly as to expansion, new equipment, extension of services and increase in staff.

It was a basic feature of the federal legislation that there should not be a single national scheme in view of the constitutional setup ;and the historic tradition. There should be a series of schemes developed and administered by the provinces and assisted financially and technically by the federal government. Their broad outlines must conform to the general principles laid down by the federal act, but their details are to be geared to local conditions and practices. This is what has happened.

It was only in 1965 that the federal government proposed to the provinces that a comprehensive physicians' service be made available to all Canadians on a universal basis and that the program be publicly administered and coverage

transferable between provinces. In 1965, the Medical Care Act was passed and was implemented on July 1, 1968.

Before any province is eligible for federal cost-sharing, its medical care plan must adhere to four provisions:

1. The plan must provide as a minimum, comprehensive coverage for all medically required services rendered by physicians, without dollar limit or exclusions, provided there is medical need, unless coverage is available under other legislation.

2. Coverage must be available to all eligible residents on uniform terms and conditions and covering no less than 95 per cent of the population.

3. Benefits must be portable when the insured is temporarily absent anywhere in the world and also when he is changing jobs or retiring or moving his place of residence from one participating province to another.

4. The plan must be non-profit and administered by a public agency accountable to the provincial government for its financial transactions.

When all the above four points have been met the federal government contributes "an annual sum equal to half the national per capita cost of insured services multiplied by the average number of insured persons in that province."

In December 1976, the federal and provincial governments reached an agreement that changes the health care field radically. The agreement took effect April 1, 1977. The open ended feature of the shared-cost programs was ended. Contributions from the federal government are no longer directly related to provincial expenditures, but instead will rise with the growth of the economy. In return for provincial commitments to continue to meet certain standards, the federal government surrendered two percentage points of its

personal income tax -- half in cash and half as "tax room." In addition, a special complementary arrangement is devised to provide the provinces with cash payments of \$20 per capita to support initiatives in developing alternative forms of health care delivery -- home, ambulatory and various forms of residential care.

It is misleading to consider these programs merely as programs of hospital and medical care insurance. They are not primarily fiscal programs; they are essentially programs for the provision of health care to the population. These programs are good for the public. They have made hospital and medical care available to all or virtually all the population.

We hear much as to the danger inherent in government health insurance to the autonomy of hospitals. It must be kept in mind that all autonomy is relevant, and even before the advent of national health insurance program, the operation of hospitals in Canada, as elsewhere, was regulated to a degree by legislation. At present, the degree of control being exercised is mainly in the realm of finance and construction. Let it be clearly understood, however, that ownership of the hospital remains as heretofore. Board of trustees are just as responsible, both legally and morally, for the operation of the hospital as previously.

I would not want to leave the impression that hospitals have no financial problems under our present program. In general terms, this may be true. However, it would be fairer to say that the bulk of financing is now assured.

Government health insurance in Canada has not produced Utopia. Yet, the average Canadian trustee, although he may complain about some of the aspects, would not wish to return to the days before the plan's introduction.

Moreover, trustees became duly concerned about the involvement of

government in hospital affairs. It became increasingly apparent that hospital governing boards should be better organized to be able to negotiate from a position of strength. It was realized that an effective planning and delivery of health services for all people would not be achieved by the voluntary "system" and the government "service," if we took an adversary position. The greatest force in negotiations is good will.

In general, we subscribe to the observation of former U.S. Supreme Court Justice Robert Jackson that:

"It is not the function of our government to keep citizens from falling into error; it is the function of citizens to keep the government from falling into error."

In the matter of health and hospitals, Canadians and Americans have a deep concern about the role of government in our lives. It is the rationale of many sincere citizens who contend that the evolutionary processes of the voluntary system have yielded what is reputed to be the highest level of health in the world. They therefore argue that there is no need for government to take us down the road to further socialism by intruding in the affairs of hospitals, trustees, administrators, and physicians through legislation, regulations, and controls.

On the other hand, there are equally earnest exponents of democratic action who insist that the health of every person is in the national interest, essential to the contentment, productivity and security of our people.

One group fears that mounting government control is endangering the voluntary system. The other that successful planning requires both government and private action.

Small wonder that the average person is confused.

