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DOMINION - PROVINCIAL CONFERENCE

on

HOSPITAL STATISTICS

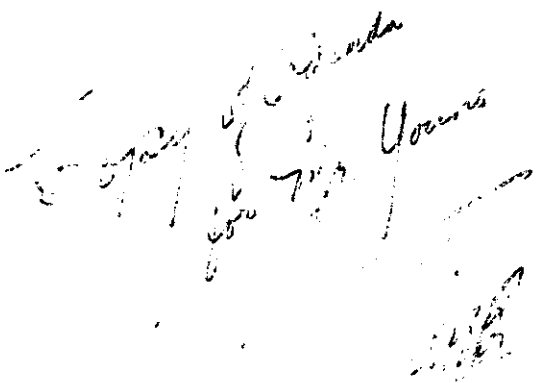
- - - - - - -

OTTAWA

February 14th - 16th, 1949

- - - - - - -

The Convention Hall
Chateau Laurier



Dominion - Provincial Conference -

on

Hospital Statistics

- - - - - - - - -

OTTAWA

February 14th - 16th, 1949

- - - - - - - - - -

Morning Sessions - 9.30 a.m. - 12.30 p.m.

Afternoon Sessions - 2.30 p.m. - 5.30 p.m.

All sessions will be held in

The Convention Hall

Chateau Laurier

Monday, February 14th, 1949

Registration - 9.30 a.m.

Morning Session - 10 a.m. to 12.30 p.m.

Address of Welcome - Right Honorable C.D. Howe, M.P.,
Minister of Trade and Commerce

Election of Chairman, Vice-Chairman and Secretary

Opening Remarks by the Chairman

Remarks by: Dr. G.D.W. Cameron

Mr. David L. Butler

Dr. Louis S. Reed

Mr. Graham L. Davis

Consideration and Adoption of Agenda

Appointment of Committees: Resolutions

Other Committees -
(at discretion of Conference)

- - - - - - - - -

## Tentative Agenda

1. Purposes of Hospital Statistics.

2. Terminology and Classification.
   (Document "C" and "D")

3. Standards of Care.
   (Document "E")

4. Movement of Patients and Morbidity.
   (Document "F" and "G")

5. Finance and Administration.
   (Document "H")

6. Reports of Committees.

7. Other business.

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# Dominion - Provincial Conference -

# on

# Hospital Statistics

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OTTAWA

February 14th - 16th, 1949

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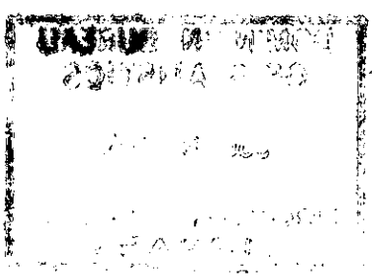
The Convention Hall

Chateau Laurier



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## Attendance

| | |
|---|---|
| Rt. Hon. C. D. Howe | Minister of Trade and Commerce |
| Hon. J. Philip Matheson | Minister of Health, P.E.I. |
| Dr. G.D.W. Cameron | Deputy Minister of National Health and Welfare |
| Mr. D.L. Butler | Senior Assistant Secretary, Dept. of Health and Welfare, Newfoundland |
| Canadian Hospital Council<br>Dr. Harvey Agnew | Executive Secretary |
| Mr. A. F. Moffat | Treasurer, Ottawa Civic Hospital |
| Mr. Walter B. Dick | Consultant Accountant and Actuary |
| Mr. Graham L. Davis | Director of Hospitals, W.K. Kellogg Foundation, Michigan, U.S.A. |
| Dr. Louis S. Reed | Division of Hospital Facilities, U.S. Public Health Service |

### Official Delegates Appointed to Represent Their Respective Province

| | |
|---|---|
| P.E.I.<br>Mr. J.W.T. Crockett | Vital Statistics, Dept. of Health |
| N.S.<br>Dr. J.J. MacRitchie | Inspector of Hospitals, Dept. of Health |
| N.B.<br>Mr. A. Warren | Division of Hospital Services, Dept. of Health |
| Que.<br>Dr. A. Lessard | Special Representative, Dept. of Health |
| Ont.<br>Dr. A.H. Sellers | Medical Statistician, Dept. of Health |
| Dr. M.E.J. Stalker | Medical Inspector of Hospitals, Dept. of Health |
| Mr. A.R. Davey | Hospital Accountant, Dept. of Health |
| Man.<br>Dr. E.R. Rafuse | Director of Hospitalization, Dept. of Health and Public Welfare |
| Mr. A. E. Turner | Hospital Accountant, Dept. of Health and Public Welfare |

| | |
|---|---|
| Sask. | |
| Dr. T.D. Mott | Chairman, Health Services Planning Commission, Dept. of Public Health |
| Mr. G.W. Myers | Executive Director, Health Services Planning Commission, Dept. of Public Health |
| Alta. | |
| Dr. M.G. McCallum | Director, Division of Hospital and Medical Services, Dept. of Public Health |
| Mr. John McGilp | Assistant Director, Division of Hospital and Medical Services, Dept. of Public Health |
| B.C. | |
| Mr. D.W. Simmons | Hospital Insurance Staff, Dept. of Health |
| Miss A.E. Scott | Statistician, Dept. of Provincial Secretary |

## Other Delegates

| | |
|---|---|
| Mr. Herbert Marshall (Chairman) | D.B.S. Dominion Statistician |
| Dr. J. H. Horowicz | D.N.H.&W. Health Insurance Studies |
| Mr. J. E. Howes | B. of C. Research |
| Dr. G.A. Winfield | D.V.A. Treatment Services |
| Lt.Col.H.M. Stephen | D.N.D. Medical Service & Morbidity |
| Mr. H.D. Clark | Finance Administration |
| B. R. King | Aud.Gen. |
| Geo. N. Barker (Secretary) | D.B.S. Hospital Statistics |

## Observers

| | |
|---|---|
| Dr. P.E. Moore | D.N.H.&W. Indian Affairs |
| H. G. Hughes | " Hospital Design |
| H. W. Willard | " Research |
| Mr. J.T. Marshall | D.B.S. Asst. Dom. Statistician |
| Dr. Mary Ross | D.B.S. Public Health Section |
| Miss F. Weekes | D.B.S. " " " |
| Mr. J.H. Lowther | D.B.S. Public Finance |
| Mr. J.H. Melanson | D.B.S. Hospital Statistics |
| G. H. Josie | D.N.H.&W. Research |
| K. M. Pack | D.V.A. Financial Adviser |

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THE CHAIRMAN: Ladies and gentlemen, I will ask the Right Honourable C. D. Howe to open this Conference.

## Address of Welcome

RT. HON. MR. HOWE: Mr. Chairman, ladies and gentlemen:

I am very happy to welcome to this Conference the representatives of the Provincial Departments responsible for the supervision of hospitals, and I am particularly pleased to see that all Provinces in the Dominion are represented here today. I wish to extend a cordial welcome to our guests.

Mr. David L. Butler, Senior Assistant Secretary of the Department of Public Health and Welfare for Newfoundland is present today. This marks the first time that a representative from Newfoundland has attended a Dominion-Provincial Conference on Hospital Statistics. We are also pleased to have with us Dr. Louis S. Reed of the United States. Dr. Reed is from the Division of Hospital Facilities of the United States Public Health Service. We are pleased to have him at this Conference. I also wish to extend a word of welcome to Mr. Graham Davis, who is Director of Hospitals for the W. K. Kellogg Foundation, Battle Creek, Michigan. Mr. Davis has been associated for a considerable length of time with the study of problems relating to the reporting of hospital services and costs, and we are delighted that he has found it possible to be present.

Health authorities recognize the growing importance of reliable comparable information concerning hospitals in connection with the development of a more complete health program for Canada. It seems appropriate that this Dominion-Provincial Conference on Hospital Statistics should be convened at this time to study the problems involved in improving the scope and the quality of hospital statistics.

Hospitals fulfill an important place in maintaining the health of a nation. Their importance has become greater with the increase in hospitalization plans in which more and more Canadians are now participating. Hospital accommodation and facilities must expand to meet the ever increasing needs of our people. The Government of Canada recognized this growing problem and has given encouragement and assistance to the Provinces through the Health Grants, the benefits of which have been extended to all Provinces in the Dominion.

It is apparent that the statistical information required as a guide to the formulation of policy and the implementation of plans for both the Provincial Governments and the Dominion should now be reviewed, co-ordinated and improved.

The Dominion Bureau of Statistics first collected information concerning hospitals in connection with the Decennial Census of 1931. This action was taken as a consequence of a recommendation received from a Convention of Provincial Government delegates and hospital authorities, held in Winnipeg in 1924.

The Canadian Hospital Council has been for years

an important factor in the development of our Hospital Statistics. We owe them much for the considerable progress which has already been made in the development of the system of reporting in Canada.

Since its inception, the Council has worked diligently and progressively for the improvement of hospital standards of care. The development of reliable and comparable Statistics has always been a goal of the Council and the foresight of this Organization can only be explained by the broad outlook and progressive thinking of the men and women who have been its leaders and supporters.

The Dominion Bureau of Statistics' policy is to co-operate with the Provinces and private organizations towards the improvement in the scope and the quality of statistical information concerning the nation. The demands for more extensive and comparable statistics have been increasing. Therefore, we are meeting today to study one phase of this work with the purpose of attaining new goals in the extension of hospital and health services to all Canadians.

I now declare this Conference open and call for nominations for the position of Conference Chairman, Vice Chairman and Secretary.

Election of Chairman, Vice Chairman and Secretary

DR. RAFUSE: I would nominate as Chairman Mr. H. Marshall.

RT. HON. MR. HOWE: If there are no other nominations I declare Mr. Herbert Marshall elected as

Chairman and I will ask him to take the chair.

(Mr. H. Marshall, Dominion Statistician took the chair.)

THE CHAIRMAN: Ladies and gentlemen: I appreciate the honour of being selected as your Chairman and I look forward to working with you in this important Conference. This is, I believe, the first Conference on Hospital Statistics sponsored by the Bureau of Statistics. There was however one in Winnipeg in September of 1937 called I think by the Canadian Hospital Council in which the Bureau did co-operate. Some of you will recall the discussions at that conference. Mr. J. C. Brady was actively engaged in the work of the conference in his capacity as Chief of our Institutional Statistics Section. He retired last year and I should like to take advantage of this opportunity to pay tribute to the excellent work he did during the years he was with the Bureau. The Canadian Hospital Council has been for many years an important factor in the development of good Hospital Statistics and I should like at this time to acknowledge the excellent co-operation we have had with it and with the Provinces.

Much progress has indeed been made in the past but now situations have arisen which make it imperative that we confer together again and take steps to meet them. We live in a period when more and more efforts are being put forth in the direction of better health and welfare. Governments as well as private social workers are becoming increasingly active in these fields. The problems connected therewith are so complex that they must have

statistics of the highest quality to assist them in the study of these problems and in the making of policy decisions and in the administration of those decisions. The purpose of this Conference is to examine the statistical tools we have been using, lay bare their inadequacies, and endeavour to arrive at practicable measures to remove such inadequacy.

A preparatory committee was set up in Ottawa to suggest an agenda for this Conference and to prepare material which would serve as a basis for discussion. These materials I think you have all had in advance and they are included in the Conference Folders given to each of you this morning. In it are included memoranda as follows:

Hospital Terminology and Classification, Sections "C" and "D".

Hospital Standards of Care, Section "E".

Movement of Patients and Morbidity, Section "F" and "G",

Classification of Income and Expenditure, Section "H",

Three supplementary documents are also included because of their related interest, and I refer to Sections "I", "J" and "K".

I hope we shall find that these materials will give us a good start in our discussions. We have a considerable agenda before us and I trust that by the end of the Conference we shall have arrived at a series of decisions which will simplify in certain cases and change and round out in others so that we shall have in future high standards, adequacy, and uniformity in Hospital Statistics.

We shall proceed next with the election of a

Vice Chairman.

DR. E.R. RAFUSE: I would nominate Miss A.E. Scott as Vice Chairman.

THE CHAIRMAN: Are there any other nominations? I declare Miss Scott the Vice Chairman.

We are open now for the nomination of a Secretary. Mr. Barker has been doing the secretarial work up to the present.

DR. RAFUSE: I would again speak and nominate Mr. Barker as Secretary.

THE CHAIRMAN: Apparently Mr. Barker is to have no competition with respect to that onerous job and I declare him elected as Secretary.

Opening Remarks by Guests

THE CHAIRMAN: We have some special guests from whom I think it would be appropriate to have a few words. I would therefore first call upon Dr. G.D.W. Cameron.

DR. G.D.W. CAMERON:

Mr. Chairman, ladies and gentlemen:

My purpose in being here is I think to testify to the fact that the Department of National Health and Welfare is vitally concerned and interested in this meeting. The Minister referred to the National Health Program and the grounds which constituted that program. He also referred to the fact that the most proper implementation of that program calls for very careful studies of existing facilities in order to make plans for improved facilities. One of the most complex features will undoubtedly be the hospital phase of the program. We are therefore vitally concerned that there should be as complete understanding as possible regarding two things--first the extent of the

statistical coverage on hospitals, and secondly uniformity.

One of the grants has to do with surveys. That grant is to enable provinces to survey their facilities and obviously it would be of the greatest advantage if the terms of each survey were uniform. Another grant has to do with construction and obviously we would be greatly aided if our studies in that field were based on a sound plan of statistical analysis.

I think having said that, I have said all that I usefully can. I wish the Conference every success and I assure the Conference that the Departmental of National Health and Welfare is most anxiously following your deliberations.

Thank you.

THE CHAIRMAN: I now have much pleasure in calling on Mr. David L. Butler of Newfoundland.

MR. D.L. BUTLER, Senior Assistant Secretary, Department of Health and Welfare, Newfoundland:

Mr. Chairman, ladies and gentlemen:

First of all I wish to thank you for the cordial welcome extended to me as a representative from Newfoundland. It is indeed a pleasure for me to be here and I bring you warm and friendly greetings from our Island. Should you have occasion to visit our shores I hope we shall have the opportunity of offering you our hospitality and if you have time, I hope you may see something of our hills, valleys, fjords, and fishing streams of which we have just reason to be proud.

Hospital Statistics in Newfoundland will be somewhat of a new field, but I wish to assure you that we shall do everything possible in the collection, compilation, and submission of such statistical material as you may

from time to time require.

Thank you.

THE CHAIRMAN: Mr. Graham L. Davis.

MR. GRAHAM L. DAVIS: Mr. Chairman, ladies and gentlemen:

It is a pleasure to be back again. I was here, as you perhaps know, not so very long ago with the first meeting of the Survey Directors for your Provincial Surveys.

As I wrote Mr. Martin afterwards, I probably gained more from the Conference than I contributed to it and I expect that the same thing is going to happen again. You folks are keeping ahead of us in the United States somewhat in the matter of planning. For instance we have never had a National Conference on Hospital Statistics, we are not that far along yet and so I expect to learn from you and carry back to my own country some of the benefits which I will obtain from having participated in this Conference.

I have been associated with Hospital Accounting and Statistics for quite some years now and in fact it has been my pleasure to work with Canadians on the committee on Hospital Accounting and Statistics of the American Hospital Association. I remember that perhaps fifteen years ago Father Vero was the Canadian member on that committee at the time when we were developing a uniform accounting system which was later published. We decided to break with the older concept of Hospital Accounting that we had obtained from the British through the King's Fund which was the common thing in both countries at that time. Father Vero insisted that Canadian Hospital Accounting Statistics had not progressed to the point where you were in a position

to adopt a more modern functional classification of accounts. We went ahead in the United States and we have made some progress. In retrospect I think that Father Vero was a little too diffident about Canada and I am wondering whether Canada is not really as far advanced in its thinking and in its development of Hospital Statistics as is the United States. The development has been spotty in our country and in some States you will find uniformity of accounting and also that statistical procedure has reached a fairly high degree of accuracy. In other States that is not true and so in the over-all picture as I said at the beginning I do not think we are as far advanced on a national basis as you are in Canada.

I believe that what I will hear at this Conference will be very valuable and I am sure the proceedings will be valuable to the United States when we, perhaps before many years, get around to holding a National Conference on Hospital Accounting and Statistics.

I appreciate very much the honour of being here.

THE CHAIRMAN: Thank you Mr. Davis.

Consideration and Adoption of Agenda

THE CHAIRMAN: The next item, gentlemen, is to consider whether you will adopt the tentative agenda as set out here. Is there any objection on the part of anyone to accepting this agenda as it stands?

You will notice that under item No. 7 we have the heading "Other Business" so if there are additional items which bob up in our minds we can deal with them under that heading.

DR. A.H. SELLERS (Ontario): I would move that

we accept the tentative agenda.

DR. G.A. WINFIELD (Treatment Services D.V.A.): I will second that motion.

THE CHAIRMAN: It has been moved and seconded that we adopt the tentative agenda. (Agreed.)

Purposes of Hospital Statistics

THE CHAIRMAN: The first item on the agenda is "purposes of Hospital Statistics". I do not think that at the moment we need spend very much time on that item. The very fact that the provinces are so well represented here indicates, it seems to me, that we all recognize the importance of these statistics. Doctor Cameron and the others who have spoken have indicated a good deal of concern over the matter but I think we are all very cognizant of that importance. I have some notes on the subject but I think the best thing to do would be to have the notes mimeographed and a copy made available for each of the representatives from the provinces who would like one.

Would you agree that we should prepare such a memorandum outlining the purposes, the uses to which such statistics may be put, and the need for them? (Agreed.)

Terminology and Classification

Document "C" and "D"

We will go on then with item No. 2, Terminology and Classifications.

MR. J.T. MARSHALL: Mr. Chairman, perhaps it might be wise for us now to appoint a Resolutions Committee because as the Conference progresses we shall undoubtedly have material for resolutions.

THE CHAIRMAN: That is very sound, could we have

nominations for the Resolutions Committee.

Resolutions Committee

(The Committee on Resolutions was nominated as follows:

Chairman - Dr. A.H. Sellers

Members - Dr. G.E. Wride

- Mr. G.W. Myers

(Dr. H. Agnew's name was put forward for membership on the Resolutions Committee but at his request it was withdrawn.)

THE CHAIRMAN: We seem to be having difficulty in obtaining additional names and I would suggest that you might leave it to the Chairman to appoint two other members. The three who have been nominated will be included and we will try to add two other members.

Constitution of Sub-Committees

THE CHAIRMAN: I think the next matter that we must discuss is that concerning Terminology and Classification. The question arises whether we desire to discuss the matter in plenary session. Do we want to discuss all of these items in plenary session or would we make greater progress if the Conference were broken up into a series of committees to go over the various memoranda and then perhaps the committees could come to the plenary session with recommendations. Of course all of the subjects would be discussed in plenary session but I would like to have your idea on that method of proceeding.

These subjects do cover a variety of aspects of Hospital Statistics. You will notice the Item No. 5 is Finance and Administration, a subject which perhaps some of you are well acquainted with and it would facilitate

matters if those people were on the committee. On the other hand, those same people are perhaps not so well versed in movement of patients and morbidity.

DR. E.R. RAFUSE (Manitoba): Mr. Chairman, I think that we will make much better progress if we divide into sub-committees and come back to the plenary session at which time the recommendations of those committees can be considered.

THE CHAIRMAN: As I look at the agenda it would seem that if we had four committees, in addition to the Resolutions Committee, that number might be adequate.

DR. RAFUSE: I would move that we be divided into four committees corresponding with the four classifications which remain on the agenda.

DR. M.E.J. STALKER: I would second that motion.

THE CHAIRMAN: Is there any discussion?

(Agreed.)

(Sub-committees were constituted as follows:

Terminology and Classification

Dr. G.E. Wride - Chairman
Mr. G.N. Barker - Secretary
Dr. J.H. Horowicz
Mr. H. Marshall
Mr. J. T. Marshall

Standards of Care

Dr. M.E.J. Stalker - Chairman
Mr. G. Josie - Secretary
Dr. M. G. McCallum
Dr. E. R. Rafuse
Dr. H. Agnew
Dr. A. Lessard

Standards of Care (Cont'd)

Dr. J. J. MacRitchie

Dr. H. A. Ansley

Mr. H. G. Hughes

Mr. J. H. Melanson

Movement of Patients and Morbidity

Dr. A. H. Sellers - Chairman

Miss F. Weekes - Secretary

Mr. J. McGilp

Miss A. E. Scott

Mr. J. W. T. Crockett

Dr. G. A. Winfield

Lt. Col. H. Stephen

Dr. Mary Ross

Dr. L. Reed

Finance

Mr. A. F. Moffat - Chairman

Mr. J. H. Lowther - Secretary

Mr. G. W. Myers

Mr. W. B. Dick

Mr. O. Smith

Mr. D. W. Simmons

Mr. A. R. Davey

Mr. A. E. Turner

Mr. J. E. Howes

Mr. B. R. King

Mr. H. D. Clark

Mr. G. L. Davis

THE CHAIRMAN: Now that we have decided upon the personnel of the various committees I shall ask the Secretary to advise the respective Chairmen of the rooms

in which the committees will meet.

I might say that we hope that the committees will be able, this afternoon, to go over their particular memoranda and be in a position to make a report at the plenary session tomorrow morning. At the session tomorrow it is possible that we will decide that the committees should do additional work and bring back additional reports.

