CHAPTER X

PUBLIC HEALTH AND HOSPITAL SERVICES

I. The Need for Better Planning and Controls in the Hospital Care Programme

1. A brief history of public health services and of the public hospital care programme is sketched in Chapter 5 above. Since the start of 1961, standard ward hospital care has been available to all residents of the province free of any "fee for service" charge. The total operating costs of this service are met by the provincial government from general tax revenues and federal government grants. The patient is billed only for charges made for services which are not included in standard ward care. The main components of these charges are the per diem amounts for private and semi-private rooms. These "differential" charges are set by the different hospitals, subject to approval by the Hospital Services Division of the provincial Department of Health. The charges vary from hospital to hospital. In effect, the Department is responsible for all differential charges. The hospital is allowed to retain 25 per cent of the revenue from these differentials for use as it sees fit. The other 75 per cent is deducted from expenditures when the hospital's budget is calculated for operating expenses — the annual amounts which the Hospital Services Division approves for payment to the hospitals.

2. The initiative for the building of a new municipal hospital or an addition to an existing one usually rests with the locality. The decision for construction is made by the municipal council, only occasionally after approval by a vote of the ratepayers. A request for approval is submitted to the Hospital Services Division for its analysis of the need for the new structure and of the costs to the municipality and to the provincial government. Approval by the federal Department of Health must be obtained in order to qualify for the federal grant of $2,000 per bed, and no new hospital may come into operation in the province without the prior approval of the provincial Minister of Health. The initiative for the construction of a private hospital rests with various parties. Strangely enough, it is the information of the Commission that no overall plan for hospital development and locations is followed.

3. All new, approved hospital facilities receive a total grant of $4,000 per bed — $2,000 each from the federal and provincial governments and are provided with equipment, including beds, by the provincial Department of Health, according to the Department's schedules of standard equipment. The cost of equipment not included in the Department's schedules and the extra cost of equipment more expensive than that provided by the Department, falls upon the hospital board. The total cost of construction of new hospitals now ranges from $13,000 to $22,000 per bed, depending upon the type of hospital.

4. In 1961 the province instituted grants to assist with past indebtedness for hospitals in existence or under construction as at June 30, 1959. These grants are described in Chapter 5. The formula used to calculate them is a strange one with the result that the grants amount to as much as two-thirds of 2½ per cent of the net debt outstanding at that date, plus as much as two-thirds of the interest paid on the same amount. There is no provision for any provincial contribution to the debt servicing charges in respect of hospital facilities not already built or under construction as at June 30, 1959.

5. The heavy capital costs might appear to constitute a deterrent to the construction of new hospitals by municipalities. However, at the cost of the annual charges on the debt incurred for its share of the capital costs, a municipality can, provided it obtains approval, elect to have hospital services provided to its residents at the location and on the scale of its choosing. This debt service cost is small in relation to the total cost of operating the hospital. It is apparent, therefore, that the monetary deterrent to localities deciding in favour of new hospitals is not very substantial. Political pressures may be the only explanation of many of the decisions taken concerning hospital locations, types of facilities and adequacy of facilities.

6. The brief which the Department of Health presented to the Royal Commission on Health Services in 1962 estimated that by the end of 1965 the capacity of active treatment general hospitals will be adequate for the needs of the province. At a 90 per cent occupancy rate, the anticipated capacity would provide a ratio of 5.7 beds per 1,000 of population and would be capable of providing 1,870 hospital days of care per 1,000 of population. This may well be true, but it may also be misleading. Information coming to the Commission is that the number of hospital beds is inadequate in some areas and the standard of building is extravagant in others. It appears that the tendency in some localities to build unnecessarily ornate hospitals is following the extravagant pattern developed by school boards.

7. It was asserted to the Commission on several occasions that the statutory powers of control which the Department of Health has over the operating expenditures of the general hospitals and over the proposals submitted for new hospitals are exercised with insufficient stringency. This general assertion, and the more specific complaints mentioned below, are not susceptible to proof by documentation. Nevertheless, from our own observations, the frequency and assurance with which the assertions are made, and the absence of arguments presented to the contrary, we are convinced that certain changes in the administration of the hospital care programme would be in the public interest.