Up until a few years ago there was a famous character in baseball named Satch Paige, a great pitcher, who managed to keep on playing professional baseball until an incredible age. He really had a great job for living; he used to give sound advice to the younger players. In his list of recommendations, he included:

"Keep the juices flowing by jangling around gently as you move...

"Go very light on the vices, such as carrying on in society; the social rumble ain't restful...

"Don't look back; something might be gaining on you."

If there are hospital administrators and trustees who appear worried, it could be attributed to the fact that they look back to see if government is gaining on them. And the fact is; it is.

Some of these administrators and trustees welcomed the first infusions of government aid some time ago, but they are now blinking with astonishment and viewing with alarm. The initial misconception and later waking to reality appears to have been forecast by Lewis Carroll in one of his writings not as well known as Alice's Adventure in Wonderland and Through the Looking Glass. He wrote:

"He thought he was a banker's clerk

Descending from a bus;

He looked again and found it was

A hippopotamus.

'If this should stay to dine!' he said,

'There won't be much for us!'"

What we are doing in our hospitals is of passionate concern to patients and their families. The public wants hospitals to be excellent, efficient,

and economical. It is in hospitals that problems of health practice, education, and economics acquire their greatest visibility. What the public wants, the public will get.

I suspect that someone will come up to me after these remarks and say "What you do not understand is, that in the United States the hippopotamus has already come to dinner." Perhaps someone will point ahead to 1980 and declare that the hippopotamus will then not only supply the main course but will consume it as well, and that the voluntary system will be left with the bones.

A person who thinks of government as something to be shut out at all costs is like one who erects what he conceives to be a plate glass barrier against the enemy. He stands before the glass, gesticulating and shouting words which are incoherent to the fellow on the other side, who is also shouting and waving. And suddenly it is realized that the glass is not transparent; it is a mirror.

Those people we see there in the glass are ourselves. The state is we. We, you and I, and the people about us -- we are the state.

Then if we are the state, let us be about our business.

I have sometimes expressed some impatience with the citizen who feels alienated from the purposes of government because he regards "government" as something in which he has no responsible part. The longer I look into and study the hospital world, the more convinced I become of the need of the obligatory symbiosis of the voluntary system and the government, a system which we now have.

The growing interest of government in matters of health have created and will create new problems and new opportunities. It is our belief that government is relying largely on the voluntary system to set the pace and

standards for the future. And since "pluralism is the essence of democracy," the hospital of today must establish a relationship with government. We have therefore a duty to develop collective strength for negotiation with government in order to achieve an effective partnership; with the realization by all parties that a system of governmental health services is not desirable, but a productive partnership of government and the voluntary system is. In short, successful planning to meet the hospital needs of the American public requires selective use of both government action and private initiative.

In Canada, hospitals are not part or parcel of the government of any province. Hospitals do, since the advent of national health insurance, provide services to the residents of these provinces, which services are paid by government agencies. When it undertakes to provide services, it is essentially performing the operations for which it has been created; nevertheless, this does not alter the fundamental nature as an autonomous and voluntary entity.

Our hospitals have accepted and welcomed hospital care insurance plans because of the social philosophy mentioned above and for no other reason.

Our hospitals do realize and do accept the premise that, if government funds are used to pay hospital care, it follows that the government is responsible for seeing that such funds are not abused.

Our hospitals say that they are in partnership with the different government commissions to implement the social philosophy, namely, that every person has an inalienable right to hospital care when needed.

In brief, our hospitals believe in regulations but not in regimentation; in surveillance, but not in controls.

Hospital associations have to impress on their member hospitals the fact

that there is a big job of management to be done at the local level because, in the long run, the degree of control, financial and otherwise, will be proportional to the effectiveness with which the local board administers its own affairs. If local boards do not make the very best attempt to give leadership, then it will follow that government authorities will increasingly assume control. As far as we can discern, provincial departments of health or commissions in Canada not only want local participation, but also recommend it to the fullest extent. No central authority is in as good a position to do the full job as is the local group. However, we can detect a tendency which is too prevalent at the moment,, for both boards and administrators to dump into the lap of government agencies problems which can, and should, be solved at the local level.