(Mr. Barker, the Secretary of tne Conference advised the Sub-Committees of the respective meeting places.)

THE CHAIRMAN: Unless there is something further which we should discuss as a whole I shall adjourn the Conference and the various committees will meet immediately. The plenary session will open tomorrow morning in this room at 9:30 a.m.

. . . . . .

Tuesday,

February 15, 1949

Conference Room, Chateau Laurier.

(Mr. H. Marshall in the Chair.)

THE CHAIRMAN: I would first this morning like to welcome to our Conference Dr. Louis S. Reed who was not able to get here yesterday. We are very glad to have you with us this morning, Dr. Reed.

DR. LOUIS S. REED (U.S. Public Health Service, Division of Hospital Facilities): Mr. Chairman, I am very glad to be here. Do you want me to say something?

THE CHAIRMAN: If you would, please?

DR. LOUIS S. REED: I am much impressed with your Hospital Statistics. It seems to me that you have rather more complete statistics on hospitals than we have in the United States. So far the Federal Government has not developed any Hospital Statistics of its own although we may be in the process of so doing by using statistics developed by the individual States in their State plans and hospital construction programs. Except for what we may get out of those programs we are depending upon the records of the American Hospital Association and the American Medical Association which together are not as complete as are your statistics.

I think you might be interested in just a few words concerning our hospital construction program in the States which I think is getting along nicely. Perhaps you know that the Federal Government pays up to $75,000,000 a year--a lot of money--to the individual States but the

the States to take advantage must submit a plan in which they inventory their existing hospital facilities and indicate their needs, putting forward a scheme of priority as to which areas are to get hospitals first. That plan is approved and the money is available to meet one-third of the project. So far we have approved six hundred and forty projects which will give us an additional thirty thousand beds and the total cost of construction of those projects is about $330,000,000. About eighty per cent of the money is going into general hospitals. About one-quarter of the projects are for additions to existing hospitals and the remainder represents new projects. Most of the hospitals which we are building are quite small, about twenty per cent are under twenty-five beds. We are somewhat concerned about it but that is what the people seem to want and they are the ones who are putting the projects forward. The State approves and the Federal Government then approves. We hope sometime to develop a plan for linking the smaller places with the larger ones.

Most of the hospitals are going up in areas which may be classed as rural. I think the object of the legislature is being carried out in that hospitals are being constructed in rural areas and areas of low financial resource. It seems to me we will be able to go just a certain distance and then the question of support will arise. There are a lot of areas that won't build hospitals because they know they cannot support them and the whole program will in time raise the question of some more adequate and some more assured means of supporting hospital care.

I should only say further that is very nice to be here.

THE CHAIRMAN: Yesterday we appointed four committees and those committees worked very vigorously and zealously for the remainder of the day. Three of the reports are available this morning and those reports reflect the work which the committees did. The fourth report, that of the Finance Committee is not quite ready.

I propose now to ask Mr. Moffat, the Chairman of the Finance Committee if he will report progress and then I understand he would like to take three or four of the members of his committee away from this meeting and they will finish the report of the deliberations of the Finance Committee.

MR. A.F. MOFFAT (Chairman, Finance Committee): Mr. Chairman, ladies and gentlemen:

As Mr. Marshall has said we went through a very heavy session yesterday and we met again early this morning.

In connection with the Income and Expenditure statements there were differences of opinion as to the form of the report and also as to the items which should be included. Those differences have been reconciled but we feel that before any intelligent discussion can be had we should have an opportunity to redraft the forms. We will then write and submit a report. With your permission I would like to have Mr. Dick, Mr. Lowther and Mr. Davey assist me with the work.

THE CHAIRMAN: I think we will agree to let these gentlemen withdraw from the Conference and go on with the work of the committee.

Report of the Committee on Terminology and Classification

THE CHAIRMAN: We shall now proceed to take the report of the Committee on Terminology and Classification of which Committee Dr. Wride is Chairman.

DR. G.E. WRIDE: Mr. Chairman, ladies and gentlemen:

We have found our task rather difficult. Many of the specimen definitions given were felt to be other than acceptable, however in several instances we were unable to suggest satisfactory compromises. Our work is presented for your discussion in the hope that you will freely suggest corrections and substitutions wherever necessary. In fact some of us felt this morning, subjected to the cold clear light of day, that many of the decisions which we made last night do not stand up too well.

However, as we were assured that the purpose of the Committee going aside and drawing up recommendations was to allow free discussion and correction at a later time.

The Committee reviewed Exhibit No. 3 in the Conference Folder, namely the Consolidated Report on Revision of Definitions and Explanatory Notes concerning Annual Report of Hospital Schedules 1 and 2. I think it would be well if you would refer to the Folder now.

It is my purpose to read the definitions slowly and as we go along I shall ask you to turn those definitions over in your minds and raise any criticisms or have any discussion on the definitions as we proceed. I think that will be better than going through the whole report and retracing our footsteps.

The first is the definition of a hospital.

Definition of a Hospital

"A hospital means an institution operated for the regular accommodation of in-patients in which medical or surgical care for illness or injury, or obstetrical care is provided, and which is recognized as a hospital by a Dominion agency or by the government of the province in which the hospital is located."

THE CHAIRMAN: You have heard the definition read and it has been accepted by the Committee. Are there any objections on the part of any representative here?

DR. WRIDE: I may say that the word "institution" bothered us a little. We thought that it might reflect mental institutions or tubercular institutions but we could not find a more satisfactory word.

DR. M.E.J. STALKER: In the Committee on Standards of Care we dealt yesterday with a number of definitions and we have had them typed on a sheet. Perhaps the Secretary could circulate those now.

DR. A.H. SELLERS: I would like to raise a point in connection with the expression contained in the second line. Is it not true that the definition would be more specifically correct if it read--"medical and/ or surgical care, or obstetrical and/ or surgical care--".

THE CHAIRMAN: Is there any objection to making that change?

MISS F. WEEKES: Is not the definition as it is sufficient? The use of the term "or" alone is quite proper is it not? I think that was the feeling of the preparatory committee.

DR. H. AGNEW: It seems to me that "and/ or" removes any possible doubt.

THE CHAIRMAN: Is there any objection to including in this definition the words "and/ or" for each of those

parts of the definition? If there is no objection we will do that.

MR. A.E.TURNER (Manitoba): Do you think this definition is going to conflict with the requirements of your Department of Health and Welfare grants? Should not a nursing unit be included?

DR. J.H. HOROWICZ: A nursing unit is classified as a hospital with eight beds so there would be no difference in the inclusion of a nursing unit.

THE CHAIRMAN: May we pass the definition by inserting the words "and/ or" where required so that it will read "A hospital means an institution operated for the regular accommodation of in-patients in which medical and/ or surgical care for illness or injury and/ or obstetrical care is provided, and which is recognized as a hospital by a Dominion agency or by the government of the province in which the hospital is located".

Is that definition accepted? (Agreed.)

DR. WRIDE: We next deal with "Kind of Care".

Kind of Care

The Committee accepted the suggested first sentence which reads:"A classification of hospitals according to the kind of care rendered is made from the point of view of the kinds of hospital services provided".

We accepted that sentence. We next deal here with a general hospital.

General Hospital

"A general hospital is a hospital which provides for the treatment of a wide range of conditions. (Hospitals for women and for children which render general medical or surgical services are to be classified as general hospitals."

Perhaps it would be of assistance if I deal with the definition of a special hospital at the same time.

Special Hospital

"A special hospital is one which restricts admissions exclusively or almost exclusively to persons with particular conditions."

We left the "particular" in, in that case.

The Chairman of the Committee on Standards of Care has suggested a somewhat different definition. I shall read it:

"General Hospital: A general hospital is a hospital which provides for the treatment of a wide range of conditions. (Hospitals for women and for children which render general medical or surgical services are to be classified as general hospitals.)

Special Hospital: A special hospital is one which restricts admissions exclusively or almost exclusively to persons with particular conditions."

THE CHAIRMAN:
Well, gentlemen, what is your opinion?

DR. WRIDE: I think it is rather surprising that with a little different wording the two committees arrived at the same statement.

THE CHAIRMAN: Which definition do you prefer, or have you further ideas?

DR. J.H. HOROWICZ: I think the definition of the Committee on Terminology and Classification is better, not because I was on that committee, but because the definition avoids the use of the word "admission", and of course that is our criterion for hospital classification. We, in the Committee on Terminology and Classification say that it is a hospital--"which has facilities for special

conditions". We did not use the phrase "restricts admissions" because we reserve that phrase for other classifications.

DR. H. AGNEW: As a member of the Committee on Standards of Care perhaps I should speak for the idea which the committee was developing. I speak particularly with respect to the definition of a special hospital. If we were to take the definition which Dr. Wride has submitted, that a special hospital is one which provides special facilities for the treatment of particular conditions, I think we would have to list most of our large general hospitals not as general hospitals but as special hospitals because they do have orthopaedic and psychiatric and pediatric wards. Really they are general hospitals but they do have those special facilities and when we speak of a special hospital we really mean a hospital that restricts its clientele to a certain type of patient. A children's hospital for instance only takes children, an obstetrical hospital only takes obstetrical cases. On the other hand we did not want to make it too exclusive because a tuberculosis sanatorium would if the occasion demanded admit casualties from a motor accident.

Of course I am only one member of the committee it is true, but I think that it is a question of the correct use of English when we speak of the treatment of general conditions. A person does not have a general condition, he or she has this or that illness and therefore I am inclined to favour the statement "a wide range of conditions" as the phraseology to be applied to the general hospital.

THE CHAIRMAN: Perhaps we might confine the discussion at the moment then to the definition of a general

hospital. Dr. Agnew has suggested that the word "general" is not the best word and that it might be better to say "a wide range of conditions".

Would you wish the definition submitted by Dr. wride amended by substituting the words "a wide range" for the word "general" or are you in favour of the definition which appears in the memorandum submitted by the Committee on Standards of Care?

DR. WRIDE: My committee does like the expression "a wide range". We are glad that these suggestions are being made and you can understand the difficulty which we had in turning over these words in our minds.

THE CHAIRMAN: I do not think that anyone objects to the use of "a wide range of conditions" instead of "general conditions".

Shall we accept the definition with the suggested amendment? I will read it.

"A general hospital is one which primarily provides facilities for the treatment of a wide range of conditions. (Hospitals for women and children, which render general medical or surgical services, are to be classified as general hospitals.)"

DR. AGNEW: If you use "a wide range of conditions" then the word "primarily" is redundent.

DR. WRIDE: Not necessarily. The first consideration is "a wide range of conditions".

DR. AGNEW: I would not labour the point.

THE CHAIRMAN: Shall we accept the definition as read? (Agreed.)

Dr. Horowicz, have you anything further to say with respect to the special hospitals?

DR. HOROWICZ; No, I think Dr. Agnew has convinced me of the correctness of his views.

MR. BARKER: There does seem to be two concepts in connection with the special hospital definition and the definition of general hospitals. A special hospital is one which restricts admissions exclusively or almost exclusively to persons with particular conditions. On the other hand in the definition for a general hospital no reference is made to the admission question and therefore I do not think the two definitions are quite parallel in that respect.

DR. LOUIS S. REED: I think Mr. Barker's point is well taken and perhaps the solution would be to introduce the same concept in the definition of a general hospital.

DR. WRIDE: Would it improve the definition if we said "a special hospital is one which primarily provides facilities for the treatment of particular conditions"?

THE CHAIRMAN: Would you repeat that?

DR. WRIDE: Would it switch the emphasis if you said "a special hospital is one which primarily provides facilities for the treatment of particular conditions"?

THE CHAIRMAN: Dr. McCallum, would you care to express an opinion on that suggestion?

DR. M.G. McCALLUM: I think that putting in the word "primarily" might overcome the difficulty. As has been mentioned some of our large general hospitals provide orthopaedics and psychiatric services and those general hospitals would come under the definition of a special hospital as it stands but if you used the term "primarily" I think it would overcome any doubt. I would be quite

satisfied with the definition of a special hospital as it is here with the "primarily".

THE CHAIRMAN: The definition would read: "A special hospital is one which primarily provides facilities for the treatment of particular conditions".

DR. WRIDE: That takes care of Mr. Barker's suggestion.

THE CHAIRMAN: Shall we accept the definition as I have just read it? (Agreed.)

DR. WRIDE: I will continue with the report and next we deal with service.

"Nature of Service to the Community

A classification of hospitals according to nature of service to the community made on the basis of whether a hospital admits any and all members of the community or restricts its admissions to specific groups."

We accepted the definition in Exhibit 3 but we felt it was necessary to insert a heading as follows:

"Hospitals with Unrestricted Admissions

Public Hospital

A public hospital is one which is not operated for profit which accepts all patients, regardless of their ability to pay, and is recognized as a public hospital by the province in which it is located."

We thought we needed that heading to balance with the definitions later on which deal with restricted admissions.

A public hospital before was defined as a hospital which is not operated for profit, accepts all patients regardless of ability to pay, and is recognized as a public hospital by the province in which it is located. We had

considerable discussion, particularly with respect to the "is not operated for profit".

We felt that the main emphasis might be well transferred to "a hospital which accepts patients without restriction", but our final definition was as I have given it, "one which is not operated for profit, which accepts all patients, regardless of their ability to pay, and which is recognized as a public hospital by the province in which it is located".

The word "profit" disturbed us a good deal. We felt that it should not be in the definition.

MR. A.E. TURNER: I think the committee would have been better if it had defined general hospital, private hospital and special hospital and then gone ahead with the service. You are now bringing in the matter of a private hospital but we have had no definition of a private hospital.

THE CHAIRMAN: I am afraid that we did not quite catch your remarks at this end of the table.

MR. A.E. TURNER: I am sorry, Mr. Chairman, but I notice now that there is a definition for a private hospital and so my remarks do not apply.

THE CHAIRMAN: We have two definitions of a public hospital one put forward by Dr. Wride's Committee on Terminology and Classification and the other put forward by the Committee on Standards of Care. The definition given by the Committee on Standards of Care for a public hospital is as follows:

"A public hospital is a hospital which is not operated for profit, accepts all patients coming within its range of service regardless of their ability to pay, and

is recognized as a public hospital by the province in which it is located."

DR. J.H. HOROWICZ: I would move that we accept the definition put forward by the report of the Committee on Standards of Care after removing the expression "coming within its range of service".

DR. AGNEW: I am, I presume, invited here to be a spokesman from the hospitals and I think the suggestion put forward by Dr. Horowicz would be strongly approved.

DR. WRIDE: We certainly pondered for a considerable time over the advisability of having the words "is not operated for profit" in there.

DR. AGNEW: I think I would like to see some reference to the non-profit feature in the definition. Dr. Reed will appreciate that in Canada we use the terms private and public in a different way from the use made of them in the United States. Our public hospitals are constantly under fire from misinformed members of the public who think these hospitals make large profits. It is known that a fair number of private hospitals do make profits and I think the public hospitals feel that one of their main assets is that they are incorporated not for profit. No one can make any profit in running a public hospital because the profits are ploughed right back into the institution and I would like to see a reference to that in the definition.

THE CHAIRMAN: It is an important point and I would like to have some further expressions of opinion.

DR. WRIDE: As a committee after long discussion we came to the conclusion that reference to profit was not

necessary. I hate to express the personal opinion here for fear of being taken as condemning hospitals for the motive of profit. Since they do not use the money for personal gain of individuals they have not a profit motive but our experience with individual hospitals is that they would like to make a profit on their operations as a going concern. I just throw that out and I would not detract from the humanitarian side of hospitals in any way. The committee in turning it over and over in its mind just wondered whether the non-profit motive should be put into a definition such as this and we would be guided by the larger group.

THE CHAIRMAN: Is there any further discussion? I think I must put this in the form of a question. How many are in favour of including in the definition the words "not operated for profit"?

How many are opposed?

I declare that the majority favours having the phrase included in the definition.

The definition, as finally approved by the Conference then is:

"A public hospital is one which is not operated for profits, accepts all patients, regardless of their ability to pay, and is recognized as a public hospital by the province in which it is located."

Is the definition as I have read it acceptable?

(Agreed.)

DR. WRIDE: We shall go on with "Hospitals with Restricted Admission".

MISS F. WEEKES: Mr. Chairman, the Committee on Standards of Care, under the heading "Nature of Service

to the Community" made an amendment to the draft definition by the exclusion of the term "any and all" and I would suggest that be accepted.

THE CHAIRMAN: I wonder if we could discuss that in the report to be given by Dr. Stalker?

MISS F. WEEKES: I just want to bring the matter forward now in order that the difference may not be lost to view.

THE CHAIRMAN: Oh, I see what you mean. The suggestion made refers to the note set out by the Committee on Standards of Care, under the heading "Nature of Service to the Community" which reads as follows: "The title is left to the discretion of the Dominion Bureau of Statistics. A classification of hospitals according to whether or not a hospital admits any members of the community or restricts its admission to specific groups."

In Dr. Wride's report the definition in Exhibit 3 was accepted and it reads: "A classification of hospitals according to nature of service to the community is made on the basis of whether a hospital admits <u>any and all</u> members of the community or restricts its admission to specific groups."

MISS F. WEEKES: The suggestion made by the Committee on Standards of Care is that the words "and all" be deleted.

THE CHAIRMAN: I see. The definition would then read: "A classification of hospitals according to nature of service to the community made on the basis of whether a hospital admits any members of the community or restricts its admission to specific groups."

Is there any objection? (Agreed.)

DR. WRIDE: We had quite a time with the next section, "Hospitals with Restricted Admission".

Hospitals with Restricted Admission

We accepted the statement in Exhibit 3 "This group includes hospitals which are primarily operated for particular categories of patients", except that we substitute the word "limited" for "particular".

Before we discuss that point however, I think we should go through the remaining headings.

Private Hospital

"A private hospital is one which ordinarily restricts its admission to patients paying for the care provided at rates determined by the management."

That was presented to the committee and it rather shocked me for a moment because I realized that in Saskatchewan, paying private hospitals as we do under the plan, this definition might mean that we would not have any more private hospitals. Our so-called private hospitals are few in number, mostly under ten beds in size, and they are all paid as well as public hospitals for the care of patients under the plan. Of course in calling a place private the criterion is ownership and in this definition we do not use the word ownership. As I understand it we might have no private hospitals in Saskatchewan because a private hospital "is one which ordinarily restricts its admission to patients paying for the care provided at rates determined by the management".

MR. A.E. TURNER: In Manitoba all rates are fixed by the management and therefore I do not think this applies to us. My suggestion would be to say "A private hospital is one which ordinarily restricts its admission"

and leave it at that.

DR. H. HOROWICZ: I am in favour of the definition submitted by the Committee on Terminology and Classification. The definition brought in by the Committee on Hospital Standards contains two elements, the matter of ownership and ability to pay--restricting admission of those patients to those who are able to pay rates set out by the management. I my committee we tried not to combine the two factors. In my committee we wanted to say that a private hospital was one which charged rates to patients--and only accepts patients who actually agree to pay the rates, and that was entirely apart from the question of ownership.

Theoretically a public owned hospital might be in this sense a private hospital and it seemed to us that for statistical purposes it would be better to deal with the one criterion at a time and therefore we dealt with the classification of a hospital by ownership. For the sake of expediency you could call privaten hospitals proprietary hospitals but this definition restricts inclusion to the question of the ability and the agreement of patients to pay rates determined by the management.

MR. TURNER: I do not agree with that. I do not think that ownership enters into the picture at all and rules and regulations must be laid down which determine whether it is a private or a public hospital.

THE CHAIRMAN: Are there any other opinions?

DR. AGNEW: Most provinces have a Public Hospitals Act and a Private Hospitals Act. It may be that the name varies but there are the two divisions. The public hospitals,/under the Public Hospitals Act and there come

are two conditions. First of all it must be non-profit and secondly it must accept any patient which comes within the scope of their facilities. A Private Hospital as I have found it over a number of years, is a hospital operated by individuals or perhaps by groups or companies such as mining companies where, if there is a profit, it goes back to the owners and the hospital is not necessarily compelled to take in everyone who comes to the door whether they are able to pay or not. You really get down to this fundamental question of whether it is a profit or non-profit organization. I agree that if we could leave out the non-profit it would be all right but if you are compiling statistics across Canada we should try to conform with what is the generally accepted view of a Private Hospital and for that reason I rather like the definition of the Committee on Terminology and Classification because I do think the meaning is expressed pretty well.

THE CHAIRMAN: I think all these aspects will come out in the various classifications suggested in the memorandum. We have a classification on the basis of ownership and in another memorandum we are dealing with the question of costs so I do not think by accepting this definitions that you are failing to bring out all the facts relative to Private Hospitals.

DR. RAFUSE: I believe the two main things are first that it is owned and operated by a private person and secondly it is operated for a profit. Those are the two main elements which should be included.

THE CHAIRMAN: How many are in favour of accepting the definition which has been presented by the

Committee on Terminology and Classification, that is to say:

"A Private Hospital is one which ordinarily restricts its admission to patients paying for the care provided at rates determined by the management."

That is under the caption of the scope of service rendered to the community and it has got nothing to do with ownership which comes along later.

MR. A.E. TURNER: The fact that you say "rates determined by the management" means nothing because all rates in every hospital are determined by the management.

DR. WRIDE: I do not think that is the emphasis. The emphasis has to do with "one which ordinarily restricts its admissions to patients paying--".