8. Evidence that we are not alone in holding this view is to be found even in the official statements of the provincial government:

> However, our costs in this particular field have been rising at a rate in excess of the national average. This represents something more than just the normal public reaction to a government programme, since most of the other provinces in Canada have already introduced similar types of operation. But in fact, it is now becoming increasingly more obvious that certain elements of abuse have been, and are, creeping into the plan. There have been instances where this abuse has emanated from all those groups or individuals for whom the plan is designed to provide benefits: the medical profession, the hospitals themselves, and the public at large. This is alarming and one main principle should be borne in mind — that is, the hospital care plan is being financed with public funds from the general revenues of the province. Therefore, abuses which have the affect of overly inflating operating costs are actually being borne by all the taxpayers of the province. I might emphasize that this relationship between rising costs and rising levels of taxation is not a new one. (1962 Budget Address)

9. A specific allegation made of deficiencies under the present administration is the statement that there exists no overall plan for the location of new hospitals, based on population trends, present occupancy rates, and a division of functions among hospitals of different types. At the outset of the hospital care plan, the intention was that facilities would be so located that the large urban hospitals equipped for the most intricate surgery would be supplemented by a network of small and cottage hospitals so that all residents would be within a safe distance of a hospital by automobile; the occupancy rates of all wards would be at about the same high level, and the ratio of accommodation of general purpose wards to population would be about the same in all regions of the province, This intention, it is said, "has been warped by political pressure, local pride and the lack of direction by the appropriate departments of government." In fact, it is said, there is no plan in effective existence to control the location of new hospital facilities and some areas are more adequately provided for than are others. The higher-than-average capacities cannot always be detected by a simple examination of occupancy rates since low rates in most wards of a hospital might be offset by a very high occupancy rate in the maternity ward. Table 10: 1 shows the number of beds per 1,000 of population in the various 1963 hospital regions. The calculations used 1961 populations and the 1963 distribution of beds. The range is from a low of 4.0 to a high of 9.8 beds per 1,000 persons. The same table shows similar calculations based on the original hospital regions. In this case, the ratio of beds per 1,000 persons ranges from 5.2 to 6.9. In examining the table, it should be remembered that a region is a fairly large area and that if each were cut up into sub-regions such that every resident could be shown to be within a safe distance of a hospital, the range of ratios would doubtless be wider. Some variation in beds per 1,000 of population would, of course, be in keeping with the intention, mentioned above, that the largest and most specialized hospitals should serve the entire province. However, not all of the variations shown in the table can be explained by this consideration.

10. Our Commission is puzzled by such occurrences as the announced discontinuance of the 100-bed Hotel Dieu de l'Assomption in Moncton as an active treatment hospital, accompanied by the announced plans for a new active treatment hospital of 300 beds.

11. Since hospital operating costs are now paid from public funds, effective government control over hospital budgets is clearly an indispensable requirement for protection of the public interest. At present, annual budgets are prepared by the administrators and boards of the various hospitals and submitted to the review committee of the Hospital Services Division of the Department of Health. These budgets, as approved by the review committee, become the basis on which periodic payments are made to the hospitals through the year. In short, operating expenses are paid from federal and provincial government funds, but the actual expenditures are determined and incurred by the various hospital boards and administrative officers. It is readily apparent that, unless stringent budgetary restraint is imposed by the review committee of the Hospital Services Division and by the Treasury Board, the utilization of hospitals by the public and by the medical profession, and the quality and cost of hospital care, will increase more rapidly and beyond the

levels intended by govern.ment policy — and they have done so. In theory, the budget review procedure iust described leaves little to be desired.- The actual practice is another matter. We were informed that, typically, hospital budgets are not even approved until mid-year — or six months after expenditures were begun and far too late for effective control to be imposed. The estimates of hospital expenditures included in the annual budgets of the province are, therefore, no more than rough preliminary figures. On adoption of the hospital care plan, operating costs rose sharply — in some cases tripling. Admittedly, some of the increased expenditure rectified past 'neglect. But we have been informed that a goodly proportion of the rise is attributable to defective administration and inadequate controls.