Basing its action on a statement developed by a special committee in 1964 and entitled "The Changing Hospital and the American Hospital Association (Appendix A)", the Board voted in May 1965:

"To record the belief of this Board that impending federal legislation, current changes in the scope and potential of hospital service, and other significant social and economic forces all suggest the need to reformulate the program of the American Hospital Association to assure its continuing usefulness in giving sound leadership to hospitals...(and) to appoint a committee that shall, at the earliest possible opportunity, make a report to the Board recommending changes it deems necessary in the program, structure, and financing of the AHA, and the steps necessary to implement these recommendations. In the performance of its duties the committee shall be given all possible staff assistance and is authorized to retain independent counsel and advice."

The Committee entitled the Committee on American Hospital Association Programs, commonly known as the Knowles Committee, submitted its report on February 9, 1967.

In regard to the involvement of hospital trustees, it reported:

A great defect in the Association structure is the inadequate provision for the involvement of hospital trustees. A more active participation by trustees in some of the direct concerns of the hospital field would be most helpful now and in the future in such areas as government relations, capital financing, regional planning, or the use of community resources. It might be well for the Association -- through an ad hoc committee or a newly formed group of trustees -- to reappraise the effectiveness of trustees, and to determine whether or not the unpaid, busy businessman is the person best suited to serve on the hospital governing board, or whether the role of the trustee is adequately fulfilled in the contemporary hospital. A commission of hospital trustees, responsible directly to the American Hospital Association Board of Trustees, is therefore recommended, with voting power on the Board accorded to its chairman. The size of such a commission should be flexible, at the direction of the Board, and in keeping with the task assigned.

The committee recommends that such a commission on trustees, if established, undertake, as a high priority item of business, an analysis of the recruitment, participation, effectiveness, and potential contributions of hospital trustees.

In 1973, the AHA appointed a Committee on Hospital Governing Boards, which for the past five years "has provided a trustee perspective to the Association's policy deliberation." In 1978, the Board of Trustees approved the National Advisory Council of Hospital Governing Boards. The purpose of

the new advisory council is fourfold: (Quote from Trustee magazine, January 1978 issue)

"...to enhance trustee's understanding of their responsibilities while recognizing that the Chief Executive Officer has been, and must remain, primarily responsible for developing an effective board; to heighten trustees' awareness of the major issues confronting the nation's hospitals; to encourage and assist governing boards in their contacts with federal, state, and local officials and with the news media; and to provide trustees with a mechanism to enable them to meet with their peers at the state, regional, and national levels."

National health care issues are being debated in your country. You should prepare for your role in the coming debate. May I be permitted to intrude into your debate with personal observations. For your hospitals to remain viable and to effectively play their essential role, reorientation and reorganization will be required. More than anything else adequate financing will be required.

Too often we argue about definitions when we should be arguing about facts. The facts are: on the one hand, we hear that mounting governmental control is endangering the voluntary system. On the other hand, we are told that successful planning requires both government and private action.

The first school of thought states that hospitals must surrender their insistence on autonomy and coordinate their services to meet community needs, otherwise government controls will increase and maximum performance will decrease. This subject is generating considerable concern and often heated discussion by trustees, medical staffs, and, particularly, administrators. And yet are we not the very ones responsible for this turn of events. Some,

whose hospital careers embrace most of the last two decades have accepted the increase of government controls of hospitals as an unexplained phenomenon. Perhaps our intimate involvement in patient care has prevented us from reorganizing the remarkable alterations in public thinking regarding the role of hospitals. Perhaps it is our abdication of the responsibility to establish voluntary controls that would meet the demands of and reassure today's hospital -- conscious public that has, most openly, invited government intervention. Today's hospital costs are borne by the public through taxes. The truculent and stubborn conservatism still evident in some hospitals is certainly accentuated by the traditional autonomous climate that we have enjoyed for so many years. Many medical changes have occurred, but the attitudes of those who have governed and administered have vigorously and, perhaps blindly, guarded this autonomy. The volunteer hospital is no longer "an island unto itself." Our responsibility can no longer be confined only to "our hospital," but we must reach out into the surrounding community. Voluntary regulations must be effectively established because we cannot prevent further government controls if we cannot convince the public that the voluntary way is the best way.