MR. D.W. SIMMONS: In your definition of a Public Hospital you say that it is "One which is recognized as a Public Hospital by the province." A Private would then be, would it not, any which was not recognized as a Public Hospital.

THE CHAIRMAN: This is a statistical classification. It seems to me, and I may be subject to correction, that it might not conform exactly with the rules and regulations of the province. These classifications are purely for statistical purposes so that we will have groups in which the concepts are mutually exclusive. If it can be arranged that way it seems to me that the statistics have a much greater clarity.

MR. SIMMONS: That was my point. The hospital might not meet the requirements of your definition for a Private Hospital and yet it might not be recognized as a Public Hospital by the province. It would have to be

included as either one or the other?

MR. A.E. TURNER: Why would you not say "A Private Hospital is one which ordinarily restricts the admission of patients."

MR. BARKER: Do you not have to indicate on what basis they restrict their admissions?

DR. LOUIS S. REED: Could you say "--which restricts its admission to paying patients".

DR. E.R. RAFUSE: That is the matter about which Mr. Turner is worried--paying at rates determined by the management. They are paying rates and those rates give the owners a profit.

MR. A.E. TURNER: We should not have to infer these things, it should be down in black and white.

DR. J.H. HOROWICZ: I think the definition as it stands is clear.

THE CHAIRMAN: I wonder if we could have an expression of opinion from Dr. MacRitchie?

DR. J.J. MacRITCHIE: I would be inclined to accept the definition put forward by the Committee on Terminology and Classification.

THE CHAIRMAN: It seems to me that I must put this to a vote. How many are in favour of the definition as it stands in the report of the Committee on Terminology and Classification--"A Private Hospital is one which ordinarily restricts its admission to patients paying for the care provided at rates determined by the management"?

I declare that the majority favours that definition.

DR. WRIDE: The next matter was that of the

Industrial Hospital.

Industrial Hospital

"An Industrial Hospital is one operated primarily for the care of the employees of an industrial establishment."

We wondered about "an". We wondered whether it limited that to one employer and we felt that an Industrial Hospital might be established in a city catering to many industries and finally we came to the conclusion that "an industrial establishment" would cover it.

THE CHAIRMAN: In this connection the Committee on Standards of Care has suggested that "an Industrial Hospital is a hospital operated primarily for the employees of an industrial establishment and/ or their families".

DR. WRIDE: I would question the inclusion of "families". An Industrial Hospital is one which would limit itself to the care of people suffering from diseases found in industry.

DR. H. AGNEW: I think there would be exceptions to that. We have a number of firms--mining companies and lumber companies--which operate hospitals primarily for their own employees but they will take in the families.

DR. WRIDE: It is primarily for the employees though.

DR. AGNEW: And the families. "And/ or"would not be quite right but they do include the families in most cases. In a great many of these communities there are only half a dozen other townspeople who are not members of the company and they will take those people in.

DR. WRIDE: We were afraid it would immediately lose its status as a restricted hospital and become a more general type with unrestricted admission unless we used

the words "primarily for diseases peculiar to industry".

DR. E.R. RAFUSE: I do not believe that is correct at all. These are not hospitals for the treatment of industrial diseases but they are General Hospitals in the actual sense of the term. However they are restricted or limited generally to members of the community--employees and families of employees of the company.

DR. J. H. HOROWICZ: It seems to me the word "primarily" takes care of any doubt.

MR. GRAHAM L DAVIS: May I ask if there is then a difference between a Private Hospital and an Industrial Hospital?

DR. E.R. RAFUSE: The Committee on Standards of Care thought that an Industrial Hospital should be one type of classification under Private Hospital.

DR. J.H. HOROWICZ: The profit is not perhaps quite so clearly visible in an Industrial Hospital. A company generally operates the hospital not so much for profit as for the benefit of their employees.

THE CHAIRMAN: I take it that you want to be sure that this type of hospital is included under the heading "Hospitals with Restricted Admission".

Are there any other expressions of opinion?

MR. JOHN McGILP: In Alberta we have two Industrial Hospitals, at Nordegg and at Cadomin and both are now on the approved list. They did start admitting patients other than those for the care of whom they were constructed. We placed them on the approved list and they are now Public Hospitals. I am curious to know whether they should be shown under Public Hospitals or Industrial Hospitals?

DR. H. AGNEW: As far as Ottawa is concerned the decision of the provincial departments will have to be taken. The Provincial Governments, in their wisdom, will decide whether they are operating for a profit or whether they are Public Hospitals owned and operated by the company. Whatever the province does in the way of a decision will be reported on the return made to Ottawa.

DR. H. A. ANSLEY: In the definition of a Public Hospital you have included "and is recognized as a Public Hospital by the province in which it is located". It would therefore mean that the province would say "you report on such and such a form and then statistically we can classify your return".

It seems to me, following what Dr. Agnew said, if we added to the Hospitals with Restricted Admissions a note--"This includes hospitals which are primarily operated for a certain few patients", it would take a great deal of thought to separate the shades of grey. If the province was to designate whether it was a Private Hospital or an Industrial Hospital it might possibly take care of the point.

DR. M. G. MacCALLUM: I believe Mr. Simmons was getting at that point but there is the possibility that certain of our hospitals would be neither Public nor Private.

THE CHAIRMAN: There is the category "other".

MISS A.E. SCOTT: Would not the status of an Industrial Hospital be shown under"ownership"?

THE CHAIRMAN: Could we let this definition stand as it is?

"An Industrial Hospital is one operated primarily for the care of employees of an industrial establishment?"

(Agreed.)

DR. WRIDE: The next matter is the "Dominion Hospital".

Dominion Hospital

"A Dominion Hospital is one operated by the Government of Canada primarily for the care of special groups of patients."

DR. J.H. HOROWICZ: By way of explanation hospitals in this category will be hospitals operated by the Department of Veterans Affairs, by the Department of National Health and Welfare, and will include mainly two categories of patients, hospitals for Indians and hospitals for veterans.

MR. A.E. TURNER: Should they not come under the heading of "Hospitals with Restricted Admissions"?

DR. J.H. HOROWICZ: There is not the restriction to special types of cases.

DR. A.H. SELLERS: Does the definition include hospitals operated under the Department of National Defence?

DR. WRIDE: Yes.

THE CHAIRMAN: I take it there is no objection to the definition of a Dominion Hospital? (Agreed.)

Other (Hospitals)

THE CHAIRMAN: The Committee on Terminology and Classification accepts the statement included in Exhibit 3 which reads:

"This group includes all other hospitals where admissions are restricted to particular groups of patients."

Is that acceptable? (Agreed.)

The next section has to do with Ownership.

Ownership

DR. WRIDE: "Ownership of the hospital is usually determined by the name of the person, persons or corporation

under which the Deed to the real estate is registered. However, for purposes of classification, a hospital, the right, title or interest in the property of which is vested in the Government (Dominion, Provincial or Municipal), or in any board, commission or agency thereof shall be classified as a government owned hospital."

I hesitated for some time because of the conception that a Municipal Hospital is government owned. When we speak of Government in the province, we mean the Provincial Government or the Dominion Government and we have about 79 different hospital districts which are groups of municipalities which have agreed to build and own a hospital. We are certainly going to have a lot of government owned hospitals.

MISS F. WEEKES: Is not a municipality a government?

DR. WRIDE: It is, but it is difficult to accept that suddenly.

DR. M. G. McCALLUM: Alberta is in the same position in that it has a great number of Municipal Hospitals and our Government does not want to recognize them as government hospitals. If the government recognized them as government owned hospitals half of them would be included.

THE CHAIRMAN: In the Bureau of Dominion Statistics we certainly classify various statistics under three main headings, Dominion, Provincial, and Municipal.

DR. E.R. RAFUSE: I also quibbled over that word "Municipal", and making it parallel with Provincial and Dominion because in Manitoba we have district hospitals which are much more parallel to a community hospital or volunteer hospital than to a Provincial or Dominion hospital.

MR. A.E. TURNER: I think there would be cases

where the title would not be an indication because the buildings are rented. Who would have ownership then?

MISS A.E. SCOTT: In British Columbia there are quite a few hospitals which do not own the buildings.

THE CHAIRMAN: The title must be registered in someone's name and I think the classification schedule provides for various alternatives.

MR. BARKER: In the Conference Booklet, Schedule 1, an attempt is made to lay out the wording and information desired relative to this definition. If we refer to that it may help the discussion. Under the heading "Classification of Hospitals (for Statistical Purposes), Item No. 3," ownership is intended to be indicated by the tick method or the check method, referring to the body or group that owns the hospital. Before that section however the question is asked directly, "State in whose name the hospital real estate is registered--".

DR. J.H. HOROWICZ: I think Mr. Turner's point is very well taken but, to take care of this situation, we inserted the word "usual". If the hospital owned the property that would determine the ownership but if it does not we would have to look for some other criterion. Usually the matter is determined by the title to the land but if the hospital does not own the land we would have to look for another criterion.

THE CHAIRMAN: As a general working principle would you be satisfied to accept this definition of ownership?

MR. D.W. SIMMONS: Could you not cover it by having a new item (c) under "ownership" which would show whether there was some other owner.

THE CHAIRMAN: What do you think of that, Dr.

Horowicz?

DR. HOROWICZ: I did not hear it.

THE CHAIRMAN: The suggestion is made that we might add another line which would show that the hospital is under some other ownership.

MISS F. WEEKES: Is that matter not taken care of under Item 5 on the Schedule which deals with continuing administrative responsibility?

THE CHAIRMAN: We are talking about ownership.

MISS F. WEEKES: There is a distinction made in Item No. 5.

THE CHAIRMAN: I think that here we are particularly anxious to know how many of these hospitals are government owned.

MR. GRAHAM L. DAVIS: I might say that we have had that problem when gathering statistics on hospitals in the United States. In general our criterion is governed by the control of the plant. For instance where the plant was owned by a religious order it would be classified as a religious hospital and a non-profit organization. If you were dealing with statistics regarding the plant it would be important for the provincial and dominion governments to know who owned the plant but for statistical purposes and determining what to charge for hospital services we ignore the ownership and go by the actual operator of the plant whether it is government, a non-profit corporation or a Private Hospital and we do not go by the owners of the plant at all.

THE CHAIRMAN: It seems to me that the situation is simple. If you will accept the definition of ownership as a general working principle then when it appears in the questionnaire--we have the two sections, (a) and (b), it

could be worked out in practice. These hospitals not owned by the government, lay or religious orders, or Private Hospitals, could be covered by the heading "Other". I do not think it is necessary to put another item in there and I think they can be included under "Other". We are only concerned with the hospital property and equipment. Now, if you were following out the questionnaire, it seems to me that what could be said is that of course the equipment is owned by the hospital but the building. Would there be any difficulty about that?

Are you willing to accept the definition of ownership as a working principle? (Agreed.)

DR. WRIDE: We may continue then with "Financial Responsibility".

Financial Responsibility

"Is intended to indicate who accepts continuing financial responsibility for possible deficits incurred by the hospital."

You will notice that the next section deals with "Continuing Administrative Responsibility.

Continuing Administrative Responsibility

"Is intended to indicate who accepts responsibility for the administration of the hospital."

Then follows the Operating Body.

Operating Body

"Is intended to indicate who actually operates the hospital."

MR. GRAHAM L. DAVIS: For statistical purposes we indicate who operates the hospital.

THE CHAIRMAN: Then there are the 3 sections. The Committee on Standards of care has suggested a definition for "Operating Body". The definition reads:

"Operating Body is intended who actually provides

the services in the hospital."

DR. WRIDE: Would that not be the staff of the hospital--the doctors, nurses, and technicians?

DR. H. AGNEW: That point arose in the discussions of the Committee on Standards of Care because if you say "Operating Body" or the body which operates the hospital that is more or less going around in a circle and your committee thought that the phrase "provides the services in the hospital" was a little clearer. In Canada we have a number of hospitals which are owned by lay organizations but the actual service in the hospital is provided by orders of Sisters. They do not own the hospital, but they operate the hospital. In some cases they only operate the nursing services and outside of the nursing services the administration is done by the board which operates the hospital--the lay board. I think that across Canada we would find that there were various degrees of administration by bodies other than that which services the hospital.

I think it is something that should be defined not too narrowly and that it would be well to leave it to the committee in Ottawa to say whether there is sufficient operation by the Sisters to include them as the operating body. The lay organization that owns the hospital may of course have the major share in providing the services.

THE CHAIRMAN: Suppose we take the subjects in order, the first one being continuing financial responsibility.

Are there any objections to the wording as it has been given? (Agreed.)

The next is continuing administrative responsibility and that has been read as "Indicates who Accepts Responsibility for the Administration of the Hospital."

Under Section E of the Conference Folder, in the Statistical Questionnaire, you have Item 5, continuing administrative responsibility and there again it is broken down into items which it is intended will indicate to us where the continuing administrative responsibility is.

Are there any comments?

MR. BARKER: I have a note on the discussion which took place in the Committee yesterday and that is whether "government" should be broken down further instead of being just "government--religious orders--lay groups--". The question is whether it should be dominion, provincial, or municipal--and religious orders, lay groups, and if that applies in Item 5 it should apply in Item 4 above.

There was no discussion on the matter in the Committee and that is why I bring it forward now.

THE CHAIRMAN: I think it would be clearer, if instead of having the overall term government we indicated which kind of government it was. Then we would have the whole of the information.

Are there any comments?

I will declare the statement on this item accepted. (Agreed.)

Now we come to the item about which there has been some comment, namely "Operating Body".

The one committee proposes that "it is intended to indicate who actually operates the hospital," and the

Committee on Standards of Care has suggested "Operating Body is intended to indicate who actually provides the services in the hospital".

Dr. Horowicz, have you any comment on the suggested change?

DR. J.H. HOROWICZ: I can see the shortcomings of our definition but on the other hand we put the emphasis on the word "actually". We were a little reluctant to use the term "runs" and I do not think there is very much difference between the two definitions and I personally favour the one submitted by the Committee on Terminology and Classification.

THE CHAIRMAN: Is there any further comment?

DR. E.R. RAFUSE: You have enough difference in the definition to separate it from continuing responsibility. I believe the definition of the Committee on Standards of Care make that distinction.

MISS F. WEEKES: I think Dr. Rafuse has expressed the view of the committee.

THE CHAIRMAN: How many would favour the acceptance of the definition submitted by the Committee on Standards of Care, namely "Operating Body is intended to indicate who actually provides the services in the hospital"?

How many are in favour of the definition submitted by the Committee on Terminology and Classification which reads "Is intended to indicate who actually operates the hospital"?

I declare the definition suggested by the Committee on Standards of Care carried.

DR. F.W. JACKSON: Might there not be some confusion there in the matter of the medical services provided to the hospital?

DR. E.R. RAFUSE: We are dealing with hospital services and not medical services.

DR. F.W. JACKSON: We must be careful with "providing the services in the hospital" because actually the doctors practising provide most of the services and the hospitals provide the facilities.

THE CHAIRMAN: I take it that there is not too much difficulty there and that we accept the definition "Operating Body is intended to indicate who actually provides the hospital services". (Agreed.)

Perhaps, ladies and gentlemen, we should try to push along faster because there are the reports of the other committees to be considered. One way of saving time would be when we come to a definition if no change has been suggested by either of the committees I will ask if any representative has any change to suggest and if I receive no reply we will pass on to the next item.

DR. WRIDE: The next item is the "Rated Bed Capacity".

Rated Bed Capacity

"The Rated Bed Capacity represents the largest number of beds in the hospital established on the following minimum floor areas in space used for hospital beds:

| | | |
|---|---|---|
| Singe patient room | - | 100 square feet |
| Multiple accommodation | - | 80 square feet |
| Child single room | - | 80 square feet |
| | (minimum width 8 feet) | |
| Children's ward | - | 50 square feet |
| Infant (not in nursery) | - | 30 square feet" |

Would you give particular attention to the first two lines. The committee sets it out "The Rated Bed

Capacity represents the largest number of beds in the hospital established on the following minimum floor areas in space used for hospital beds."

We have endeavoured to get away from measuring wards and kitchens and saying that under certain circumstances beds could be set up and thereby rating the capacity. It also gets away from the difficulty which we had in Saskatchewan, We would have a hospital built as a hundred-bed hospital but they never put the beds in because in one of the wings perhaps the nurses were living or they set up the record system or the business office in that wing.

If we had taken the original one hundred bed size as being the rated capacity of the hospital it would have meant that for years afterwards our statistical calculations would have been inaccurate. By taking the actual number of beds set up in the space devoted for nursing care and taking it on a standard of so many square feet per bed we came to the actual rated bed capacity for that year. You can see by this method that a year or two later you may have removed the nurses from the wing in which they were living and your bed capacity increases.

DR. M.E.D. STALKER: In our committee it was suggested that the word "largest" be omitted for the reason that in certain rooms the area might be present and yet the shape of the room would not be suitable for the number of beds which it would hold.

In Ontario, the standards of floor space differ somewhat from these and I am wondering whether they might object?

THE CHAIRMAN: Has anyone any objection to leaving

out the word "largest"?

Very well we shall omit "largest".

We are open for comment on the proposed definition.

DR. H. AGNEW: I should mention that the Chairman of the Canadian Hospital Council Committee on Accounting and Statistics, in a letter received yesterday, made the suggestion that he would prefer a basis of measuring the space between beds. I realize that would be more complicated but he thought it would be a more accurate method. Presumably there would be a minimum space between beds and between the beds and the walls to prevent over-crowding even though there might be the actual space.

DR. WRIDE: It does become very difficult for hospital inspectors to compute that way.

DR. A.H. SELLERS: I would be interested in hearing something about the word "rated".

DR. WRIDE: The word "rated" was intended to imply that the space had been measured and checked. I wonder if even the much abused word "official" would not be good. Whatever adjective is used is likely to imply that there might be other capacities but in this particular instance we are not confining it.

THE CHAIRMAN: Can anyone suggest a better word than "rated"?

MR. JOHN McGILP: I agree with Dr. Sellers--there is only one capacity.

DR. WRIDE: There is an estimated capacity and an actual capacity.

THE CHAIRMAN: Could you use the word "measured"? Call it the measured bed capacity.

DR. WRIDE: That might upset the meaning of the rest of the sentence.

DR. A.H. SELLERS: I would like to have Dr. Agnew give his reaction to the use of the word "official" instead of the word "rated".

DR. H. AGNEW: I think of the two words I would prefer "rated" but if you are asking me to define "rated" I will pass the opportunity.

THE CHAIRMAN: If this questionnaire goes out and those who have to fill it in see the word "rated", would they interpret it as meaning a bed capacity which has been actually measured or is it to be the bed capacity that has been estimated? Does not the word "rated" have a connotation that there must be some measurement?

DR. H. AGNEW: It seems to me that most hospitals realize there are two figures, the official capacity and additional complement. I think if you send out the questionnaire reading "rated" capacity the hospitals will understand it as being a definite basis as set down here.

DR. LOUIS S. REED: Would "standard" be any improvement?

THE CHAIRMAN: I believe this definition is based to some extent on the general standards of hospital construction, a bulletin on which has been issued by the Department of National Health and Welfare and in which the word "rated" is used.

How would it be to try it out as "rated"?

How many are in favour of accepting the definition as read by Dr. Wride except that the word "rated" is substituted for the word "largest"?

MR. D.W. SIMMONS: I suggest that we amend it

slightly by saying "the number of beds which can be established in the space used for hospital purposes".

DR. WRIDE: We found that it gives a false picture when you say "which can be established". We want the number established on the basis of these minimum standards. If you depart from that at all you get different answers depending on who is dealing with the hospital.

MR. D.W. SIMMONS: All you get is the number of beds for a certain space but still more can be put in.

DR. M.G. McCALLUM: I think the hospital bed number is the number for which the hospital was established. You cannot put beds in a sun-parlour and include it in the bed capacity because that is complement.

MR. McGILP: Reverting to the Department of National Health and Welfare, when we deal with hospitals for construction grants we must eliminate any sun porches, day rooms, etc, which were not constructed for beds. I think that we should be consistent in following that pattern through even for statistical purposes.

DR. WRIDE: In actual practice you can have a potential rated capacity on the suggested basis of, we will say 10,000, while in actual practice you might at no time have a rated capacity of more than 8,000.

We have had 100-bed hospitals with 75 beds as the rated capacity on the space being used for beds but the number of beds actually set up is a different thing. Some of the beds may be out in a sun porch which is too small, they may be in front of doors and so on, and the number of beds set up is a different thing.

Our original statistics gave us a great deal of

trouble because we used these other yardsticks.

THE CHAIRMAN: How many are agreeable to accepting the definition as it stands with the elimination of the word "largest"?

The definition would then read:

"The Rated Bed Capacity represents the number of beds in the hospital established on the following minimum floor areas in space used for hospital beds:"

I shall not read the rest of the detail.

How many are opposed?

I declare the definition with the deletion of the word "largest" carries. (Agreed.)

DR. WRIDE: May I make a suggestion?

When the provinces are analyzing the potential rated bed capacity they could set up an extra column for the purpose of construction requirements--how many beds do you want to build in your province. You should know the potential bed capacity if you move the nurses out of a particular wing and so on.

THE CHAIRMAN: Shall we go to the next definition?

Beds Set Up

DR. WRIDE: The committee submits the following definition:

"The term "bed complement" is to be replaced by the phrase "number of beds set up", which is intended to represent the number of beds actually set up for the accommodation of in-patients."