12. The source of these shortcomings, whatever their degree, is not to be found in the controlling legislation. Provision is made for the full scrutiny of hospital budgets by the review committee of the Department of Health; capital grants may not be made for new buildings unless their construction has been approved; and no institution may operate as a hospital without the prior approval of the Minister of Health. Two explanations have been advanced concerning the "warping" of the efficiency of the hospital programme. One is that the authorizations vested in department officials are over-ridden. The other explanation offered is that inadequate information is marshalled to guide the decisions of the provincial government; consequently decisions are made on the basis of incomplete and therefore misleading information. It is our view that, whatever reasons are offered to explain the failure of the provincial government to realize the stringency of economy appropriate to a province with resources as limited as those of New Brunswick, the root of the matter lies in what is on all sides conceded to be the most pressing problem facing governments of this province today, namely: that sound programmes, probity and efficiency should be insulated from the narrow local interests and other political pressures which work to undermine decisive government leadership.

Table IO: 1

PUBLIC HOSPITAL BEDS PER 1,000 OF POPULATION, NEW BRUNSWICK, 1963

A. ***According to present eight hospital regions***

Counties	Population	Rated Bed Capacity	Beds per 1,000 of Population
York	**52,672**	**350**	
Sunbury	22,796	**25**	
½ Queens	**5,820**		
Total	**81,288**	**375**	**4.6**
Charlotte	**23.285**	**152**	**6.5**
Saint John	89.25 1	791	
Kings	25,908	**54**	
½ Queens	**5,820**		
Total	120,979	**845**	**7.0**
Kent	**26,667**	11	
Westmorland	93,679	692	
Albert	**12,485**	**13**	
Total	132,831	**716**	**5.4**
Victoria	19,712	**114**	
Madawaska	38,983	**206**	
Total	58,695	**320**	**5.5**
Carleton	**23,507**	94	**4:o**
Restigouche	40,9 73	**403**	9.8
Gloucester	**66,343**	**325**	
Northumberland	**50,035**	229	
Total	**116,378**	**554**	**4.8**
TOTAL	597,936	3,459	**5.8**

Table IO: 1

PUBLIC HOSPITAL BEDS PER 1,000 OF POPULATION, NEW BRUNSWICK, 1963 (concluded)

B. ***According to original five hospital regions***

Counties	Population	Rated Bed Capacity	Beds per 1.000 of Population
Restigouche	40,973	403	
Gloucester	66,343	325	
Total	107,316	728	6.8
Westmorland	93,679	692	
Kent	26,667	11	
Northumberland	50,035	229	
Albert	12,485	13	
Total	182,866	945	5.2
Saint John	89.25 1	791	
Kings	25,908	54	
Charlotte	23,285	152	
½ Queens	5,820		
Total	144,264	997	6.9
York	52,672	350	
Sunbury	22,796	25	
½ Queens	5,820		
Carleton	23.507	94	
½ Victoria	9,856	57	
Total	114,651	526	4.6
Madawaska	38,983	206	
½ Victoria	9,856	57	
Total	48,839	263	5.4
TOTAL	597,936	3,459	5.8

Source: Ratios were calculated using populations reported in the 1961 census and rated bed capacity of public hospitals at June 30, 1963, as reported by the Department of Health.

13. It has also been asserted that there is inadequate forward planning and insufficient investigation of methods by which a given level and standard of care should be provided at lower cost — by greater use of convalescent homes, for example. An examination of the Department of Health's submission to the Royal Commission on Health Services lends some support to this contention.

14. Concerning the rapid rise in the operating expenses of hospitals, we were told that much could be done to tighten up the budgetary review procedures and strengthen the hand of the Department of Health and the Treasury Board in their endeavour to impose economy upon hospital boards. The medical profession, it was said, exerts adequate pressure for the adoption of up-to-date equipment and methods of treatment. What is required is an opposing pressure to ensure that; adequate treatment is provided efficiently and at the lowest attainable cost consistent with sound medical practices.