The second school of thought, in rebuttal to the statement "that mounting government control is endangering the voluntary hospital system," states that government has a place in our general hospital system. This school states that successful planning requires selective use of both government action and private initiative. Among the fields in which government can play an effective role, in collaboration with private boards, are determination of hospital cost; licensing to reinforce the accreditation system, and regulation of the supply of hospital beds.

It is peculiar that the Marxist assertion that private initiative under free enterprise will inevitably break down is frequently used by persons who are otherwise fairly conservative in their social and economic viewpoints. For myself, I reject it completely.

Almost always, exhortations against enlargement of government controls always lead to loss of personal freedom. People forget that "...law for the sake of (and not against) freedom..." most often characterize democratic legislation. Law most often reinforces human freedom.

Actions of governments since the implementation of the hospital prepayment plan and Medicare raised troubling questions. Does free enterprise have much of a future? If so, what should be done to preserve and strengthen the system? If not, what will replace it?

Actually the system has never been as free as its folklore suggests. Business and government have often been partners in a common-law marriage. What is happening now is largely an intensification of a long process of government involvement.

Many early Americans built their fortunes by prying favors and subsidies out of the government, including publicly financed roads tailored to their needs, direct land grants and protective tariffs. The first steps toward government regulation of industry were prompted not primarily by bureaucrats but by businessmen themselves. They persuaded the government to referee ruinous competitions, stabilize markets and guarantee a steady line of credit by creating agencies to that effect.

The government's influence on the private economy will become even greater in the future. But the nation is not creeping toward a corporate state or outright socialism. Still, the government will increasingly exert

its great power and involve itself more and more as a goal setter and rules maker.

I do subscribe to the premise that free enterprise should be valued, preserved and strengthened. It is not fundamentally endangered by government attempts to set rules and goals to solve social problems. The real threat comes from quite other sources among which are the apathy of boards of trustees, and the abdications of the powers and trusts granted them by their respective communities.

The modern view is that a board of trustees should reflect the community to the hospital and the hospital to the community. Hospitals are not all powerful, but they do have a tremendous effect on society, and social considerations must always enter into hospital decisions. If that is so, then we should be looking forward to still further diversification and activism of the board of trustees.

It is not easy to sympathize with the hospitals' demand for unbridled autonomy without public accountability. We cannot expect governmental subsidies without governmental controls on expenditures and expansion of facilities. We cannot pursue independent paths oblivious to public needs or costly and unnecessary duplication of services.

But even if hospitals themselves come to recognize these obligations, at which point governments will stop short of turning hospitals into institutions subject to political controls and governmental whims? Politics and good health care do not mix well. However, neither side appear to have faced squarely the complex issues involved and proposed an acceptable solution. Let us be on our guard that the balance between government and hospitals be not subtly shifted in favor of the politicians and bureaucrats in governments.

The threat of an all-prevading government is dangerous only if we fail to use both private and public programs selectively and rationally.

The question presents a real challenge to every hospital trustee, administrator, and all others involved in the voluntary hospital system. We must put aside our stubborn allegiance to the absolute autonomy of our individual hospitals. We must keep the public well informed of what we, as voluntary hospitals, are doing to maintain high standards of care, and greater community service. Let us admit that our image with the public is quasi non-existent. We have failed to reach the public.

Trustees must seek to establish an honest and free communication, flowing both ways, from the hospital to the community and from the community to the hospital. After all, community relations has long been recognized as an important hospital function. I am convinced that if the health community will recognize the challenge that grows with the crucial influence it wields, we will not only insure a better future for our voluntary system, but also provide a renewed sense of meaning, purpose, and fulfillment for board members. Trustees should react against what they perceive to be the negative aspects in this emerging partnership between governments and voluntary hospitals. I am also firmly convinced that the future of our voluntary hospitals is going to be determined more by the day-to-day decisions of an alert trusteeship than by any other single influence.

Let me summarize by stating that health is too important to be left to the academic. May I add also that health is too important to be left to the government and its bureaucrats. Both governments and academics must share responsibility for better health care in a system where government plays a role of coordinating self-governing institutions -- a policy no one would

quibble with.

We are surely strong and diverse enough to accommodate the best features of both systems.

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