I think that was done originally because the word "complement" means different things in different places. It means something different in the United States to what it does in Canada. We finally decided, in the committee,

to discard it and speak of the number of beds set up which is intended to represent the number of beds actually set up for the accommodation of in-patients.

"In order to obtain an indication during the year in the variation of the number of beds set up for the accommodation of in-patients, the committee suggested the following three sub-headings:

(a) Maximum number of beds set up at any time during the year.

(b) Minimum number of beds set up at any time during the year.

(c) Number of beds set up for the accommodation of patients at December 31st."

That conception is a little different but it recognizes that the bed situation in a hospital is something like the leaves on a tree--some are falling, some are unfolding, and the picture changes even during one day.

THE CHAIRMAN: The report of the Committee on Standards of Care suggests that beds set up be shown as:

"Bed complement (total beds actually set up for in-patient use)."

If we leave out the words "bed complement" it would read--"--number of beds set up (total beds actually set up for in-patient use)".

Is there any discussion on that distinction?

The point which the Committee on Standards of Care wishes to make in the definition is that they thought the term "bed complement" was one which was well understood but to make it clear they put in the bracket in which they

indicate that it is the total number of beds actually set up for in-patient use.

MR. A.E. TURNER: May I ask why the term "bed complement" is required? I do not recall it in use at all in our set-up and I wonder why you want that?

THE CHAIRMAN: I know, when the preparatory committee was meeting, that was one of the terms which several representatives were anxious to include.

Dr. Horowicz, can you say something on this?

DR. J.H. HOROWICZ: I think it is an indication of the actual situation in the hospital.

DR. H. AGNEW: In the discussion yesterday a practical example of the necessity for having some idea of the complement was discussed. During the recent war, and before the Department of Veterans Affairs got well under way with its building program, there was considerable apprehension that there would not be enough beds in Canada to handle the wounded if we had a shooting war in the earlier stages. I remember there was a question asked which resulted in the making of a very quick estimate of the complement of Canadian hospitals with a view to see just what would happen and what could be handled in an emergency.

I think it would be a very important matter if there was another war and I think there are many other reasons why we should be able to compute the complement.

DR. WRIDE: We must use it as some indication of over-crowding. If the rated capacity is 100 beds but, with the complement, there are 150 beds set up, it gives a picture of over-crowding.

MR. McGILP: That is the value on the provincial

level but I fail to see the value of it on the dominion level. We ask a hospital to tell us the maximum number of beds it can set up and by so doing I think there is a tendency to encourage the hospitals towards over-crowding, something to which we are opposed.

THE CHAIRMAN: If trouble should arise certainly the information would be wanted for the Dominion as a whole.

DR. M.E.J. STALKER: The actual bed complement would not give you the bed capacity of a hospital.

DR. WRIDE: I do not think you can really get the total number that you can put in any one hospital. You could put them in bunks, one above the other, and you could have artificial ventilation and really there might be no end.

THE CHAIRMAN: How many are willing then to accept the definition as set out by the Committee on Terminology and Classification? It reads:

"The term 'bed complement' is to be replaced by the phrase 'number of beds set up', which is intended to represent the number of beds actually set up for the accommodation of in-patients. In order to obtain an indication during the year in the variation of the number of beds set up for the accommodation of in-patients, the committee suggested the following three sub-headings:

(a) Maximum number of beds set up at any time during the year.

(b) Minimum number of beds set up at any time during the year.

(c) Number of beds set up for the accommodation of patients at December 31st."

DR. H. AGNEW: I would support that, personally,

if you would put the word "complement" in brackets. I would like to see it put in either after the title or before.

THE CHAIRMAN: Is there any objection to that--to putting the word "complement" in the title after the "beds set up"? (Agreed.)

Hospital Bed

DR. WRIDE: We thought we should do something to define a hospital bed and we say:

"A hospital bed is one provided for the regular use of in-patients, but exoludes bassinets."

THE CHAIRMAN: Is there any comment? Shall we accept that definition? (Agreed.)

Adult Bed

DR. WRIDE: Here we are falling into some difficulty. We say:

"An adult bed is a hospital bed provided for the use of adults or older children."

We did not like to define it simply as a hospital bed.

MR. A.E. TURNER: Why not just say "children" instead of "older children"?

DR. WRIDE: We were not entirely happy.

MR. A.E. TURNER: You might also say "larger children".

DR. M.G. McCALLUM: Yes, it should be "larger" instead of "older".

DR. WRIDE: Could we just leave the word "older" out?

DR. H. AGNEW: "Larger" would be more accurate.

MR.McGILP: I do not think you can use the word "large".

DR. LOUIS S. REED: You could make the distinction when dealing with the word "crib".

THE CHAIRMAN: The report of the Committee on Standards of Care recommends with respect to cribs that the word "younger" be deleted.

MR. BARKER: I think Dr. McCallum's comment has to do with Schedule 2, Exhibit "E" in the Conference Folder and the section that asks for children's beds and cribs. at the tope of page 2. We were trying to define all the words relative to the Schedule.

MISS F. WEEKES: There is no distinction on the Schedule between children's beds and grown-up beds.

THE CHAIRMAN: Would you be satisfied if we changed the definition of an adult bed to read as follows:

"An adult bed is a hospital bed provided for the use of adults or larger children."

DR. F.W. JACKSON: I am wondering whether there is any need to define an adult bed. Could we not just define a bassinet?

DR. WRIDE: Yes, we could exclude the adult bed and crib and define bassinet.

MR.McGILP: The questionnaire calls for adult beds and then children's beds and cribs so if we define what a child's bed and crib is, the other is self-explanatory

THE CHAIRMAN: What would the definition of a bassinet be?

DR. WRIDE: It gave us a lot of trouble.

Bassinet

THE CHAIRMAN: You say "a bassinet is a bed provided for the accommodation of a 'new-born'".

DR. WRIDE: Yes. We were talking all about

receptacles for new-born and so on but finally settled for that definition.

DR. M.G. McCALLUM: Does that include an incubator?

DR. WRIDE: I would think so.

THE CHAIRMAN: Are you satisfied with the definition of a bassinet? (Agreed.)

We shall then leave out the definition of an adult bed and crib and accept the definition of a bassinet as being a bed provided for a new-born.

DR. WRIDE: An incubator would be just a special bassinet.

MR. McGILP: I do not believe that an incubator could be counted as a bassinet for the construction grant.

DR. GRAHAM L. DAVIS: The American Hospital Manual says to exclude them when rendering figures on bassinets.

DR. H. AGNEW: I would be inclined to consider an incubator as a bassinet.

DR. F.W. JACKSON: For the purposes of a hospital construction grant if an incubator was put in a cubicle it could be considered eligible. If you had a nursery with five cubicles and then a separate cubicle with an incubator that would be considered sufficient. It would classify as a bassinet if it was in a cubicle.

THE CHAIRMAN: Are we agreed then that we shall accept the definition of a bassinet as being "a bed provided for the accommodation of a new-born" and incubators would not be included.

DR. F.W. JACKSON: An incubator takes a new-born.

THE CHAIRMAN: Shall we accept that definition.

(Agreed.)

Regular Staff Member

DR. WRIDE: This definition reads "A Regular Staff Member is one who has been duly appointed to the medical staff of the hospital".

It is taken as understood that each hospital has by-laws governing the admission of staff.

THE CHAIRMAN: The Committee on Standards of Care has suggested a change. Their definition reads:

"Recommended that this be:

Medical Staff Member -

A medical staff member is one who has been duly appointed to the medical staff of the hospital by the governing body under the approved by-laws of the hospital."

DR. RAFUSE: The word "duly" conveys the idea that the staff is appointed under the by-laws. If that is not so then the definition of the Committee on Standards of Care is better.

THE CHAIRMAN: Are you willing to accept the definition of the Committee on Terminology and Classification to the effect that a regular staff member is one who has been duly appointed to the medical staff of the hospital.

DR. M.E.J. STALKER: I think the feeling of the Committee on Standards of Care, with respect to the word "duly", was that in cases where the hospitals have no by-laws there would be an incentive to obtain them.

THE CHAIRMAN: Is there any objection to adding the phrase which deals with by-laws?

MR. A.E. TURNER: Do you not think that you can get a better heading? I think "regular staff member" would be the staff in general.

DR. WRIDE: Do you want to insert the word "medical"?

DR. H. AGNEW: I do not know that the term "regular" is quite right.

THE CHAIRMAN: Is the heading "medical staff member" satisfactory to everyone? (Agreed.)

DR. WRIDE: We will proceed.

Organized Medical Staff

"An organized medical staff consists of duly appointed medical staff members with elected officers who meet regularly for staff conferences."

When there are less than three members it is difficult to elect officers to form the organized medical staff but the committee felt that it did not have to take that into consideration here.

Do you think that the definition should be changed so that two men on the medical staff could be organized and could hold meetings, perhaps with the superintendent of nurses or some such arrangement?

DR. H. AGNEW: The Committee on Standards of Care wished the definition on page 20 of the Conference Folder to be accepted.

One of the reasons for that suggestion is that we find in looking over the reports as compiled that some hospitals do not have organized medical staffs. We have reasonably good evidence from their correspondence that they are far from being organized. The old definition in that event seems to aid in keeping at least a certain standard.

THE CHAIRMAN: What is the general opinion? The recommendation of the Committee on Standards of Care is

that we adhere to the definition in the Dominion Bureau of Statistics instruction.

DR. WRIDE: It would certainly be all right with me.

THE CHAIRMAN: Is there any objection to following that course?

MR. A.E. TURNER: I wonder, when you are dealing with staffs, whether you should not get something that would cover the whole of the staff at the hospital at the same time. Why should you pick out the medical profession?

If we are going to have a definition for the medical staff some of the hospitals will want a definition for the balance of the staff of the hospital.

THE CHAIRMAN: I think that what we are particularly interested in, as far as this item is concerned, is the organized medical staff.

Have you any remarks, Dr. Horowicz?

MR. McGILP: Could Dr. Reed give the definition of an organized medical staff as laid down by the American College of Physicians and Surgeons which rates some of our hospitals?

DR. LOUIS S. REED: I do not know the definition and there are other people here better qualified to try and summarize it. I think probably Mr. Graham L. Davis could do that for you.

DR. GRAHAM L. DAVIS: I cannot define it off-hand but it is in the Manual of Hospital Standardization.

DR. H. AGNEW: I think in substance it is the same as what is contained in the old definition but it has

been dealt with in greater detail. Certainly the old definition would be up to the American College of Physicians and Surgeons requirements and in that way we would have a better qualification.

MR. McGILP: I imagine that a lot of the hospitals right across Canada are rated by the American College of Physicians and Surgeons and the definition approved by that body and our old definition I am sure could be related.

MR. BARKER: In reply to Mr. Turner's remarks, if I understood him correctly, the purpose of trying to define the organized medical staff was to indicate the type of information which the committee felt it was desirable to receive in connection with Exhibit 2, page 2, and Section "E". The question there is relative to the hospital medical staff only. On the next page there is a question concerning the rest of the hospital personnel for which a different type of information is desired.

THE CHAIRMAN: With that explanation are you willing to revert to the definition of an organized medical staff which is set out at page 20 of the manual entitled Instructions and Definitions for Filling In Annual Reports on Public Hospitals?

The definition reads:

"An organized medical staff is one with duly elected officers, through which the doctors working in a hospital exercise supervision over the clinical work of the hospital, hold monthly meetings, discuss the clinical work done in the hospital, provide for the setting up of services, or, in the case of small hospitals, of clinical committees."

Is that acceptable? (Agreed.)

Certified Specialist

DR. WRIDE: We accepted that definition as it stood in the D.B.S. instructions. There was some question about the words "approved by the Royal College but we left it as it was set out in Exhibit 3, Section "C" of the Conference Folder. The definition reads:

"A certified specialist is one approved by the Royal College of Physicians and Surgeons of Canada."

THE CHAIRMAN: Shall we accept the definition? (Agreed.)

Qualified Medical Social Worker

DR. WRIDE: Our definition reads:

"A qualified medical social worker is one who has graduated--" and then we accept the definition as it stood.

"A qualified medical social worker is one who has graduated from a school of social work approved by the Canadian Association of Social Workers, and who has medical or psychiatric field work experience; or a person who has had five years experience in social work under qualified supervision, at least one of which has been under medical or psychiatric supervision."

THE CHAIRMAN: There is just a slight change in the English. Shall we accept that definition? (Agreed.)

DR. WRIDE: The next definition is that of the dietician.

Certified Dietician

"A certified dietician is one who has satisfactorily completed a post graduate course in hospital dietetics

approved by the Canadian Dietetic Association."

THE CHAIRMAN: Is there any objection to that revised definition?

DR. AGNEW: I have no objection to the definition and I am only asking for information.

I want to be sure that we are not accepting something which will fail to receive approval by the hospitals as a whole. The Canadian Dietetic Association has very fine and high standards and they only admit to membership individuals who have graduated from certain schools of Dietetics and then they approve only certain dietetic interneships.

I am not leaning one way or the other but I know there are a good many hospitals which are employing dieticians who are graduates from schools not approved by the Canadian Dietetic Association but they come from good schools--technical schools and certain colleges. They may even have taken interneship but that interneship is not necessarily approved by the Canadian Dietetic Association.

I am bringing the point out because I am not clear on it and I say again that I am not prepared to argue one way or the other but we might find some criticism in having too narrow a definition.

THE CHAIRMAN: Would it be satisfactory if we left off the phrase "approved by the Canadian Dietetic Association"?

MISS F. WEEKES: Does not that raise the same question which is involved in the definition of the certified specialist. It does make a high standard but at the same time if you wish to adopt standards there is something to be said for adopting a recognized standard.

DR. H. AGNEW: The standards are excellent but I do not know whether they are too high to be fair to the other dieticians.

MR. BARKER: In answer to Dr. Agnew's last remark, the definition as contained in the memorandum--the Conference Folder--has not been materially changed by the recommendation of the Committee. That definition too was approved and handed to us by the Canadian Dietetic Association.

MR. JOSIE: The change that has been made in the definition is the deleting of the requirement of the possession of a certificate.

DR. WRIDE: In the committee we felt that mere possession of a certificate should not be the criterion.

MR. JOSIE: If they do not possess a certificate they are not certified dieticians.

DR. WRIDE: You may quarrel with the wording but as a committee we ended up with the feeling that it should be "one who has satisfactorily completed a course--".

THE CHAIRMAN: Will you accept the definition?

MR. BARKER: We could make that read "a qualified dietician" and meet Mr. Josie's comment. Perhaps to be consistent with the two definitions above we should do so but I am afraid that we then could count on two hands the number of qualified dieticians which we have in Canada.

DR. AGNEW: I would be afraid of that. There are many dieticians who, by any standards, would be well qualified for the positions they hold but they would not meet the approval of the Canadian Dietetic Association because that association has certain criterions essential to approval, that is to say certain specified schools for

graduation, certain specified places for interneship, etc.

THE CHAIRMAN: It seems the consensus of opinion is that we might leave the definition as it is. (Agreed.)

DR. WRIDE: Mr. Chairman, the next two subjects, in-patient and out-patient took considerable time in committee and I think any discussion would take at least fifteen minutes more and I would suggest that we adjourn and begin those subjects this afternoon.

THE CHAIRMAN: We will adjourn now and meet at two o'clock this afternoon.

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AFTERNOON SESSION

Tuesday,
Feb. 15, 1949.

Conference Room, Chateau Laurier, Ottawa.

(Mr. H. Marshall in the Chair.)

In-Patient

THE CHAIRMAN: Ladies and gentlemen, we will open the meeting. I shall ask Dr. Wride if he will kindly resume where he left off just before lunch.

DR. WRIDE: Mr. Chairman, we were with some timerity approaching the subject of in-patients and also the subject of out-patients. We finally settled upon the definition of an in-patient.

In-Patient

"An in-patient is one who is duly admitted to the hospital, who would ordinarily occupy a hospital bed or bassinet."

We were occupied with the difficulties inherent in someone who is admitted, goes through the formalities, and is in other words duly admitted, but who arrives at the case-room or operating room and may many hours later perhaps go to the morgue or in some fashion does not reach a bed in the hospital.

Our feeling was that such patients should be considered as in-patients. In the provinces having prepaid plans ours at least pays for in-patient care and we would like to pay for a patient going to the operating room under those circumstances or, to the case-room. We do not pay at the present time for out-patient care. Perhaps it would be wise now to go into the matter of an out-patient.

Out-Patient

"An out-patient is one who makes use of the

diagnostic or treatment services of the hospital but who does not occupy a regular hospital bed or bassinet,--(emergencies not admitted as in-patients and the group formerly classified as outdoor patients are included)."

Emergency, not admitted as in-patients--it is conceivable a patient could come to the admitting room of the hospital and receive treatment right there without the formality of having been admitted to the hospital in the sense that forms were filled out. Service was given, but we thought possibly such patients should be considered as an out-patient. We dropped the term outdoor entirely.

THE CHAIRMAN: Is there any discussion on these suggested definitions?

DR. WINFIELD: I would like to know and I ask why the phrase--"who would ordinarily occupy beds--" is included in the definition of an in-patient.

DR. WRIDE: I think we wanted to show that such a patient, if he had not died, would ordinarily have gotten into a hospital bed. You can see what we were trying to sort out.

We were not happy about it.

DR. WINFIELD: Your definition is being put forward as an amendment to facilitate charges. Would you charge for a patient who was admitted as an emergency, went to the operating room, and died on the table?

DR. WRIDE: Yes, in our province we would. As a province we would pay, considering that patient as an in-patient.

MR. A.E.TURNER: What was wrong with the original interpretation? An in-patient is defined by the Dominion Bureau of Statistics as "--any person housed in the hospital

who occupied a regular hospital bed, crib or bassinet while receiving hospital care". What is wrong with that?

DR. WRIDE: Well, we did not like the word "housed".

"An in-patient is an individual housed in the hospital who occupies a regular hospital bed, crib or bassinet."

MR. A.E. TURNER: You could out out the word "housed".

DR. WRIDE: You mean that it would read "who occupies a regular hospital bed--". The sense of that, we thought, would be a patient had to occupy a bed before he could be considered as an in-patient.

DR. WINFIELD: Mr. Chairman, I rather feel with the words phrased in that way it would allow for taking care of an emergency which might be admitted, let us say to the accident room, and who might occupy a bed in the accident room for a matter of hours without being admitted. The individual occupies a bed but he does not occupy a regular hospital bed.

DR. WRIDE: Mr. Chairman, we would like considerable discussion on this if we could get it, because it is a difficult definition.

THE CHAIRMAN: Yes, now we would like to have views all around the table if necessary on this. Mr. Warren, what have you to say?

MR. A.WARREN: I think this is a perfectly good explanation. A patient who is admitted and who occupies a bed, crib or bassinet, should be classed as an in-patient.

THE CHAIRMAN: Is there anyone who seriously

objects to that definition?

MR. A.E. TURNER: I do not think there is any difficulty with the hospital, at least in our province. Our matrons definitely know what an in-patient is. I do not think there is any question about that point and they do know what an in-patient is.

THE CHAIRMAN: Then there would not be much difficulty about answering this question if it were worded this way.

MISS F. WEEKES: Mr. Chairman, do I understand Dr. Wride to say that the reason he wishes to take occupancy of the bed as the criterion by which an in-patient is defined is because of the fact that people who actually are given extensive care might not occupy a bed and yet be classified as in-patients.

DR. WRIDE: That is a situation which might occur. For example, a patient may spend a lot of time in the case-room. A patient might be admitted directly to the case-room and spend time, perhaps on into the next day, and then actually never occupy a regular bed in the hospital. It would be an unusual thing but it could happen.

DR. J.H. HOROWICZ: Mr. Chairman, might we amend this old definition to read--"an in-patient is one who is duly admitted to a hospital and who usually occupies a regular hospital bed".

MISS F. WEEKES: That is substantially what the definition means.

DR. WRIDE: You would put the word "usually" in place of the word "ordinarily"?

THE CHAIRMAN: The definition would now read:

"An in-patient is one who is duly admitted to the

hospital, who usually occupies a hospital bed or bassinet."

DR. WRIDE: Should it not be "would usually"--

THE CHAIRMAN: Yes, "who would usually--".

I take it there are no objections now? (Agreed.)

We will pass on to the out-patient.

DR. WRIDE: "An out-patient is one who makes use of the diagnostic or treatment services of the hospital but who does not occupy a regular hospital bed or bassinet. (Emergencies not admitted as in-patients, and the group formerly classified as outdoor patients are included.)"

THE CHAIRMAN: Are you satisfied with that definition? (Agreed.)

DR. WRIDE: The next definition is one which caused us considerable difficulty. The definition of an organized out-patient department which we finally offered for your consideration is as follows:

Organized Out-Patient Department

"An organized out-patient department is a department in a hospital--andhere we have repeated department--of a hospital set apart and provided with facilities for the examination, diagnosis and treatment of patients not admitted as in-patients."

Now that is the sense of the definition but we have added another part bedause we felt that the original definition had been helpful to the hospital in organizing its out-patient department. We have added the words--"and where provision is made by the hospital authorities for the regular attendance of members of the medical staff and for the maintenance of records".

THE CHAIRMAN: We are open for discussion. Are there any comments?

Shall we accept the definition as it stands? (Agreed.)

New-Born

DR. WRIDE: We have accepted the definition

of new-born and stillbirths.