15. As a further explanation of the problem of rising costs facing the hospital care programmes of all provinces, several "off -the-record" commentaries were offered concerning the extravagant use of hospital facilities by some members of the public and by some members of the medical profession. As in other provinces, it is said that some doctors will treat a patient in hospital, often at the patient's suggestion, in order to relieve the) patient of an expense he would otherwise have to incur. Similarly, some doctors put patients in hospital for their own convenience, even though diagnosis and treatment could be conducted in the doctor's office. Indeed, it is reported that a few doctors have even discontinued office hours. It is also said that the medical profession shares with

the other professions a deep reluctance to change work routines in order to reduce the costs of their services to the public. In particular, some doctors complain that hospitals close their operating rooms and laboratories on week-ends, except for emergency cases, to the detriment of the care of patients. Some hospital administrators complain that they have not been able to make the maximum use of operating rooms because of the ingrained habit of doctors to do hospital work in the morning and keep office hours in the afternoon. It is reported that it is difficult or impossible to attract a doctor to practice in a rural area unless there is a hospital in the district, even though adequate hospital facilities are available close at hand in terms of automobile travelling time.

16. Finally, it is apparent from the resume of hospital services given in Chapter 5 that there is no rationale nor equity in the present programme of grants toward past hospital capital debt. The incidence of the aid among different municipalities and therefore among different groups of residents of the province, is quite capricious. The province has accepted that as a matter of public policy, adequate hospital facilities should be made available to all residents. Consequently, the capital costs of all public hospitals, regardless of when they were constructed, should be equitably shared by all residents of the province. This can be achieved by making them a charge against general provincial revenues or by covering their cost by a province-wide tax. We recommend the former.

II. Various Possible Approaches Toward Achieving More Effective Controls

17. There are only two broad types of control over the cost of services rendered without charge to the public. Either a powerful central authority, like the Treasury Board of the federal government, has jurisdiction over the spending units and scrutinizes all proposed expenditures before authority is granted for any payments, or financial responsibility is placed upon the administrators of the spending unit. The latter system is most effective when the spending unit has to raise all of the funds required to cover any expenditures beyond those approved. A mixture of these two systems rarely works well, and the present system in New Brunswick is a mixture.

18. It is a fair statement that no province in Canada has devised a fully satisfactory system of accountability for the costs of hospital care. On the one hand, provincial governments vote the funds which they consider adequate for the purpose, given a reasonable level of economy and efficiency by the hospitals. On the other hand, apart from some instances of avoidable extravagance, hospitals are caught by inevitably rising wage costs and by the adoption of newer, more effective and more costly methods of treatment. But the absence of any ideal solution is no reason for failing to press for the greatest attainable economies — keeping in mind that on occasion the failure to make an expenditure may be a false economy.

19. Some observers in New Brunswick are of the view that there should be greater incentive for hospitals to become more economical and more efficient in their operations. To this end merit and performance budgeting are proposed. Alternatively, it is suggested that hospitals be provided with an independent source of funds, to be used as they see fit, sufficient to afford them the measure of financial freedom of action necessary for their individual initiative to be exercised. There is merit in the latter suggestion. Administrators must possess some independent authority and freedom of action if they are to improve performance and adopt new equipment and new methods. Beyond this, however, it is difficult to see how effective incentives could be provided to any non-profit administrative unit. The goad to efficiency and economy in non-profit enterprises arises mainly from the devotion to duty and the energies of individual administrators, especially among those who are members of religious communities, although it does not follow that such characteristics make it unnecessary to offer competitive salaries and adequate opportunities for advancement to recruit and retain an adequate supply of able hospital administrators.

20. It has been proposed that hospital boards be elected by the municipalities and that the boards be made responsible for their own budgets by requiring that all expenditures beyond predetermined standard amounts for standard services be a charge against the real property of the municipality, or against the hospital's patients. However, the technique of making a special charge when the costs of standard services are above a certain level is effective as an over-all control only if there is also resistance to rising costs for the non-standard services. In addition, there is a financial consideration weighing against charging non-approved expenditures to patients, since grants received from the federal government would be reduced proportionately. The formula for calculating the federal grants for general hospital services is: (25 per cent of national average cost of standard ward hospital care per capita plus 25 per cent of the province's actual costs of ward care per capita) times the number of persons in the province covered by the public hospital programme, minus total revenue from authorized charges payable by the patient for standard ward care. Moreover, charges which impeded access to adequate hospital care by the poor would defeat a central purpose of the public hospital programme. Accordingly, the ***per diem*** charges

which are now made in Alberta and British Columbia are authorized by reasons other than as a spur to economy on the part of the hospitals;. they are intended rather to give the patient a sense of financial participation in the programme.

21. In any event, hospital patients are not in a position to become a focus of resistance to rising costs. Neither is it likely that the council of a municipality or the ratepayers could or would exert effective pressure upon hospital boards to be economical. The reason is that neither the councils nor the ratepayers are in a position to decide whether hospitals are operating with stringency and economy and whether a refusal to authorize an expenditure would be a false economy. In any event, the residents of the province who are served by particular hospitals must not be localized since the largest and most specialized hospitals should serve the entire province. It is for this reason that we are gratified that the recent efforts of some parties to have the hospitals of Saint John County restricted to residents of the county were not successful.

22. The point is that expenditures are either warranted or not warranted, and considerable detailed information is required for a qualified person to judge which is the case in any given situation. Similarly it is virtually impossible to measure hospitals' performance and extremely difficult to judge it, even when the required information is available. For these reasons, we consider that a continuation of the existing centralized approach to the control of hospital expenditures is expedient, subject to the recommendations which follow.

23. The particular objective of our recommendations is to establish the administrative structure which, in the circumstances of New Brunswick in the 1960's, offers the greatest promise of shielding sound government policy relating to hospital care from warping by "local interests, political pressure and the lack of decisive direction" by existing government agencies. As we have already stated, this problem is acknowledged by all sides to be the greatest impediment to increased government efficiency and improved performance. To this end, we recommend that the powers now conferred upon the Minister under the Public Hospitals and Hospital Services Act and exercised through the Hospital Services Division of the Department of Health be transferred to an independent Hospital Commission. This change would not entail an administrative upheaval, such as was occasioned by the change from the premium to the present system. In fact the administrative dislocations would be minimal. The adoption of the recommendation would, however, enable the budgetary review of hospitals to be greatly tightened and would facilitate the imposition of direction upon the continued development of hospital facilities.

24. It is suggested that a hospitals review procedure should be investigated by the Commission as one of the controls to be instituted to prevent abuse of the hospital programme. These procedures are followed in British Columbia and elsewhere and are strongly recommended by the officials of the hospital programmes there. The system would work in the following manner. A report on every admission to hospital is completed by the patient's doctor and mailed to the Commission on the day of admission. The report is examined at once by a medical council consisting of a doctor and staff of nurses. An appropriate deduction from the year's payments to the hospital is made for any admission not approved by the medical council. The hospital must then seek to obtain the charges from the patient. Frequently a form signed by the doctor authorizing an admission is returned to him for more information or explanation than he has provided. For example, diagnosis is supposed to be made, if possible, in the doctor's office and the admission form may not have explained why diagnosis in hospital is necessary. If the doctor insists upon the correctness of the admission, his signed statement is normally accepted. We are told that this review procedure, which is carried out with care and tenacity — it is not a mere formality — has reduced unnecessary admissions; a doctor does not wish to perjure himself. The procedure also lends support to the doctor in his dealings with patients. He can truthfully say that the medical council will not approve unwarranted expenditures for hospital care. This affords a measure of protection to the doctor dealing with public funds.

25. It is also suggested that the Hospitals Commission appoint a medical director for each hospital, who will be responsible for administration, including the supervision of admissions, releases and lengths of stay. The medical director should be an employee of the commission.