MISS F. WEEKES: As Secretary of the Committee on Movement of Patients and Morbidity I think I should draw attention to the fact that the definition of a new-born was considered in part of the Schedule covered by the committee and perhaps Dr. Sellers would like to bring that up now.

THE CHAIRMAN: Would you like to bring that up Dr. Sellers?

DR. SELLERS: I think the only point that would be important as far as our group is concerned is that there is apparently a difference of viewpoint in respect to the suggested limitation inherent in the definition as it stands. I take it that up to this point the definition of a new-born in the handbook that is used by the Bureau is "an infant born in a hospital". The attachment to that definition of a limited period of time seems to me to create some difficulties, first in the enumeration of the individuals to be classified as new-born and in the calculation of new-born days. Formerly, under the payment grant arrangement in the Province of Ontario there was a limited period of time in which the new-born grant was paid and I think that interval of time was fourteen days. Under the present grant arrangement I think I am correct in saying that no limitation is applicable. I think, as far as Ontario is concerned that we would be satisfied as it formerly stood with a period after the word hospital. Perhaps that would be sufficient. I know there are viewpoints to be expressed for example from the Province of Alberta but personally on behalf of Ontario I feel there would be some difficulty in setting an arbitrary period of thirty days.

Dr. M. G. McCALLUM: What about the case of a baby which is a month premature. It stays in the hospital six weeks--in the nursery/but it still cannot be classified as new-born. It is no further along at the end of the six weeks than is the average fully matured baby.

DR. WRIDE: I am not just answering your question but I am adding our experience in Saskatchewan with the pre-payment plan. We had difficulties with new-born infants and prematures. We did not mention immatures but we were looking for a simple question that we could ask the hospitals--how many prematures did you have in the past year--and we put in brackets some short simple explanation. We never did get anything that we could ask the hospital as the difficulty is with the definition of prematures. That definition is involved with prematures and immatures and so on. If you ask the hospital how many prematures did it have you do not get an accurate answer. They will tell you they have nine month gestation babies and they will do anything. The matrons and nurses look at anything which is a little on the small side and they will include that infant in their figures. The figures just cannot be depended upon. From the payment point of view, in the first year of our operation we paid the same for infants--new-born--as we did for adults. Then we made a change whereby we paid $2 for new-born as against an adult rate of so much to the individual hospital. In fact we pay $2 flat rate to all hospitals for new-born so we had to establish what a new-born was for the purposes of the payment. We took the definition of an infant. The feeling was that when it had a lengthy stay, and there was a question as to whether there would be a payment

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If you ask a hospital for the number of prematures it had you do not get an accurate answer. References are made to so many-month gestation period babies; the matrons and nurses look at anything which is a little on the small side and they will include that infant in their figures. The answers just cannot be depended upon.

From the payment point of view, in the first year of our operation we paid the same for infants--new-born--as we did for adults. Then we made a change whereby we paid $2 for a new-born compared with an adult rate of so much to the individual hospital. We had to establish what a new-born was for the purposes of the payment and we took the definition of an infant. When there was a lengthy stay involved a question arose as to whether there would be a payment

at the $2 rate or the adult rate. The feeling was that if the new-born stayed in the hospital long enough to become an infant it was probably sick enough--whether it was a premature or older--to cost the hospital a lot of money and we could reasonably pay the adult rate. So then even a premature, at the end of a month becomes an infant. I am just giving you our experience of what is necessary to meet the need.

MR. A.E.TURNER: Could the baby not be discharged when the mother went out of the hospital and then be re-admitted the same day?

DR. WRIDE: That is the difficulty. When a new-born is re-admitted, as it often is, for a feeding problem or because it had developed an enteritis after ten days--it gets sick and comes back to the hospital--my feeling is it should come in as an infant because it cannot be re-admitted to the nursery because of the need of isolation. It cannot be re-admitted to the original nursery where the $2 rate really applies. If it is re-admitted to the hospital it must be at the adult rate even although it is an infant.

MR. A.E.TURNER: My point was that if a premature baby remains in the hospital and the mother is then discharged at the end of ten days, at the end of that period the baby should be discharged with her.

DR. WRIDE: It remains as a new-born if it stays in the hospital up to the end of one month.

DR. HOROWICZ: I might mention, Mr. Chairman, that our main consideration in setting the thirty-day period was that the neo-natal mortality rates are based on that thirty-day period.

MR. A.E. TURNER: A lot of these babies which are premature take much more looking after than does an adult. It requires more nursing service and I think it is only fair that the hospital receive the extra little bit of money if possible. I would suggest that the baby be discharged at the time the mother is discharged and that might be at the end of ten days, fifteen days perhaps, but not thirty days.

MISS F. WEEKES: Mr. Chairman, is it not true that in Ontario there is a fourteen day limit?

DR. SELLERS: That was the limit formerly but it does not apply now.

MISS F. WEEKES: What is the limit now?

DR. SELLERS: The grant is not based on the interval period it is based on the number of beds.

MISS F. WEEKES: Oh, I see.

DR. McCALLUM: The fact that the baby remains in the maternal nursery has some bearing on the subject.

THE CHAIRMAN: All of the members did not hear you, would you repeat that?

DR. McCALLUM: The fact that the baby remains in the maternal nursery has some bearing on the subject of whether it is still a new-born or not.

DR. WRIDE: We appreciate that and we take care of it when we say that a re-admission does not go back to the maternal nursery.

DR. McCALLUM: Yes, I understand but you get the case of a new-born who never goes back to the nursery but remains more than thirty days.

DR. WRIDE: We would put it on the higher rate at the end of a month.

DR. McCALLUM: We have had experience with that very thing over a number of years.

DR. WRIDE: Is a baby born in a hospital referred to as an admission in your province? Is it admitted to the hospital by virtue of the fact that it is born there? During the committee meeting there was some discussion about that.

DR. SELLERS: If the mother is one the way to the hospital and the baby is born outside the hospital we still call it an admission. The fact that she did not get to the hospital first has no bearing on the subject.

THE CHAIRMAN: Are there any other expressions of opinion? Perhaps we should put this to a vote to see just what the Conference desires. The definition as it stands is--

"A new-born,for statistical purposes, is an infant born in a hospital and remaining therein for a period of not more than thirty days after birth."

Now it has been suggested that the definition be abbreviated and that it read--

"A new-born, for statistical purposes, is an infant born in the hospital."

Some of you would end the definition there.

How many would be in favour of the shorter definition?

How many would be in favour of the longer definition?

I think the shorter definition certainly carries.

DR. HOROWICZ: Would it continue to apply until the baby is entitled to an old age pension, Mr. Chairman?

MR. A.E. TURNER: I would like to have a ruling

on it. We do not think, in my province, that there should be an indefinite period. Would you make it a ten day period?

THE CHAIRMAN: What do you suggest Dr. Sellers?

DR. RAFUSE: Usually the criterion is the lying-in period of the mother.

DR. SELLERS: Mr. Chairman, looking at this from a statistical standpoint, it seems to me that there are two definitions involved and the suggested definition should not be accepted as the definition of a new-born for the purpose of counting the number of such individuals in the hospital statistical returns, because the definition would exclude all new-borns who perchance do remain longer than thirty days. One definition is for the purpose of counting the actual new-born in the hospital and the second definition might be set up to enable the counting of the days of service rendered for those new-born infants. What that definition properly might be I do not know but the suggestion appears to me a good one as it could tie in with the nature of the service rendered.

THE CHAIRMAN: It would seem that the discussion should be re-opened.

DR. RAFUSE: Instead of setting a number of days I think you should refer to the lying-in period of the mother which is the essential thing.

MISS SCOTT: Mr. Chairman, in the old definition it is stated that a new-born is a patient born in the hospital. Then, there is the additional statement that a new-born transferred from the nursery to another division of the hospital is considered, for statistical purposes, a new-born, if treatment is continuous until discharge or death.

I think we should change that and say "for statistical purposes an infant--" in other words, once it goes out of the nursery it becomes an infant and we should not set a time limit. That would cover your difficulty.

DR. WRIDE: We have a regulation wherein if a new-born in the nursery contracts an infectious disease--gets a cold--it is moved out of the nursery and never goes back into it. It might go out of the nursery on the second day.

DR. McCALLUM: It goes into an isolation nursery.

DR. WRIDE: Well, yes.

MISS SCOTT: I do not think it goes to another division of the hospital. I would say it was still a new-born unless it went into another division of the hospital.

DR. McCALLUM: The isolation nursery is part of the nursery and the premature nursery is also part of the nursery.

MR. McGILP: Mr. Chairman, the committee on which I served yesterday,under Dr. Sellers, came to a conclusion on the definition of a new-born.

DR. SELLERS: I missed that.

MR. McGILP: Did our committee not come to a conclusion yesterday on the definition of a new-born?

DR. SELLERS: No.

THE CHAIRMAN: Mr. J.T. Marshall, did you have a suggestion here.

MR. J.T. MARSHALL: What we are trying to do is to get around the point which some of the members wanted to cover, where a mother goes out of the hospital before

the baby and it was felt that the baby should be re-admitted as a new-born at the end of the lying-in period. Some of the members objected to that solution however and we, in the preparatory committee, put down the thirty days merely to bring on discussion. I think the important feature is the lying-in period of the mother.

MR. McGILP: I would like to object to that suggestion because in hospitals in Alberta a new-born in the nursery remaining after the mother is discharged is still treated as a new-born and the charge is made to the mother accordingly. We have no children's rates and if that new-born is no longer a new-born after the mother's discharge a charge will be made to the mother at the full adult rate immediately following her discharge. It would encourage an extra charge.

DR. WRIDE: Would you accept the theory that a new-born leaving the nursery loses its status?

MR: McGILP: Yes, I agree with the definition that it is a new-born as long as it remains in the maternal nursery.

MR. G.W. MYERS: Mr. McGilp's remarks have a bearing and we do change the rate of payment after the infant has been in the hospital thirty days, but for our own statistics we classify new-borns in accordance with the previous definition of the Dominion Bureau of Statistics. If an infant is born in the hospital it is classified as a new-born until the end of its stay. If the type of accommodation is changed and it is taken out of the nursery and put into some other classification the Hospital Plan has no means of knowing that. If the Plan receives a bill

for so many days they know that up to the thirtieth day the charge will be so much and subsequently a higher rate but they cannot know what class of accommodation is received. I know that for our scheme and for any similar insurance schemes that might be set up it would be somewhat difficult to classify new-borns on any other basis than the one followed in the past by the Dominion Bureau of Statistics.

MR. D.W. SIMMONS: I would suggest that the difficulty oe overcome by obtaining a new admission form from the hospital.

MR. G. W. MYERS: That has the objection of putting more patients in than are actually received in the hospital.

THE CHAIRMAN: I understand there is another suggestion which will be put forward in a moment.

DR. WRIDE: The new suggestion is taking these lines. A new-born, for statistical purposes is a baby--we thought if we could perhaps put it that way and get away from the expression infant, as that is a later stage of development, it would be better to say that "a new-born, for statistical purposes, is a baby born in the hospital, for the period during which it receives care in the nursery".

Does that interfere with your mechanism, Mr. Myers?

MR. G.W. MYERS: It would mean another admission form for every infant that remains.

MISS F. WEEKES: Strictly speaking they are new cases. It may be the same individual but from the hospital point of view it is a different case.

DR. M.G. McCALLUM: If they can be moved from the nursery I think it is a new case because it is then being treated for a different condition than that for which it was in the nursery.

THE CHAIRMAN: We seem to be running into considerable difficulty with this definition. I wonder if it would not be a good idea for some representatives of the two committees to get together and try and work out a new definition which could be presented tomorrow?

DR. RAFUSE: Could we not settle this now? I favour the lying-in period of the mother and what you are now suggesting is almost the same thing. The point is if the mother is discharged without the baby being discharged, the baby is not there as a new-born but it is there on account of something else. I believe this new definition has that idea and I would settle for it.

THE CHAIRMAN: I think we should refer it back to the committee and the committee may consult some of the members of the other committees and it will try and work out something.

We will now go on to stillbirths.

Stillbirths

DR. WRIDE: We accepted the definition of stillbirth as set out by the Dominion Bureau of Statistics.

"A stillbirth is the birth of a foetus after a minimum of twenty-eight weeks pregnancy in which pulmonary respiration does not take place after complete birth.

Such foetus may die (a) before birth, (b) during birth, (c) after birth, but before it has breathed."

The committee feels that this definition should

be used until some new definition is adopted for international use.

THE CHAIRMAN: Are there any comments? Is the Conference prepared to accept that definition?

DR. RAFUSE: This does not vary from the usual legal meaning.

MR. J.T. MARSHALL: The definition is used by the League of Nations and the Expert Committee on World Health Organization has on its agenda for its next meeting this item which is to receive early consideration.

THE CHAIRMAN: I take it then that we have completed all of the definitions except the one on new-borns and that will receive further consideration and be presented to us tomorrow.

The next report then will be Dr. Stalker's report on Standards of Care.

Report of the Committee on Standards of Care

DR. M.E.J. STALKER: Mr. Chairman, we have distributed sheets containing a record of our work of yesterday and I think we cannot do better than proceed to examine the various items. Page 1 sets out the definitions which we have already considered this morning. Mr. Josie will deal with the report then starting on page 2, General Information.

General Information

MR. G.H. JOSIE: This deals with Exhibit II, Schedule 1 in Section "E".

Under the heading "General Information" the first item reads--"Is your hospital approved by the American College of Surgeons?"

Yes: Fully.....Yes: conditionally.....
No: .....

There is an amendment there to provide for

conditional approval.

Item No. 2 is "date of last report by the College.....

THE CHAIRMAN: Does the Conference agree to those changes? (Agreed.)

DR. M.E.J. STALKER: The next item is classification of hospitals.

Classification of Hospitals

MR. JOSIE: For statistical purposes it is recommended that: (i) Item 3, ownership be deleted.

(ii) Item 4 be renumbered as Item 3.

(iii) Item 5 be renumbered as Item 4.

(iv) Ownership (above classification) be placed under Classification and be numbered as Item 5.

THE CHAIRMAN: That does not involve any change it is just a re-arrangement. Does the Conference agree with that? (Agreed.)

MR. JOSIE: The deletion of the section is not effected, because ownership is covered as a separate item.

THE CHAIRMAN: Yes, I see what you mean.

MISS A.E. SCOTT: Under the section on Ownership you put the provision for "other" which we discussed this morning. Will that be added to the top of this section? It refers to your Private Hospital set-up and you do not have any place in that grouping to show the Private Hospital.

DR. M.E.J. STALKER: We have an amendment there, Mr. Chairman. Under Ownership we have a new section, Section 2(c). It is recommended that proprietary (private or profit) be added under the new Item 5, Ownership.

MR. JOSIE: The next recommendation is that an

asterisk be placed against "lay" in 2(b) under Ownership, (new Item 5,) and against "religious" in 6(b), with the explanatory footnote to read as follows: "If the hospital is owned by a lay corporation but the services are provided by a religious body, it should be entered as lay under Ownership 2(b) and as religious under Operating Body, 6(b).

DR. M.E.J. STALKER: This morning Dr. Agnew gave us an example of where the Sisters in a hospital supply the services but they do not own the institution. It was felt this provision might help clarify the situation a bit.

THE CHAIRMAN: Is there any discussion on the suggested change regarding Classification of Hospitals for Statistical Purposes? Are you ready to accept the changes that have been made? (Agreed.)

MR. JOSIE: As Dr. Stalker said, it is further recommended that proprietary "private or profit" be added as (c) under the new Item 5, Ownership.

THE CHAIRMAN: Are there any comments or objections? (Agreed.)

DR. SELLERS: Before proceeding further, I would like to raise a question in respect of Item 1 of the classification, the expression "kind of care"? While it does not come into the reports it is sub-divided into General and Special. Is it not a type of service rather than a kind of care that Section 1 refers to? Would that not be a better expression to use?

THE CHAIRMAN: It relates to a definition which we passed this morning and we have to be careful. Is there anyone else who thinks the heading should be changed

from "Kind of Care" to "Kind of Service"?

MISS SCOTT: I think "type of service" is a better expression.

THE CHAIRMAN: How many are in favour of "type of service" rather than "kind of care"?

SOME MEMBERS OF CONFERENCE: We prefer "type of service".

THE CHAIRMAN: That is agreed? (Agreed.)

MR. JOSIE: On page 2 of Exhibit 2, we next come to classification of hospital beds.

Classification of Hospital Beds

MR. JOSIE: It is recommended that Item 2 read as follows:

"2. Bed Complement (Total beds actually set up for in-patients use).

DR. RAFUSE: If any of the members of the Conference object to the way the matter was settled this morning it could quite easily be turned around and I do not think that anyone will quarrel with the way it was settled this morning.

DR. SELLERS: Before we leave the last item I would like to draw attention to the definitions we agreed upon for beds--children's beds and adult's beds in the one definition. In view of the fact that there is now no difference in the type of beds there should be but two columns instead of three.

THE CHAIRMAN: Shall we amend that matter accordingly?

DR. RAFUSE: Will we be amending that in our Standards of Care--deleting it?

MR. McGILP: I do not think it follows that we have to take it out of the Standards.

MISS SCOTT: No.

DR. RAFUSE: You will have to define it then if you are going to use it.

MR. McGILP: It is defined as far as Standards are concerned and the space that is required.

DR. RAFUSE: If you leave this in you will have a better picture of the hospital.

DR. SELLERS: I raise it now because Dr. Jackson proposed the elimination of the two sub-divisions--adult and children's beds. I merely throw it out so that we may simplify the whole procedure.

THE CHAIRMAN: This would have two columns instead of three. Is that agreeable? (Agreed.)

MR. JOSIE: Shall I continue?

THE CHAIRMAN: Yes.

Hospital Medical Staff

MR. JOSIE: It is recommended that Items 1 and 3 read as follows:

"1. Number of doctors on medical staff

Active or attending.....Courtesy.....

Other.....

3. Is hospital open to all qualified medical practitioners for treatment of their patients:

In private and semi-private rooms? Yes...

No.....

In standard wards (a) paying-patients: Yes...

No.....

(b) non-paying patients: Yes....No....."

THE CHAIRMAN: Is there any discussion or any objection to adopting this amendment? (Agreed.)

Facilities for Training of Internes

MR. JOSIE: We proposed that the title should read: "Facilities for Medical Education" and that the section read:

"1. Is hospital affiliated with a medical school for undergraduate medical eduaation?
Yes.....No.....Name University.....

2. Is hospital approved by the Canadian Medical Association for training of internes?
Yes.....No.....

3. Is hospital approved by the Royal College of Physicians and Surgeons of Canada for resediencies in specialties? Yes...No.....
Specify with specialties.....

4. Is hospital affiliated with a university for the training of undergraduate internes?
Yes.....No.....Name University....."

THE CHAIRMAN: Is there any discussion? Is anyone opposed to the amended version?

I take it the section is accepted. (Agreed.)

Nursing Education

MR. JOSIE: The committee recommends that Items 1(c) and 1(h) read as follows:

"1(c) Are the graduates of your school entitled to qualify for, or to apply for, provincial registration? Yes.....No.....

1(h) If school is affiliated with any other institution to provide special courses for the student nurses of your school:

Give name of institution.....

Give nature of course....."

It is also recommended that Item 3(c) read as follows:

"3(c) Are the graduates of your training course entitled to apply for provincial licenses?

Yes.....No.....Not Applicable....."

It is also recommended that section "Miscellaneous" Item 2, should read, instead of "Public Wards":

"Standard Ward - Paying patients

Non-paying patients".

THE CHAIRMAN: Is there any comment or any objection to the suggested changes in this section on Nursing Education? I take it the changes are accepted.

(Agreed.)

Hospital Personnel

MR. JOSIE: It is recommended that the following changes be made in this section:

"(i) For "professional" substitute "medical".

(ii) Technicians to be placed in a new position after nursing.

(iii) Under "nursing" place in brackets after "graduate nurses" the words:

"on hospital payroll as nurses"; and show graduate nurses as:

Registered - Full-time

Part-time

Other - Full-time

Part-time

(iv) After "student nurses and probationers" add in brackets "enrolled in own school of nursing only",and delete (a), (b) and (c).

(v) After the nursing section list:

Pharmacists - Full-time

Part-time

Record Librarians - Registered

Other

Dietitians - Certified

Other."

THE CHAIRMAN: Is there any discussion?

MISS F. WEEKES: With respect to Item 4 and the deletion of subsections (a), (b) and (c), I think we would eliminate the possibility of knowing what the total student nurse personnel was after any particular time. In the discussions of the preparatory committee it was felt that information would be of value--knowing the total number of student nurses both participating in the work of the hospital at a particular time and as a measure of the volume of work in the training school. There are a number of reasons why that information would be desirable and I would be interested in hearing the reasons for having Items (b) and (c) deleted.

DR. M.E.J. STALKER: With the use of the amendment in (iii) you will get the total of nurses, including students in the hospital at the time.

MISS F. WEEKES: This is meant to be a measure of the enrollment rather than the working staff?

DR. M.E.J. STALKER: We thought that if you put in all of them, including others away on courses they might be counted twice.

MISS F. WEEKES: You are speaking of the affiliates The possibility was envisioned but the thought of the prepabatory committee was that the affiliates would not be counted as part of the enrollment but would be counted as

part of the working staff and so we would eliminate the possibility of counting the enrollment only.

MR. BARKER: In furtherance of Miss Weekes' point a question on enrollment is contained in the section on Nursing Education where we ask the question under the heading "School of Nursing - give number of nurses enrolled in your school during the year" and under the heading "Training for practical nurses- how many persons completed such training during the year", and that breakdown was made for the purpose indicated by Miss Weekes' remarks.

MR. JOSIE: I think that the enrollment alone would not cover Miss Weekes' group and I think the idea was that we should get the staff people only and not the people affiliated for training. The point was certainly brought up but the deletion here was made because we thought the information was not sufficiently important to add to our story.

MISS F. WEEKES: If that is the general opinion I am quite satisfied.

THE CHAIRMAN: Have you any comments, Dr. Jackson?

DR. F.W. JACKSON: No, there is some value I think in showing the nurses who are affiliated because certainly they will help to relieve the nursing problem in a hospital.

THE CHAIRMAN: Have you any strong views?

There seem to be some good arguments advanced as to why in recording that particular item we might leave it as it is on page 3 of Exhibit "E"--that is to have it divided into (a), (b), and (c). It would therefore appear the recommendations made by the committee would be changed to the extent that we would not delete those items.

DR. M.G. McCALLUM: You are duplicating the counting of your staff in the various hospitals--you are doubling up.

DR. F.W. JACKSON: Not necessarily.

MR. JOSIE: If we are going to have affiliates then they should be shown under"Nursing Education"rather than under "Staff".

DR. F.W. JACKSON: Yes, that is right. We should guard against the possibility of the same persons being counted in two places.

The school may count the student nurses as enrolled student nurses and some of them may be away on affiliation courses and you would get them counted twice.

MISS F. WEEKES: Could you not overcome that deficiency by classification? My feeling was that the information could be shown both ways and that it would not be difficult, physically, to overcome the problem of duplication.

DR. F.W. JACKSON: I am trying to think now of the Children's Hospital which has a training school and from a class of thirty they send ten, from a class of twenty-four they send six, away every three months to take a course in obstetrics. Those nurses will be shown in the records of the hospital to which they go for the course as affiliates.

MISS F. WEEKES: The idea is that they shall be shown as enrolled in the records of the hospital to which they belong and in the records of the hospital in which they are attending the course they will be shown as affiliates.

DR. F.W. JACKSON: How will you know whether they

are working in the Children's Hospital or not?

MISS F. WEEKES: That is the reason we have the three categories.

DR. F.W. JACKSON: You will not be able to tell where they are coming from?

MISS F. WEEKES: No.

DR. F.W. JACKSON: Out of a class of twenty-four there will six away all the time.

MISS F. WEEKES: You would know that there were eighteen working there.

DR. F.W. JACKSON: Where would you show the eighteen working in the hospital?

MISS F. WEEKES: You would show eighteen students under (a) and you would show the six that were away under (c), and the four from the maternity hospital taking an affiliation course would be shown under (c).

DR. F.W. JACKSON: Do you not think they should also be shown here?

MISS F. WEEKES: No, I would not have the enrollment under the section dealing with student nurses so that there could not be duplication.

DR. A.H. SELLERS: Should we not ask ourselves what is the function of this particular tabulation?

Is it not a tabulation of people rendering service in a hospital? Is not what we want simply the number of student nurses without any reference to the categories in which they fall?

I do not know what use can be made of that type of information at the federal level and I think the essential details--the things about which the question has been raised-

will be found in the reports of the schools of nursing and from that source they can be obtained fairly accurately. For that reason I think they might be omitted from the questionnaire.

This is a personnel statement and I imagine what we want is to get the number of individuals in various categories giving service in the hospitals. The details, however, might well be given elsewhere.

THE CHAIRMAN: Are you satisfied that we should try the amendment recommended by the Committee on Standards of Care?

DR. F.W. JACKSON: I think you should add "including affiliate nurses".

THE CHAIRMAN: Are you referring to page 2?

DR. F.W.JACKSON: No, I am referring to page 3.

MISS F. WEEKES: Would Dr. Jackson favour adding in addition some indication that the students affiliated away are not being included and that it is to be a measure of the working staff?

DR. F.W. JACKSON: You could do that.

MISS A.E. SCOTT: Why not put student nurses and probationers on the working staff, together with a note underneath "affiliates included"?

DR. M.E.J. STALKER: We wondered whether it would be worth inclusion because of the variation in the numbers of the students and the affiliates in different hospitals and the length of time which they remain. There is no uniformity. What would be the value?

MISS A.E. SCOTT: If you included student nurses and probationers on the working staff as at a certain date,

affiliates included, it would give you the working staff on the four dates which you have set out here.

THE CHAIRMAN: Would you like this wording? "Student nurses and probationers on working staff (including affiliated probationers)".

MISS A.E. SCOTT: I think that would give you the picture as of the dates about which you ask. It would give the actual staff.

THE CHAIRMAN: The suggestion has been made that instead of saying "including affiliated probationers", we should say "including affiliates from other schools".

MISS A.E. SCOTT: Yes, that would be right. You know that the affiliates then would not be included because they are away.

THE CHAIRMAN: With that amendment are you willing to accept this item? (Agreed.)

DR. A.H. SELLERS: Before you go on I would like to ask a question. I would be interested in knowing how many provinces make use of the quarterly statement and I would like to ask Mr. Barker what use would be made of the quarterly statements here in the Dominion Bureau of Statistic I am of course thinking of the time involved in preparing such figures.

THE CHAIRMAN: I think that question arose in the discussions of the preparatory committee. We originally decided upon one date but two or three people pointed out that if you took but one date there could be such variation in the staff of the hospitals that you would not get a true picture.

DR. SELLERS: Will the figures that you publish be an average?

THE CHAIRMAN: I think they will be the figures at the four dates--the actual figures.

Departmental and Service Divisions

MR. JOSIE: The suggestion is as follows:

"Recommended that the divisions be shown with medicine, surgery, obstetrics, at the top in that order, with space before listing other divisions.

And further that the list be reviewed by the D.B.S."

We felt that the whole list of specialists should be reviewed at the Bureau with the idea of re-arranging it.

THE CHAIRMAN: Shall we accept this suggestion?

(Agreed.)

Hospital Radiology Facilities and Services

MR. JOSIE: It is recommended that:

"(i) The words "in milliamperes" be inserted between the words "output" and "of" in Item 3,

(ii) Mobile replace portable in Item 3(a).

(iii) Item 4(b) be deleted.

(iv) Item 7 read:

7(a) If diagnostic services are not provided in the hospital, where are these obtained? .....
Name hospital or other agency providing service .....

7(b) Similarly for therapeutic services .....

....."

DR. G.A. WINFIELD: Why was Item (b) in section 4--"radiotherapists" deleted?

DR. M.G. McCALLUM: I will move that it be replaced.

MR. JOSIE: We discussed the matter last night and wondered whether we needed that amount of detail.

THE CHAIRMAN: Are there any other suggestions?

Are you agreeable to accepting the recommendation as read by Mr. Josie with the exception of the deletion of the section on radiotherapists which we shall retain?

(Agreed.)

Hospital Laboratory Facilities

MR. JOSIE: It is recommended that:

"(i) 2(c) read biochemists

(ii) 2(d) and 2(e) be interchanged and that "qualified" be deleted; and that opposite "Technicians" there be a space to indicate "Certified Technicians".

(iii) In 3(a) "basic" be replaced by "routine" and in the next line place the word "complete" before "blood counts"."

THE CHAIRMAN: Is there any discussion on this section? Shall we accept it? (Agreed.)

That completes the report then, of the Committee on Standards of Care and we shall proceed now with the report of the Committee on Movement of Patients and Morbidity.

Dr. Sellers is the Chairman of the committee and I shall call upon him now.

Report of the Committee on Movement of Patients and Morbidity

DR. A.H. SELLERS: The committee of which I am

the Chairman was concerned with directing attention to the material that was comprehended in documents "F" and "G" in the Conference Folder.

At the outset I would like to say the committee concerned itself with what it considered to be the objective of hospital statistical data. As members we asked ourselves the question "What needs are intended to be served by such information?" and we queried ourselves on the points of view from which we should approach documents "F" and "G".

I think I am correct in saying that it was the consensus of opinion of the committee--almost a mere statement of fact--that the needs of the Federal Government are less comprehensive with respect to statistical information than are those of the provinces. Furthermore such returns, records and hospital reports of statistical information which are received serve an important function not only for government agencies but for hospital management and the medical staffs of the individual hospitals. In effect we believed our concern was with the designation or description of the apparent minimum retirements for national use. The mimeographed statement which we have prepared contains a reasonable summary of the views of the committee in respects to documents "F" and "G".

I think perhaps we might now look at document "F" which is Schedule (ii).

Beginning with the title of the Schedule, it occurred to us that it might be closer to the truth if it were to read "Movement of Patients and Volume of Service". That is the recommendation of the committee with respect to the title.

The suggestions with respect to this Schedule are rather short and perhaps I might just pursue the Schedule before we seek comment.

The second observation which we make arises because it was thought useful that provision be made for the totals for adults and children and for new-born, with reference to Item (a), that the final total column might well be deleted.

The argument behind that suggestion is that the column at the right has no useful statistical meaning.

With respect to Item (c) it is recommended that the following changes be made.

"1. That the total column be deleted.

2. That Items 9a and 9b be deleted.
It was felt that some provinces might wish to obtain this type of information for their own use, but because of lack of precision in reporting and the lack of comparability of practice in different provinces, the items should be omitted from a national form.

3. That the columnar titles be repeated for Item 10.

4. That the following item be added as No. 11: 'Average length of stay (Item 10 divided by Items 4 plus 5)'."

With respect to Item "D" the committee was in agreement that the simple requirement as now stated was acceptable but having in mind the fact that there was formerly a special form for the collection of data on organized public out-patient departments--the second last

form in Section "E" of the Book--wherein was asked the number of patients treated, the number of treatment or visits by the service department, it was felt there was such a need on the part of the provinces and the Bureau and that need might be met by simply making a division of the column in the department and services divisions of the hospital.

The suggestion as worded in our report is:

"That Item D be adopted in the form proposed, but that provincial authorities give consideration to the possibility of showing this information in connection with the departmental and service divisions."

The suggestion was thrown out as being a simple means whereby the previous plan of collecting out-patients statistics on a separate form could be dropped but the information could be still collected in this simple fashion.

That, Mr. Chairman, is a summary in respect of our decisions respecting that section of the document.

THE CHAIRMAN: Youhave heard the suggested changes, is there any discussion?

MR. A.E. TURNER: Mr. Chairman, we would like to see Items 9a and 9b retained. Do the vital statistics people not wish that information?

MISS F. WEEKES: I think there was some question of the reliability of the returns.

MR. A.E. TURNER: There is no doubt about that.

MISS F. WEEKES: The question arose as to the distinction between care in private and semi-private rooms and the care which was paid for as semi-private or private.

Mr. McGilp made specific reference to hospitals in Alberta where there is no distinction between a public room and a private room. He indicated that for Alberta the old distinction has been pretty well abolished. After a long discussion we felt that the only really reliable guide was the amount of money being charged.

MR.A.E. TURNER: No, it is not that at all, we want the statistical information, the number of patient days.

MISS F. WEEKES: Irrespective of whether they are being paid for?

MR. A.E. TURNER: The money does not enter into it.

MISS A.E. SCOTT: For what purpose do you use the information?

MR. McGILP: I would like to ask Mr. Turner what his definition of a public ward is?

MR. A.E.TURNER: A public ward is a ward with probably three or four or five beds.

MR. McGILP: I should have asked what his definition of a private ward is?

MR. A.E. TURNER: A private room is one with a single bed and a semi-private has two beds.

MR. G.W. MYERS: Some semi-private rooms in some provinces have more than two beds.

MR. McGILP: The definition given by Mr. Turner is not correct insofar as Alberta is concerned. The small hospitals being built today in Alberta--25 to 50 bed hospitals--have two-bed rooms as the largest. That is the standard, and they have no private or semi-private

rooms. It is only in the larger hospitals where they have rooms set specially apart in which better than basic standard care is given and you pay for that extra care. It is not the number of beds in the room which determine whether it is a private, semi-private or public ward.

DR. A.H. SELLERS: Speaking as a representative from the province of Ontario and not as Chairman of this committee, I think that our feeling would be that we can collect useful information in categories 9a and 9b and that information would be particularly useful in the larger hospitals where the position is generally pretty clear. We would use that information in planning the activities of the hospital, planning extensions of building comparable facilities elsewhere and so on. I think that we in Ontario would like to retain that information.

THE CHAIRMAN: What is the reaction of the members from the Maritimes?

DR. J.J. MacRITCHIE: We do not make any distinction. In the new Victoria Hospital in Halifax a semi-private ward has six beds.

THE CHAIRMAN: Are there any other views?

DR. J.J. MacRITCHIE: The rates are the same in semi-private and private wards.

MISS F. WEEKES: In view of the fact that one of the primary considerations in the committee's recommendation that the distinction be eliminated was the conviction that we all had that there was really a lack of comparability between the provinces with respect to the item and that information shown on a national basis would be misleading, possibly it would be a good idea to meet Dr. Seller's point by leaving the items alone. The

information could be retained for provincial use.

THE CHAIRMAN: That is true, and we would not publish it for the Dominion as a whole.

Does that suggestion meet with the approval of the Conference? We shall leave the questions numbered 9a and 9b as they are but the Bureau, when making compilations for the Dominion as a whole will not include the figures submitted under those two items. If a province wishes to make use of the information it can do so.

Is that solution satisfactory to everyone?

MR. D.W. SIMMONS: Could you separate "private" and "semi-private" and make separate items of them?

THE CHAIRMAN: You would make three categories instead of two?

MR. D.W. SIMMONS: Yes.

THE CHAIRMAN: Is there any objection to that?

MISS A.E. SCOTT: In that connection the committee decided, before deleting items 9a and 9b that we would also throw out items (a) and (b) in connection with new-born which would be shown with one figure. There is no point in breaking it down.

THE CHAIRMAN: That could be covered by a note in the questionnaire.

DR. A.H. SELLERS: I am not quite clear as to the suggested useful purpose in making three divisions instead of two.

MR. D.W. SIMMONS: All our revenue is going to be kept in three divisions.

MR. G.W. MYERS: I notice that the sex of the patients in item "A" is indicated on the form with respect to in-patients but it is omitted under the heading "patient

days". I wonder if that difference was considered by the sub-committee and whether there is any value in retaining the feature in both sections?

DR. A.H. SELLERS: Actually it was not considered by the sub-committee and our aim was to achieve the maximum possible simplicity. There may be a good argument for keeping the similarity--if we have it in one place we should have it in the other.

MR. G.W. MYERS: Is it necessary to have that reference in "A"?

MISS F. WEEKES: They certainly should be consistent.

MR.D.W. MYERS: I know that statistical studies indicate that there is a difference in the volume of care required by different sexes.

THE CHAIRMAN: Does anyone object to leaving the reference to sex in section "A" and likewise inserting it in "C"?

MR. McGILP: Would it not be better to eliminate the reference from "A" to conform with "C"?

Simplicity, as Dr. Sellers says, is what we are after.

MISS F. WEEKES: That is true, up to a certain point, but we are seeking good information.

MR. D.W. SIMMONS: It is certainly making it much harder for the hospitals.

DR. A.H. SELLERS: I would like to propose that the reference to sex be deleted.

THE CHAIRMAN: Is there anyone who objects to deletion of the reference to sex in "A"? Shall we accept that suggestion? (Agreed.)

To review what has transpired here, we have decided that with respect to "C" that we shall retain items

9a and 9b, that we separate private from semi-private, but that the Bureau will not publish a total for the whole Dominion. There was also the suggestion that the title should be changed from "Movement of Patients" to "Movement of Patients and Volume of Service".

It is suggested further that we should omit the total columns in "A" and "C". The suggestion is also made that the columnar titles be repeated for number 10 under "C" and that there should be a new item, number 11, reading: "Average length of stay".

DR. E.R. RAFUSE: Would you change the words "public" to "standard"?

THE CHAIRMAN: Yes it is suggested that we change "public" to "standard".

Are there any objections to the suggestions which I have enumerated? Shall we accept them? (Agreed.)

DR. A.H. SELLERS: Before passing to the question of morbidity I think it is worthwhile to note that Schedule 2 as it now stands requires only half the information that it previously required. Two whole sections have been deleted--one was birthplace, the other was distribution by residence, and the balance has been simplified extensively.

The next section of our report deals with definitions but as all of the items have been covered we need not spend further time. Page 2 of the report deals with hospital statistics and hospital morbidity statistics.

The committee gave some quite extensive thought to collecting and preparing hospital morbidity statistics and hospital statistics generally.

Hospital Statistics and Hospital Morbidity Statistics

The committee was in agreement that such data was

valuable and may in fact be required not only locally in the operation of a hospital but in the establishment of functional control in hospitals and in the effective planning of hospitals. The committee also felt it should express the opinion that recognition should be given to the collection and analysis of hospital statistics on morbidity is a large order and an expensive contract. I shall read now from therreport.

"The committee discussed the extent to which an annual statistical return could provide all the information concerning hospital work load which was essential for the study of health problems and for hospital planning.

It was agreed that such a return could provide a convenient summary of the annual volume of care, but that it was not appropriate for collecting information describing hospital population and morbidity in relation to the care provided, nor could such a return effectively meet the requirements of those concerned with hospital planning or with the functional control of hospitals.

It was felt that it was desirable to obtain this type of information, which is ordinarily available in hospitals and the committee agreed that the Conference should recommend that the provinces give consideration to collecting hospital morbidity data. It was recognized that information of this type is already being received in the four western provinces, and in Ontario and Prince Edward Island.

The committee agreed that it was desirable to obtain such morbidity data, and could effectively be secured through the use of an individual discharge form or an equivalent arrangement. Such machinery might provide the following information with respect to every

patient:

1. Record number of patient
2. Residence of patient
3. Marital status - married, single, widowed,divorced, separated
4. Year of birth
5. Sex
6. Date of admission
7. Date of discharge.....Date of death.... Was autopsy performed?.....
8. (a) Primary diagnosis
   (b) Secondary diagnosis
   (In order of their importance).
9. Any operative procedure done during the current hospitalization.....
10. Person or agency responsible for payment of the account.

The committee recommended that, in recording diagnosis, the Standard Nomenclature of Diseases be used as the accepted dictionary of medical terms and that the International Statistics Classification of Diseases, Injuries and Causes of Death be used as a method classification.

The committee gave consideration to the problem of comparability in tabulating provincial morbidity data, with particular reference to the leading causes of hospitalization and uniform classification of chronic conditions. It was decided that discussion of these matters might be deferred until more experience is accumulated by provinces compiling morbidity data."

There is nothing further I wish to say except to

make the general comment that the committee did recognize that there was a need for morbidity data which is not being met and which can be met usefully by a compilation of the information which is being recorded day by day and filed in the hospitals across the country. The committee recognizes and wishes to give expression to the thought that it is a problem which requires experience to develop and it requires money as well. On this ground it is opportune to proceed slowly but to proceed.

If it would simplify proceedings I would like to move that the morbidity section of this particular report be accepted.

THE CHAIRMAN: It is moved by Dr. Sellers that the morbidity section be approved.

MISS F. WEEKES: I would second that motion.

THE CHAIRMAN: Do we want to have some discussion?

DR. RAFUSE: Does the Standard Nomenclature of Diseases include "operations"?

THE CHAIRMAN: I did not hear that, Dr. Rafuse?

DR. RAFUSE: I was only commenting on the fact that in the report of the Committee on Terminology and Classification the word "operations" appears.

THE CHAIRMAN: Does the Conference wish to discuss this matter of morbidity to any further extent this afternoon? Perhaps tomorrow sometime we might have a discussion as to the advisability of forming some sort of an organization, perhaps a continuing committee, which might make further studies and recommendations.

Shall we accept the report, subject to further consideration as to the advisability of setting up a committee? (Agreed.)

Report of the Sub-Committee on Finance

THE CHAIRMAN: I shall now call on Mr. A. F. Moffat.

MR. A.F. MOFFAT: Mr. Chairman, I think that I should start by reading the report.

"The committee has reviewed the material submitted to the Conference for consideration relating to the Financial Statistics on Hospitals and presents herewith revisions and modifications for such action as the Conference may deem advisable.

Primarily, the recommendations of the sub-committee with reference to the Income and Expenditure statements, which are attached hereto, apply to general hospitals only. The committee has also made minor revisions in the Classification of Balance Sheet Items, which will be reviewed when presented. Some modification of the proposed classifications may be required for sanitoria, mental hospitals, and hospitals operated by the Dominion or Provincial Governments.

The committee wishes to refer to the Conference specifically, the question of having hospital statistics handled through the appropriate provincial authorities concerned. It is felt that there would be many advantages in following this procedure and it is, therefore, suggested that the Conference give consideration to making a recommendation in this respect.

The committee recommends the adoption of the following general principles relating to the reporting of hospital plant and the evaluation of contributed services:

1. Hospital Plant - That hospitals should report the gross value of the total plant in use, including donated plant.
2. Depreciation - That depreciation should be recorded and reported on the gross value of total plant and facilities in use, including donated plant.
3. Contributed Services - It is recommended that the treatment requiring such contributed services to be recorded as income be revised. It is considered to be optional rather than mandatory.