III. Recommendations for the Hospital Care Programme

26. Our recommendations for the hospital care programme are as follows:

(1) The operations now administered by the Hospital Services Division should be transferred from the Department of Health to a Hospitals Commission. The Commission should be completely independent of political pressure in developing its administrative policy but, nevertheless, accountable to the provincial government for the discharge of its responsibilities. The hospital services budget for the year should be presented by

the Commission to the Treasury Board. Accountability should be achieved by the completeness, accuracy and relevance of the Commission's report covering the past and forthcoming year. While policy must always be the prerogative of the government, the Commission should possess complete authority for implementing that policy in the manner determined by it to be the most advantageous.

(2) The Hospitals Commission should consist of:

(a) the Minister of Health, ***ex-officio,*** and (b) six members to be appointed by the Lieutenant-Governor in Council on the recommendation of the Minister of Health, as follows:

(i) four members to be nominated by a group of citizens without interest in political and hospital affairs or in the irrelevant aspirations of local communities. For example, such a group would be 'the members of the supreme court. By law, the supreme court justices can have no interest in business, cannot serve themselves and cannot even vote in elections in which hospital care is an issue.

(ii) two members selected by the Minister of Health.

The Chairman and deputy chairman should be designated by the Commission.

(3) No member of the Hospitals Commission may have any direct or indirect personal, professional or financial interest in the hospital care programme. Doctors, dentists, nurses, hospital administrators or former members of these professions are not to be members of the Commission, which will receive its medical and other professional advice from an advisory board to be constituted as provided for in Recommendation 6. Members of the Commission should be appointed in future for three-year terms and be eligible for reappointment. However, the first appointments are to be staggered as follows to allow for continuity of Commission policy:

(a) for one year: one member nominated by the group of disinterested citizens and one by the Minister of Health,
(b) for two years: same as (a), and
(c) for three years: two members nominated by the group of disinterested citizens.

If a vacancy occurs through death or resignation, the party responsible for the position vacated shall nominate a replacement to serve the balance of the unexpired term.

(4) The Commission shall meet within the province at the call of the chairman, at his own discretion or at the request of two or more members, provided that there shall be at least one meeting each month. The Commission shall establish its own rules of procedure. Apart from the Minister who will receive his regular salary and allowances, members shall receive such remuneration as may from time to time be determined necessary by the Lieutenant-Governor in Council to attract the services of fully qualified members.

(5) The Commission shall appoint a permanent secretary to carry out duties assigned to him by the Commission and a chief executive officer, known as the chief hospital superintendent, to be responsible for the day-to-day adrninistration of Commission business in accordance with the Commission's programme. Both these officers should be experienced in hospital administration, but it is not necessary for them to have medical training.

(6) The Commission shall have the services of an advisory committee appointed by the Minister of Health for such terms as are deemed desirable by the Cornmission as follows:

(a) two nominees of the New Brunswick Medical Society,
(b) two nominees of the New Brunswick Hospitals Association,
(c) two nominees of the New Brunswick Association of Registered Nurses,
(d) one nominee of the New Brunswick Dental Society and
(e) such other members as shall be deemed necessary by the Commission.

(7) The powers of the Commission shall be:

(a) To provide, maintain, supervise, control, administer and make regulations for the public hospital care programme of the province, including general hospitals, mental hospitals, sanitoriums, nursing homes, facilities for convalescent and chronic care, outpatient services, hospital staff residences and the transportation of hospital patients as required.

(b) To assume ownership and management of all municipal and quasi-municipal hospitals, staff residences and

associated facilities and to accept complete financial responsibility for the balance of the capital debts associated with such facilities as full payment for the facilities taken over. All grants now paid by the province and municipalities in respect of capital debt incurred prior to 1959 and $11 matching of private donations to hospitals should be discontinued and the Commission and municipalities should be prohibited from extending financial assistance of this nature.