In redrafting the statistical forms, it is suggested that a standard size be used (8½ x 14); that standard typewriting spacing be provided in both the horizontal and vertical rulings; and that the financial data be reported in dollars only.

It is recognized by the committee, and considered essential as a prerequisite to the introduction of new reporting schedules, that a revised edition of the "Instructions and Definitions" for completing annual reports of hospitals, be prepared in keeping with the revisions made in the financial statements and the recommendations of this Conference."

I will now deal with Income.

"1. DAY RATE SERVICES:

10. Private
11. Semi-private
12. Wards
13. Nursery

2. SPECIAL SERVICES:

20. Operating Room

21. Delivery Room

22. Radiology

23. Medicine

24. Dressings

25. Laboratory

26. Special Nurses Board

27. Emergency

28. Physiotheraphy

29. Other (specify)

3. GROSS EARNINGS

4. DEDUCTIONS

40. Rebates

Written 41. Courtesy

off. 42. Free

43. Provision for Bad Debts

5. NET EARNINGS (Must agree with item 5 of schedule)

6. GRANTS - PROVINCIAL GOVERNMENTS

60. Per Diem Grants

61. Other Grants (Ex Capital)

62. Government Appropriations

7. GRANTS - MUNICIPALITIES

70. Per Diem Grants

71. Other Grants (Ex Capital)

72. Budgeted Appropriations or Tax Levies

8. GRANTS FROM HOSPITAL CARE PLANS (EX-CAPITAL)

80. Provincial

81. Municipal

82. Other

9. MISCELLANEOUS

90. Contributed Services of Personnel (less perquisites)

91. Private Donations

910. Endowments and Trust Funds

911. Other

92. Interest (Ex-Endowment and Trust Funds)

93. Cash Discounts on Purchases

94. Net Income from Farm or Garden

95. Other (specify)

10. TOTAL INCOME"

Mr. Chairman, ladies and gentlemen, you will note that the statement of Income and Expenditure which is first mentioned is somewhat different in form than that which is contained in Exhibit 2, section "H" of the Conference Folder.

The committee first discussed this problem relating to the information which hospitals generally keep and the information required by the Dominion Burea of Statistics. It was felt if we adopted such a method chances of success would be increased. We follow the system upon which most hospitals operate and give the Dominion Bureau of Statistics the information it requires. The analysis of net earnings, page 1(a) of the report ties in with the gross earnings referred to on page 3.

I think we have arrived at a very simple solution in adopting Schedule 1(a). It is at least the majority opinion of the committee that they would like first of all the day rate services split up into private, semi-private, wards and nurseries. Secondly, that special

services set out in this form can be linked with the functional expenditures.

The next item deals first of all with rebates, courtesy,--free service, and provision for bad debts. The committee was not unanimous, but again it was a majority opinion that free service should be included at this point. Perhaps if there is to be discussion on this matter now would be the time.

MR. A.R. DAVEY: This matter was first brought up when we were making a division of the forms in 1946. At that time we went into the question very thoroughly and felt that hospitals in Ontario--and I feel certain hospitals in other provinces too--cannot provide accurate figures on free service. In my opinion it is misleading. Not everyone can read a set of financial statements and if the hospitals turn in a statement to the hospital authorities which shows gross revenue very often they do not bother with the rebates, courtesy, and free service or if they do it seems to be exaggerated.

There is another point in the present form, if we take the item free service it is listed as one total only. From the hospital point of view I think it is desirable to know what type of free service it was. In other words they want to know whether it was free service given towards maintenance or cost of special services or was it in the operating room? There is also the objection against the amount of work involved. If you set this free service up in the books you will either have reverse entries or there is a great danger of what I think you will find in most cases that it is left in the books indefinitely and written off in a future year as a bad

debt, and that certainly gives a totally misleading picture. As far as the maintenance part goes, with respect to bed rates, I think that it was felt that they could apply a certain rate to each bed and say "that is the rate and anything lower would be free service". That may be all right for the larger hospitals but I do not believe it can be done in the small hospitals for the reason that they have to divide between male and female and the sections must be kept separate. The obstetrical section must be kept separate certainly.

It was mentioned that in Alberta that a large number of the rooms have two beds one of which may be occupied by a semi-private patient and another by a public ward patient and the beds may be interchanged according to the number of patients coming in. For that reason I believe that the free service element is definitely misleading.

MR.A.E. TURNER: Probably these gentlemen would let us know how we are to differentiate between gross earnings and what we actually get? In our province there is no such thing as charging $2 for one bed and $4 for another. We have a gross revenue and I believe that the difference between the two beds should be shown as free service. The matter of the Blue Cross rates and so on enter into the picture.

MISS F. WEEKES: I would like to ask Mr. Turner about the relationship between his charges.

If you have two patients, one is public and the other semi-private the amount you charge is not recorded as gross earnings but it is rather a theoretical charge is it? Is it the amount you would charge if you charged both of them at the same rate?

MR. A.E. TURNER: Before you get too far, the board of the hospital meets and sets the rates which are to be charged. There is a rate set for the private ward, the semi-private wards and the public wards. No one can change those rates and they must pass through the register at those rates.

MISS F. WEEKES: I think Mr. Davey wanted to ask why?

MR. A.E. TURNER: Because they are the earnings of the hospital.

MISS F. WEEKES: No, it is the rate that would be charged--I don't understand then what your earnings mean.

MR. A.E. TURNER: The rates of the hospital are generally set so that if there is one hundred per cent collection of the accounts you will come out even. The rates are set according to what the cost to the hospital will be.

MR. G.W. MYERS: I wonder if I might read from the Manual of Instructions and Definitions for Filling in Annual Reports on Public Hospitals as it refers to free service? It says:

"Enter here all credits given to persons solely because, after careful investigation, it is found they are unable to pay the whole or part of the regular hospital rate, and are not likely to be able to pay in the future."

MISS F. WEEKES: That is one of the deductions from the theoretical charge.

MR. WALTER B. DICK: It seems to me there should be one rate for the hospital and for control purposes that should be the rate which the office should use, and as Mr.

Turner has said, the difference between that rate and the amount which is collected should be accounted for, for control purposes in another fashion. I think most of the accounting manuals developed by the American Hospital Association call that gross earnings. It is a control feature and it should be important information for the Board. The question would come up as to the terminology, whether it should be under rebate, courtesy service, or free.

I think the definition given by the Dominion Bureau of Statistics is one with which I cannot agree from an accounting point of view. Although there may be two rates in fact, it should not be so and there should be one rate that would apply.

THE CHAIRMAN: Mr. Lowther, would you like to add a word?

MR. J.H. LOWTHER: I think perhaps I have contributed too many words already on this matter. This seems to be a compromise from the original submission to the Conference.

THE CHAIRMAN: Would you speak just a little louder, please?

MR. J.H. LOWTHER: The original submission to the Conference made no provision in the Income Statement for reporting gross earnings of the hospitals but it presumed that the Income Statement would reflect only the actual amount that was received for the treatment of patients.

It was found in the deliberations of the subcommittee that was contrary to the practice in a number of provinces. We were also informed that it was contrary to the practice that is followed in the United States. Mr.

Davis gave us that information with the result that the committee's recommendation was modified, recommending that both gross and net earnings should be recorded in the Income Statement for two reasons.

One reason, as Mr. Turner mentioned, is that the rates for accommodation are fixed by the hospital board at so much for each different type of accommodation provided in the hospital. It became a matter of good bookkeeping then and good administration to record the charges on the basis of the prescribed rates set by the hospital board. It then becomes necessary also to make a correcting entry against those charges where it is known that you will not receive the full amount that is charged for the particular accommodation received. Provisions is made for that in the section for deductions. The result then is that you will have both figures in your Income Statement.

It appears, however, that in at least one province they do not follow that practice. As I understand the situation the province pays a grant to each hospital at the rate of $1.75 or some similar amount per patient per day and per bed. That is not in the form of day rate service or at least it is not considered income as we normally understand it. If the municipality pays the hospital a fixed rate of $2.50 a day for accommodation and service provided that, however, would be shown as income either at day rate or special service rates as the case may be.

The effect then would be that in the Income Statement for Ontario hospitals, according to present practice, they should only show as income from patients a

portion of the total revenue because part of it comes from the municipality. Actually, if the bed were occupied by a paying patient the income would be recorded as $4 or $6, whatever the standard rate might be.

The Bureau is concerned with the actual income of the hospital and consequently the committee's revised income classification provided an analysis of the net earnings by sources and that gives the information desired by the various Federal officials concerned with Hospital Statistics.

Probably I am the last person who should support this argument but I have been slowed down in the last two days.

As Mr. Davis suggested one of the very important reasons to set up your charges at the gross rates,--standard rates the rates for your rebates and the remissions in connection with free treatment, is that you are the people who are responsible for the different classes of patients and that they should receive the service which goes with those classes.

MR. G.W. MYERS: It was a matter of compromise and there were two points of view not easily reconcilable when we learned that the Dominion Bureau of Statistics was interested in the net earnings only and wanted it split up into sources. We felt by leaving it in we might be interfering with provinces doing just as how now been described.

I can assure you that in most hospitals they do keep track of this matter of full charges and rebate for free service and it was for that reason that the majority of the committee decided to leave the matter as it stood. I do not know whether Mr. Davey has anything further to say?

MR. A.R. DAVEY: I think that takes care of it pretty well.

MR. A.R. MOFFAT: I might say that when I was making my preliminary remarks about the report page 1(a) takes the place of the draft for discussion--Exhibit 2--and pages 2, 3, 4, and 5, are now numbered similarly to the draft under discussion.

In the first Statement of Income you will see that we have incorporated all the suggestions made in the draft.

These items I think have the unanimous approval of your sub-committee and unless there are further questions we might proceed to Schedule 2.

MR. D.W. SIMMONS: Under "special services" on page 2 you have not included radiotherapy? Is that intended to be included under "other"?

MR. A.F. MOFFAT: I do not know offhand whether radiotherapy was mentioned in the draft but I think it would fall under "other(specify)". I think that might be developed too as the mechanics of this form are worked out.

THE CHAIRMAN: Are there any more questions on this part of the Statement?

MISS F. WEEKES: Any Dominion Government payments are reflected as part of the day rate service--is that right? I am referring to the first page.

MR. A.F.MOFFAT: Yes.

MISS F. WEEKES: That, I suppose, is generally true and some of the money shown as municipal grants is also shown as free service. It corresponds to some of the free service items.

MR. A.F. MOFFAT: They are generally paying going rates.

MISS F. WEEKES: I was just wondering how far this item of deductions for free service would be covered by municipal payments and how much difference between the gross and the net is attributable to it?

MR. A.F. MOFFAT: Would you suggest that Item 42 might be broken into "free" and "other"?

MISS F. WEEKES: No, but I just wondered whether the difference between the charge and what the municipality would pay would be reflected there.

MR. A.F. MOFFAT: You mean in all the provinces?

THE CHAIRMAN: If there are no more questions we will go on.

MR. A.F. MOFFAT: Mr. Lowther has made the suggestion that the title on page 1(a) should read:

"Source Analysis of Net Earnings."

I agree that it is a better title.

"1. PAYING PATIENTS

2. CONTRACTS

20. W.C.B.

21. Other

3. GOVERNMENTS (FOR CARE OF PATIENTS)

30. Dominion

31. Provincial

32. Municipal

4. GOVERNMENT HOSPITAL CARE PLANS (FOR CARE OF PATIENTS)

40. Provincial

41. Municipal

5. TO RECONCILE TOTALS

Item 5."

There is very little for comment there.

"CLASSIFICATION OF EXPENDITURES:

1. GENERAL ADMINISTRATION
2. CARE OF PATIENTS -
    20. Medical and Surgical
    21. Nursing (Including school)
    22. Medical records and library
    23. Dietary and culinary
    24. Laundry, linen and sewing
    25. Housekeeping
    26. Other (specify).....
3. SPECIAL SERVICES (Or facilities)
    30. X-ray room
    31. Laboratory
    32. Operating room
    33. Delivery room
    34. Nursery
    35. Pharmacy
    36. Cardiography
    37. Basal Metabolism
    38. Physiotherapy
    39. Other (specify).....
4. OPERATION AND MAINTENANCE OF PHYSICAL PLANT
    40. Operation
    41. Maintenance and repair of buildings
    42. Maintenance and care of grounds
5. OUT-PATIENT DEPARTMENT
    50. Care of Patients
    51. Other (specify).....

6. PROVISIONS FOR RESERVES

60. Depreciation

Buildings

Furniture & Fixtures

Equipment

61. Other (specify).....

7. DEBT CHARGES

70. Interest on Debentures

71. Interest on Mortgages

72. Interest on other borrowings

8. TOTAL EXPENDITURES."

Under the headings "General Administration" and "Care of Patients", "Special Services", "Operation and Maintenance of Physical Plant", "Out-Patient Department" there was general agreement. When we came to Item No. 6 "Provision for Reserves" it was agreed by the committee that depreciation should be shown under the various headings--buildings, furniture and fixtures, equipment, and other. It was also agreed that it should be shown in place of debenture charges and debt charges which are now shown in a separate Schedule numbered 7.

MR. D.W. SIMMONS: Is it necessary "equipment" be shown separately from "furniture and fixtures", in connection with depreciation?

MR. A.F. MOFFAT: No. In drafting this we set it up that way but it might very well be combined.

MISS F. WEEKES: I don't know very much about this but I was surprised to find Item No. 7, "interest on debentures, mortgages"and so on, as well as depreciation in that schedule. Sometimes you see schedules that contain depreciation and others have the sort of items shown in

the former schedule which include principal and interest together. Would you be kind enough to explain the reason for showing depreciation and debt charges separately?

MR. A.F. MOFFAT: The item concerning depreciation was actually in place of additions to physical plant.

The sub-committee, after much discussion, felt the changes should be made because depreciation could be included in the correct account. The debt charges set out in Section 7 do not make any provision for principal repayment which item is shown in the capital statement to which Mr. Lowther referred. Interest on borrowings however is considered part of your operating expense.

Have I answered the question?

MISS F. WEEKES: You have answered the question but I still think one sometimes sees financial statements with interest and depreciation not shown separately. This approach--showing it in this way--may be standard practice and if so I am very interested in knowing that.

MR. A.F. MOFFAT: It is not felt that payments upon principal sums of mortgages is any part of the operating expense.

MR. McGILP: I would like to hear from representatives of the Bureau why it was found necessary to change Schedule 3.

In Alberta we had some trouble getting the system started. We had a series of educational schools last year and finally educated the hospital officials concerned. It is my belief and the belief of all the hospital accountants in Alberta that there was no finer statement ever produced.

I cannot see where we are going to improve Schedule 3 by the adoption of the new proposals.

I would like to hear from the Bureau as to the reasons for the change.

THE CHAIRMAN: In the first place, it seems to me that there is undoubtedly a growing need for more comprehensive statistics in general in the health field.

When this Conference was first mooted it was felt we should have a preparatory committee working in Ottawa to find out what the needs of the various departments of the government were and later, when we had studied the matter in the committee and prepared a memorandum to send out to the provinces, we would obtain the views of the provinces and be able to find out what the other needs were. That in general is the purpose of this very Conference.

In the preparatory committee we had numerous sub-committees one of which had to do with finance. The Committee on Finance did a tremendous amount of work and they produced the work which was sent out to you. We had the larger committee appointed yesterday and that committee has gone over the report of the preparatory committee and these are the suggestions which have been evolved. The report before us seems to me to be the result of the combined opinions of the members of the preparatory committee and those who worked on the subject as delegates of the provinces.

If either Mr. Moffat or Mr. Lowther could add something I would suggest that they do so. Do not forget that this is not a Dominion Bureau of Statistics matter alone,--we are not only trying to meet the needs of the Bureau and the various departments of the Dominion government but also your needs.

MR. A.F. MOFFAT: The consensus of opinion of hospital accountants from coast to coast--I am not speaking for all of them but rather for the ones who have given considerable study to the matter--is that Hospital Accounting should be put on a functional basis. I mean to say that you want to know the cost of the x-ray service, the laboratory service, your operating room and so on, and that idea is the basis of the statement. Whether it is complete cost accounting or not in most hospitals we know that our costs are distributed by some form of accounting. We know, for instance, that the cost of our x-ray room includes salaries and equipment and other things. The old system was not set up on a functional basis but it is the recommendation of the committee that we should handle our accounting on such a functional basis.

THE CHAIRMAN: Gentlemen, we certainly cannot finish the discussion of this report this afternoon and I think perhaps this might be a very good place to stop.

MR. McGILP: I would just like to reply to Mr. Moffat's statement and say that the reason the schedule, as it stood, was so attractive was that we must remember we have small hospitals in our province. Ninety-six per cent of our hospitals are small. Those small hospitals have part-time administrators and part-time accountants. As a matter of fact I query the expression "accountant" when used with respect to those little hospitals and we have found that to the departmentalize in those little hospitals is impossible..

THE CHAIRMAN: I think Mr. McGilp's point needs to be given consideration. Perhaps the evening will give us time to turn the matter over in our minds and we will resume the discussion tomorrow morning.

. . . . . .

Wednesday,

Feb. 16, 1949.

Conference Room, Chateau Laurier, Ottawa.

(Mr. H. Marshall in the Chair.)

THE CHAIRMAN: Ladies and gentlemen:

Before we go on to further consideration of the report of the sub-committee on Finance there are two remarks which I should like to make by way of introduction this morning.

I think I should make it clear that there are two aspects as it were to this Conference. In the first place we are trying to place before the Conference a clear idea of the needs for improvement in statistical information on hospitals. We have consulted with the various departments of the Dominion Government and we have now had the benefit of the expression of opinion of the provinces and we know the type of information that would meet all needs.

On the other hand we have with us those who must supply the information. The intention of this Conference is not to say that the needs must be met but rather the purpose is to let us become cognizant of the needs and then, bearing in mind the ability of those who supply the statistics we must decide what is practical.

There is no intention in the world of trying to put over a program which is not practical. We are here to find what is practical and we must cut the coat according to the cloth. I hope the needs are not too great but what they may be met and that is the problem which we must discuss. The matters are not at all cut and dried but they are in your hands.

With those preliminary remarks I will ask the Chairman of the Sub-Committee on Finance if he will proceed.

Continuation of the Report of the Sub-Committee on Finance

MR. MOFFAT: Mr. Chairman, and delegates to the Conference: I believe yesterday I had covered and read the report and today I would like to refer back for discussion the matters concerning classification of expenditures.

I believe when we finished yesterday we were on the point which concerns whether the reports should be made on a functional basis and you asked the delegates to give their consideration to that matter overnight, suggesting that they might be in a better position to discuss it this morning.

THE CHAIRMAN: We are open for discussion of the classification of expenditures as set out on page 2.

MR. A.R. DAVEY: Perhaps I could open the discussion.

As far as the present Dominion Bureau of Statistics requirements are concerned I think we are all in agreement that the schedule cannot be separated by departments, and if we are to establish a basis of costing that is a definite principle, and you can then carry the costing as far as you wish from that point.

I think the Chairman has made it clear that the function of this meeting is not to establish actual details of the work involved but rather to lay down principles. I would say that as far as the suggested principle goes we are on the right track but it seems to me there should be a continuing committee to carry on and decide whether that is in fact the purpose desired.

THE CHAIRMAN: Is there any further discussion?

DR. M.G. McCALLUM: With reference to the gathering of this information regarding hospitals, to me our main problem seems to exist in provinces like Ontario with forty or fifty large hospitals and possibly seventy small hospitals. In a province like British Columbia where there are six or seven large hospitals and ninety-five small hospitals the problem is different. I would like to approach the subject of gathering this information by separating those hospitals into two groups.

Would that be a solution?

THE CHAIRMAN: I think there is another problem. I think a lot depends upon how these questionnaires are collected. If the Bureau sends them to the hospitals and if they are filled in and returned direct to the Bureau that is one process. I think, however, in arriving at uniform statistics if the provinces themselves received the completed questionnaires, edited them, and then forwarded them to the Bureau for compilation as a Dominion picture it would be a procedure more likely to produce better results.

It seems to me the decision we make with regard to having one questionnaire for the large hospitals and a more simplified questionnaire for the smaller hospitals depends a good deal on the method of collection because it seems to me if the provinces could collect the information we would probably receive from the records which are already in existence in the provinces a good deal more information from the smaller questionnaires than if the Bureau was to do the editing.

DR. M.G. McCALLUM: Yesterday there was some suggestion that we compile statistics at a provincial level. My answer to that suggestion is that I think we will just get normal information from our small hospitals, bring it in to our provincial level, and all we shall do is to break it up into percentages here and percentages there and we will get nothing. That is the problem we have encountered in the past.

MISS A.E. SCOTT: I think Dr. Wride will confirm the fact that it has been Saskatchewan's experience that departmentalized arrangements have not been practical except in the case of hospitals of fifty or more beds.

DR. WRIDE: We tried to apply it to hospitals of twenty-five beds but we are not yet sure of the success which we are meeting. Some of the well-run hospitals are having success but it is too soon to judge the overall picture.

MISS A.E. SCOTT: Your opinion, by and large, is that departmentalization of expenditures for smaller institutions is to say the least unreliable.

THE CHAIRMAN: Would it not be a more satisfactory process to have the questionnaires collected through the provinces?

MR. G.W. MYERS: I understand the suggested procedure is at present followed in both Saskatchewan and Ontario. It does have several advantages.