We are aware that the municipal and quasi-municipal hospitals which are to be placed under the Hospitals Commission now have at their disposal certain trust funds established by bequests. In the final analysis these funds were created for the benefit of persons making use of the hospitals concerned. As the future responsibility for the adequacy of these hospitals, and indeed for all aspects of the province's hospital care programme, is to rest with the Hospitals Commission, it is only logical and in keeping with the apparent intent of the donors that the benefits from these trusts should also pass to the Commission for its general use. We do not envisage that there would be legal difficulties in making such a transfer, as there is ample precedent for adjustments of this kind when the particular circumstances contemplated by a bequest no longer exist. If need be, the transfer can always be accomplished by legislation. In making this recommendation, however, we wish to make clear that trust funds which were established for the general benefit of a religious community should remain with the community even though they have been applied to the operations of a hospital which is purchased by the Hospitals Commission. In other words, we can see no reason why the Commission should benefit from a bequest which was established for the religious organization as a whole and not For a particular hospital.

(c) To purchase, with the agreement of the proprietor, any existing privately-owned hospital facilities at a price mutually agreed upon as reasonable compensation for the proprietor's investment in the hospital; or if any proprietor wishes to retain ownership of hospital facilities for management and operation as a public hospital under the supervision of *the Commission, to rent such privately-owned hospital at an agreed rental which may be an amount to cover the carrying charges and amortization of the outstanding capital debt of the proprietor with respect to the hospital concerned, or any other amount which the Commission determines to be equitable.

(d) To prohibit the building of any hospital other than those *initiated* by the-Commission as part of the orderly implementation of their long-term hospital construction programme.

(e) To be responsible for the construction of new public hospitals, staff residences and associated facilities, and to enter additional rental agreements, as required to provide adequate public hospital facilities in the province.

(f) To assume complete responsibility for the administration, operating revenues and onerating costs of all hospitals operated under the Commission.

(g) To appoint and employ such numbers and classes of employees and at such rates as may be approved by the Lieutenant-Governor in Council, provided that only those classes of employees designated by the Commission shall become subject to the terms of civil service legislation.

(h) To pay for such numbers and classes of employees and at such rates as may be approved by the Lieutenant-Governor in Council for the services of employees of rented privately-owned hospitals, provided that such personnel shall not become subject to the terms of the civil service act.

(i) To recommend from time to time changes in the extent of the public hospital care programme for approval by the Lieutenant-Governor in Council;

(j) To prepare for submission to Treasury Board annual operating and capital budgets covering all Commission activities ;

(k) To levy such charges for above-standard hospital care as the Commission may decide;

(1) To establish and maintain as required a programme for the training of hospital staff, including nurses and technicians; and

(m) Generally to provide for any exigencies that may arise from operation of the hospital care programme.

IV. ***Mental Hospital and Clinic Services***

27. The Department of Health now operates two mental hospitals and four community mental clinics. About four per cent of the cost of operating these mental health services is recovered from the municipalities through their contribution on behalf of their indigent patients. (The municipality of residence pays $2.00 per week for each indigent patient in the province's mental hospitals. The average operating cost per patient day of the two hospitals in 1960 was $4.70.)

28. There is a great imbalance between the sometimes lavish expenditures on active treatment hospitals and the care provided by them and the niggardly provision which is still made for mental hospital care. We recommend therefore that the Hospitals Commission be expressly charged with the responsibility for reforming and maintaining at satisfactory standards the operations of mental treatment hospitals and mental treatment services in general. All contributions by the municipalities should be terminated.

V. ***Public Health Services***

29. The responsibility for public health services is shared by the province and the municipalities. There is a sub-district board of health for each county. The chairman of each board is the district medical health officer, a full-time **employee** of the Department of Health. For the Department's own purposes, the province is divided into six health districts, each of which has a medical health officer who is charged with responsibility for the Department's programme of disease prevention in his district. These are the medical officers who act as chairman of the sub-district boards of health for the counties within their respective districts. In general a county board is responsible for the public sanitation inspection services of the county; in one case (Saint John) the board also provides a public health nursing service and children's dental clinic service.

30. In 1960, the costs of public health services were distributed as follows:

	$'000
Municipalities	$ 167
Grants to municipalities by the Department of Health from National Health Grants	60
Other public health expenditures by the Department of Health:	
District medical health offices	100
Public health nursing	299
Dental health services	36
Total	$ 662

31. The Submission to the Royal Commission on Health Services of the Department of Health stated:

> . . . There should be an increase in home care services for the sick, especially in the non-urban areas. Such programs might be supplied by increasing V.O.N. services to the rural areas or adding this type of service to that already carried by our public health nurses. Many more clinics and out-patient hospital services are needed. ***It would appear to be more economical to run services on a Health Unit rather than on a County basis.*** Geographical boundaries make for greater travelling and more wear and tear on staff, . . . (Italics added)

32. Sanitation services are provided by nineteen full-time sanitary inspectors and one veterinarian employed by the municipal boards of health and three sanitary engineers employed by the Department of Health. The Department makes grants toward meeting one-half of the salary and travel expenses of the veterinarian and most of the sanitary inspectors employed by the municipalities. The Submission of the Department of Health to the Royal Commission on Health Services suggests:

> In order to accomplish more with the sanitarians we now have, flexibility as to their work areas would be desirable. The work allowance from county to county is very much out of proportion. There is also a considerable variation in salary and working conditions. ***In order to alleviate the conditions as outlined something should be done by the Department of Health to strengthen the sanitation service. We should also consider our investment in time and money expended.*** Since it may be many years before we initiate a system of health units in this province, sanitarians might be employed to form a section of the Sanitary Engineering Division and be given Civil Service Status. They could then be trained according to their abilities and placed in the districts requiring their individual knowledge. They should be placed under the day to day supervision of the District Medical Health Officer. The Sanitary Engineering Division would give general field supervision. If the Department were to take over full financial responsibility for environmental sanitation, it would entail an estimated expenditure in 1963 of $147,000.00. At the present time the Department is providing assistance to the extent of $67,000.00 which would increase to $70,000.00 by 1963. Then the additional net expendi-

ture required would be $77,000.00 from provincial funds.

33. We are perplexed by the italicized portion of the quotation. It would appear that the Department's officials should be relieved of some of their responsibilities so that they may attend more adequately to prevention and other public health programmes.

VI. *Recommendations for Public Health Services*

34. Our recommendations for public health services are as follows :

(1) The few public health services rendered jointly by the municipalities and the Department of Health should be taken over entirely by the Department and provided through its six regional health districts. It is clear that, with few exceptions, the municipalities show little initiative with respect to sanitary inspections and that their personnel possess minimal qualifications. In its brief to the Royal Commission on Health Services, the Department suggested that public health services could be more effectively provided by its health districts. Moreover, absorption by the Department of Health Services of the services now provided by the counties is a necessary condition of the implementation of our major recommendations which would have the incidental effect that the counties would be dissolved as administrative units.

(2) The public health programmes of the Department of Health should be confined to preventive and detection measures. Public treatment should not be taken on except by an adequate programme, which is quite beyond the present capacity of the Department. It is implied by the quotation from the Brief of the Department to the Royal Commission on Health Services contained in Paragraph 31 above that the Department plans an extension of its public health services into the fields of treatment as distinguished from detection and prevention. Such a development would be alarming in view of the treatment and diagnostic staff which could possibly be developed. Incorrect diagnosis is a grave danger not to be minimized when giving consideration to the extension of already inadequate public care service.

(3) The public nursing services and the dental health clinics for children now operated by municipalities, notably Saint John, Lancaster and Moncton, should continue to be operated by the cities and towns, which should be free to supplement the province's public health programme with services of this kind. In multi-municipality communities such as the Saint John area, the metropolitan councils (described in Chapter 12) should be empowered to adrninister these services at the discretion of their constituent communities.

(4) The professional medical care of indigents is still legally the responsibility of the municipalities. In keeping with our recommendations concerning social welfare in Chapter ***9,*** the medical care of indigents, along with all other assistance rendered to them, should be the exclusive responsibility of the Social Welfare Commission.