If questionnaires are screened in the provinces there are many matters which can be checked there and yet which cannot be checked by the Dominion Bureau of Statistics. For example, if a certain department is said to be in existence at a certain hospital, it may be a

matter of common knowledge within the province that the department does not in fact exist and the correction will be made. On the other hand, if the return went directly to the Dominion Bureau of Statistics there would be no means of checking errors of that kind.

The second advantage is that the province desires to compile some statistics anyway for its own use. If the Dominion Bureau of Statistics questionnaire is submitted to the provinces by the hospitals, perhaps in duplicate, the province may go ahead with their own compilations and at the same time provide the additional information required here. Thereby a certain amount of work on the part of the hospital is saved.

With respect to the question of a separate form, although it is not mentioned in the report of the sub-committee, it was in fact felt by the Committee on Finance and Administration that when the final forms were worked out probably the answer would be to have a separate form for small hospitals which at present cannot provide exact analyses of their expenditures. There was no agreement in the committee just where the line should be drawn and whether it should be a ten, fifteen, fifty, or seventy-five bed hospital. There was some indication that the line might be drawn at different levels in different provinces. For example, I understand that at the present time in Ontario the departmentalized basis is followed right down to the smallest hospital. In Saskatchewan, as Dr. Wride mentioned a moment ago, we are hoping the line will be drawn at twenty-five bed hospitals. I understand that in British Columbia the line will be drawn at seventy-five bed hospitals.

It seems to me at least at the beginning there would have to be two forms, one of which would be used for hospitals which can provide that detailed breakdown, and one for hospitals which at the present time have not the information available.

Again I will say that I believe the handling of the problem would be considerably facilitated by passing the returns through the provincial offices.

THE CHAIRMAN: Let us discuss the aspect of provincial collection of information?

Arrangements will of course be made about the questionnaires being distributed and then the provinces will receive them from the hospital. The provinces are of course in a much better position to edit the questionnaires than is the Bureau. It seems to me, when looking at the picture of the Dominion as a whole, there is a definite in the suggestion. If the statistics must be collected by the Bureau it seems to me that we would require a tremendous amount of liaison with the provinces and there would be duplicate work done in the provinces, something which of course we do not want.

DR. WRIDE: Are there any provinces which do not process the forms?

MR. J.W.T. CROCKETT: In New Brunswick we do not.

MR. WALTER B. DICK: I would like to take the time of the Conference to read a portion of an article taken from the journal "Accountancy", the November, 1948 issue.

The article deals with the problem about which we are talking.

"In July, 1946, a joint committee composed of representatives of the Institute of Hospital Administrators, the Institute of Chartered Accountants and the Institute of Cost and Works Accountants, was set up by the first-named Institute "with the object of making a complete examination of hospital accounting and of formulating a set of accounts which could be applied to all classes of hospital in the National Health Service". The Committee held 32 meetings and its report was published in July, 1948.

The report contains sections on: General Recommendations; Income and Expenditure Account and Balance Sheet; Income and Expenditure Accounts of Special Funds; Supplementary Accounts; Grading of Staff; Working Statements; Financial Records; Salaries and Wages; Stores Control and Accounts; and Statistical Returns. A number of specimen accounts and forms is given, together with notes thereon.

A publication is a difficult one to review. It is designated a report, but it is a rather curious mixture of a report and a text-book on elementary business routine. Viewed as a report it contains far too much detailed routine matter; viewed as a text-book it fails because the information given is sketchy and incomplete. In a report of this kind one would hardly expect to find instructions on how to examine invoices, to prepare accounts for payment; the treatment of discounts; the making of entries in books; and the maintenance of personal record cards. Yet these and many other matters of a similar type are dealt with therein.

The principal recommendations of the committee

are that hospital accounts should be kept on the income and expenditure system on a departmental basis, with a suitable unit of cost for each department, e.g., Wards - per patient day; Theatres - per operation; Laboratory Services - per specimen, etc. These units of cost are suggested for use for the purposes of making comparisons as between hospitals in substitution of the two units at present in use for this purpose, viz., cost per occupied bed, and cost per out-patient attendance. The departmental system necessarily involves the maintenance of a system of stores accounts and this is recommended by the committee. The committee also recommend the adoption of a balance sheet wherein the assets and liabilities of each Fund, e.g., General, Endowment, Special, etc., are shown separately for each Fund instead of the existing method where all items are shown under subjective headings analyzed under the various Funds."

THE CHAIRMAN: The article is certainly apropos of our discussion. It of course deals with uniform systems of accounting being adopted in all provinces and in all hospitals. That is a very big question and one which cannot be decided by this Conference although a continuing committee might very well be set up to study the problem and make recommendations to a further Conference.

I would like, however, to settle the point concerning the possibility of the provinces taking over the collection of these statistics from the hospitals. It may be argued that we would have to start with certain of the provinces which are prepared to do that now. Certain provinces cannot do it immediately and the adoption of the principle would seem to be all that we could this morning.

DR. J.H. HOROWICZ: May I make a general observation?

Right now, in connection with the Health Service Grants, a certain amount of planning and surveying is being done in the provinces. Careful consideration is being given to hospital expenditure and hospital statistics, matters which are certainly the backbone of provincial planning. It seems to me that of necessity, and as a matter of logic, the data submitted by the hospitals should be processed and very carefully scrutinized at provincial levels in order that proper decisions may be made in connection with the provincial planning.

I would like also to support the suggestion put forward by my Chief, Dr. Jackson, and mentioned again this morning by the Chairman, that is the desirability of having a continuing committee formed to study the possibility of working out the details of uniform accounting.

THE CHAIRMAN: May I have an expression from the provinces regarding the collection and processing of the questionnaires on hospital statistics?

MR. J.W.T. CROCKETT: I feel that we could do that in the very near future and certainly we would be willing to try.

DR. J.J. MacRITCHIE: I am afraid that I could not give a definite opinion as I will have to take the matter up with my department when I get home.

THE CHAIRMAN: That is to be expected but you are in sympathy with the principle?

DR. J.J. MacRITCHIE: Yes.

THE CHAIRMAN: What about New Brunswick?

MR. A. WARREN: I am in very much the same position as Dr. MacRitchie. I feel that I should not commit myself

at the moment without reference to my department.

THE CHAIRMAN: What about Ontario?

MR.A.R. DAVEY: We have been doing the processing for the last two years and it is the only way in which we can get uniformity. I do not know how the other provinces find the returns, nor how you find them in the Bureau, but I know that our hospital returns require the most careful scrutiny. The most amazing things appear in the financial statements and we find mistakes not only inaccounting but mistakes in policy.

MR. A.E. TURNER: We obtain the information which we want from the Dominion Bureau's form and we make a complete analysis of the information.

THE CHAIRMAN: What is the situation in Saskatchewan?

DR. WRIDE: We have proven to our own satisfaction that the statistics submitted, I am speaking of statistics submitted directly from the hospital, are as much as 30 per cent inaccurate.

DR. M.G. McCALLUM: We would agree with that, and we screen them.

MR. D.W. SIMMONS: We have been screening the reports too.

THE CHAIRMAN: It seems to be that we might hand this matter to the Resolutions Committee at this point.

MR. J.H. LOWTHER: With that object in mind, I wonder if the Conference would be prepared to accept the recommendation of the committee in principle, as to the desirable type of information which should be received in Ottawa.

In other words, if your suggestion is carried out,

the Resolutions Committee will bring in a resolution or a recommendation that a continuing body be set up to give consideration to two things, first that a uniform system of accounting might be developed for all sizes and classes of hospitals, and second the matter of prescribing the types of forms which may be used for different classes of hospitals.

It seems to me, however, that the main problem before the Conference at the moment has to do with those two phases. While everyone is in general agreement as to the desirability of getting the reports of hospitals on a functional basis we must face the practicability of getting those reports from the small hospitals.

If the Conference feels in agreement with the principle of trying to get the information on that basis would it be prepared to accept the suggestions of the sub-committee in principle and then we might go on with the rest of the report.

THE CHAIRMAN: I would like to submit to the Conference the suggestion that we do establish a continuing committee to which will be referred the working out of some of the details of the program upon which we now agree, together with such other questions as may be involved in the desire for a uniform accounting system. The function of the continuing committee would be to study the matter and, being composed of representatives from the provinces, the committee could then report to the next Conference.

I think now we should come to a decision as to whether we will have a continuing committee. In a Conference which lasts but three days there are many problems

which certainly cannot be considered. There are a lot of borderline difficulties about which we cannot talk at all having in mind the length of the Conference.

DR. E.R. RAFUSE: Are you thinking chiefly of the functional part of the report when you speak of the continuing committee studying various problems?

THE CHAIRMAN: I am thinking of the whole report. We have similar problems in the field of Public Finance Statistics and we have a continuing committee on Municipal Public Finance and a continuing committee on Provincial Public Finance.

I think that I should now take a vote to ascertain how many are in favour of establishing a continuing committee.

How many favour the establishment of a continuing committee?

I declare that the Conference unanimously favours such establishment.

The other point raised by Mr. Lowther was whether we favour in principle the suggestions contained in the report of the sub-committee on Finance having particular reference to functional classification.

MR. LOWTHER: Yes.

THE CHAIRMAN: Perhaps, before I ask whether the principle is acceptable you should explain the matter again.

MR. J.H. LOWTHER: I think, sir, that briefly speaking it has been made very evident both at the meeting yesterday afternoon and in the informal discussions which took place during the evening that it is more or less

impractical to expect the small hospitals to complete financial returns which would give you a functional breakdown of the expenditures.

It seems to me, therefore, that we must recognize two classes of hospitals. One group can undoubtedly complete financial reports more or less along the lines recommended by the committee. The other group--the smaller hospitals--would have extreme difficulty in preparing such returns and as I see it the only practical means by which that hurdle can be overcome is to have a supplementary type of form which can be used for the small hospitals to supply the basic data to the provincial authorities. If the suggestion made a few moments ago is carried out the provinces could follow a system somewhat similar to that which is now in operation in Ontario whereby additional information in possession of the province would enable the province to assist in obtaining departmental breakdowns.

MR. A.E. TURNER: I think that would be getting away from the desired result. I think the institution of a second form would have a tendency to get away from uniformity. I think the continuing committee should obtain a form that is adaptable and acceptable to all provinces.

THE CHAIRMAN: As I understand it, in the light of the situation as it exists now, it would be necessary to have two forms. If later there is a uniform system of accounting set up then there would be no difficulty in following any model form. The suggestion made is a stop-gap and a tentative procedure.

MR. A.E. TURNER: With the introduction of another form there would be no progress towards uniformity.

If another form could be used there would a tendency in some hospitals and in some provinces to go no further towards the end which is desired here.

THE CHAIRMAN: We would have to have a good live continuing committee and another Conference.

Is there any opposition to the suggestion that we accept this functional classification in principle. It can be applied in the larger hospitals immediately and as an interim measure we will have another form for the small hospitals. We shall, however, keep before us the idea of arriving at one general form of questionnaire. In the meantime the practical question is met if for the larger hospitals we have a full-fledged questionnaire and for the smaller hospitals a short one.

DR. E.R. RAFUSE: It would be left to the province to say just where the line should be drawn?

THE CHAIRMAN: I would think that matter should be worked out in the continuing committee. We would have to try and achieve some degree of uniformity.

MR. A.E. TURNER: If we were to use one form the necessity for the second form would not come into the picture at all. After all we would not want you to set any bed limits on the hospitals.

THE CHAIRMAN: Are there any objections to the procedure as outlined?

There are no objections and I declare that the Conference is unanimously in favour of accepting in principle the functional classification.

We will have a repprt regarding the formation of the continuing committee later.

MR. J.H. LOWTHER: I think that Mr. Moffat might now go ahead with the presentation of the remainder of the report and we may get an expression of opinion from the Conference as to the acceptance of the detailed classification of expenditure by object.

MR. MOFFAT: Would you refer to page 3.

"CLASSIFICATION OF EXPENDITURE BY OBJECT.

It is recommended that a supplementary analysis of expenditures by provided on the following basis:

1. GENERAL ADMINISTRATION -
   - 10. Salaries and wages (Gross
     Less: Perquisites
   - 11. Repair and Maintenance of equipment
   - 12. Supplies
   - 13. Other expense
2. CARE OF PATIENTS -
   - 20. Salaries and wages
     Less: Perquisites
   - 21. Medical, surgical and laboratory supplies
   - 22. Repair and Maintenance of equipment
   - 23. Other expense
3. SPECIAL SERVICES -
   - 30. Salaries and wages
     Less: Perquisites
   - 31. Medical, surgical and laboratory supplies
   - 32. Repair and Maintenance of equipment
   - 33. Other

4. OUT-PATIENT DEPARTMENT -

40. Salaries and wages

Less: Perquisites

41. Medical, surgical and laboratory supplies

42. Repair and Maintenance of equipment

43. Other expense

5. OPERATION AND MAINTENANCE OF PHYSICAL PLANT

50. Salaries and wages

Less: Perquisites

51. Repair and Maintenance of equipment

52. Supplies

53. Other expense

6. TOTAL EXPENDITURES

Note: These items could be arranged in columns on page 2. and thus combine the classification of expenditures by major categories and objects.

Each object heading may have any further breakdown decided upon.

e.g. - 20. Salaries and wages

201 - Medical

202 - Nursing

21. Medical, Surgical and Laboratory Supplies

210 - Medical and Surgical Supplies

211 - Laboratory supplies

30. Salaries and Wages

301 - X-ray

302 - Laboratory, etc.

Where a radiologist serves in two capacities his salary is to be shown in the department or object heading according to weight."

MR. LOWTHER: The form of the statement would not be as you see it here but rather in columnar form.

The main change made was the taking out of replacement of equipment--that is in connection with capitalization and expenditure out of revenue funds, a subject which we will discuss shortly.

THE CHAIRMAN: Are there any comments?

MR. BARKER: I am interested in the fact that the one item on replacement of equipment has been dropped and I was wondering if I could discover the reason for dropping it. The investment department is interested in knowing the figure from the point of view of public investment statistics and this was the only item which they asked us to consider as being part of the report.

Would you tell us why that item was not included?

MR. MOFFAT: It was felt that all items of the nature of capital expenditure should be eliminated. It has not been eliminated from the report generally and you will see that section 13 provides for expenditure made out of revenue funds under the headings:

"130. General Physical Plant.

131. Improvements other than buildings.

132. Special equipment."

I think those headings cover your point.

MR. BARKER: That is fine.

MR. MOFFAT: We will proceed with page 4.

"SELECTED CAPITAL ACCOUNT TRANSACTIONS:

1. FUNDS PROVIDED FOR NEW CONSTRUCTION OR ADDITIONS TO PHYSICAL PLANT -

10. Government grants -

100. Dominion

1000. General Physical Plant (including land, buildings and general complement of equipment)

1001. Special equipment

101. Provincial

1010. General Physical Plant

1011. Special equipment

102. Municipal

1020. General Physical Plant

1021. Special equipment

103. Government Hospital Care Plans

1030. General Physical Plant

1031. Special equipment

11. Private grants and donations -

110. Endowment and trust funds

1100. General Physical Plant

1101. Special equipment

1102. Improvements other than buildings

111. Other (specify).....

12. Sale of debentures, Mortgage Loans

120. General Physical Plant

121. Improvements other than buildings

122. Special equipment

13. Made out of Revenue Funds

130. General Physical Plant

131. Improvements other than buildings

132. Special equipment

2. TOTAL FUNDS PROVIDED

3. FUNDS EXPENDED FOR NEW CONSTRUCTION OR ADDITIONS TO PHYSICAL PLANT -

30. General Physical Plant

300. Land

301. Buildings (including Permanent Fixtures)

302. Equipment

31. Special Equipment

310. Improvements other than buildings

4. TOTAL FUNDS EXPENDED

5. PROVISION FOR DEBT RETIREMENT

50. Debenture Debt

500. Principal Instalments

501. Sinking Fund Requirements

51. Mortgage Principal Repayments."

THE CHAIRMAN: Is there any discussion on Selected Capital Account Transactions?

MR. MOFFAT: If there is no discussion we should refer back to the original draft of the Classification of Balance Sheet Items. In the sub-committee's report it was mentioned that there were some minor changes:

"1. <u>Capital and Loan Fund Section:</u>

Assets -

1. Land and Buildings at Cost (incl. Permanent Fixtures)
2. Improvements other than buildings at cost
3. Furniture and other equipment at cost
4. Due from municipalities for unexpended debenture funds.
5. Cash on hand and in bank
6. Temporary investments
7. Due from other funds (specify fund)
8. Other (specify)
9. Total

Liabilities -

1. Debenture Debt (not due):-
   10. Issued by Municipality
   11. Issued by Hospital Authority
2. Mortgages or Other long-term debt
3. Accounts and Notes Payable
4. Due to Other Funds (specify Funds)
5. Other (specify)
6. Investment in Capital Assets
   (Excess of Assets over Liabilities)
7. Total"

The idea of the balance sheet having four sections is to draw it up on a fund basis--that is a capital and loan fund section, a revenue fund section, a bequest, endowment and trust fund section, and a sinking fund section.

The principle of segregating those various funds is well recognized. The minor changes made by the committee regarding capital and loan fund are first that land be shown separately and second insofar as Item No. 3, furniture and other equipment at cost, is concerned, it should be split between appreciable and non-appreciable assets.

To carry out the recommendation you then include depreciation as operating expense and under liabilities provision should be made for the set-up of depreciation reserves.

Those are the only recommendations for change in the Capital and Loan Fund Section.

"<u>Revenue Fund Section:</u>

Assets -

1. Cash on Hand and In Bank

2. Temporary Investments

3. Accounts and Notes Receivable:

   31. Dominion Government

   32. Provincial Government

   33. Municipality

   34. Government Hospital Care Plan

   35. Other

4. Due from Other Funds (specify)

5. Inventories

6. Prepaid and Deferred Charges

7. Other (specify)

8. Deficit

9. Total

Liabilities;

1. Bank Overdraft

2. Accounts Payable

3. Notes and Loans Payable

4. Accrued Salaries and Wages

5. Debentures - Interest Due and Unpaid

6. Debentures - Principal Due and Unpaid

7. Due to Municipality

8. Due to Other Funds (specify)

9. Deferred Income

10. Other (specify)

11. Reserves (specify

   110. Uncollectable Account Receivable

12. Surplus

13. Total"

THE CHAIRMAN: Are there any comments?

MR. MOFFAT: There was one change in this section.

It is suggested that under Item 3 "Accounts and Notes Receivable" a new number, No. 30, should be made entitled "Patients" and leave "Other" in as No. 35.

THE CHAIRMAN: Is there any discussion?

MR. MOFFAT: If there is no discussion perhaps I can deal with Items 3 and 4 together.

"111. Bequest, Endowment and Trust Fund Section:-

Assets -

1. Cash on Hand and In Bank
2. Investments -
   21. Bonds and Debentures
   22. Stocks
   23. Real Estate Mortgages
   24. Other
3. Real Estate Holdings
4. Due from Other Funds (specify)
5. Other (specify)
6. Total

Liabilities -

1. Bequest and Endowment Fund Balance:-
   10. Expendable Funds
   11. Non-expendable Funds
2. Trust Fund Balance:-
   20. Deposits
   21. Other (specify)
3. Due to Other Funds
4. Other (specify)
5. Total

IV. Sinking Fund Section:

Assets -

1. Cash on Hand and In Bank
2. Investments
3. Due from Other Funds (specify)
4. Other (specify)
5. Deficit
6. Total

Liabilities -

1. Reserve for Retirement of Bonds and Debentures
2. Investment Reserve (s)
3. Due to Other Funds
4. Other (specify)
5. Surplus
6. Total"

THE CHAIRMAN: Is there any discussion?

MR. MOFFAT: The only change that was recommended in connection with these two items has to do with fixed assets and their depreciation. The suggestion is to make provision for an item to be inserted between Items 5 and 6 reading "Adjustments on Assets Retired".

You will note that in the first part of the report of the sub-committee there were certain specific recommendations. We said:

"The committee recommends the adoption of the following general principles relating to the reporting of hospital plant and the evaluation of contributed services:

1. Hospital plant- that hospitals should report the gross value of the total plant in use, including donated plant.

2. Depreciation - that depreciation should be recorded and reported on the gross value of total plant and facilities in use, including donated plant."

The other general principle which the committee suggested be accepted has to do with contributed services.

"It is recommended that the treatment requiring such contributed services to be recorded as income be revised. It is considered to be optional rather than mandatory."

THE CHAIRMAN: Is there any discussion?

MR. MOFFAT: The final recommendation, and one which is extremely important, is that in redrafting the statistical forms, it is suggested that a standard size be used (8½ x 14); that standard typewriting spacing be provided in both the horizontal and vertical rulings; and that the financial data be reported in dollars only.

THE CHAIRMAN: Are there any comments?

If there is no discussion I must say that we are very grateful to Mr. Moffat and his committee for the work they did on this report. I think Mr. Moffat's committee, and the others, have done a very excellent job and their work has been a great help to the Conference.

I take it now that the report of the sub-committee on Finance is accepted. On some of the report there has been considerable discussion and we have accepted the principle with the provision that while it cannot be implemented in its entirety inall hospitals at the present time it is something which we will keep as an objective and that further we will set up a continuing committee to discuss additional problems.

## Morbidity Statistics

THE CHAIRMAN: You will recall that in Dr. Sellers' report a problem arose in connection with morbidity statistics. It seems to me that is again something which should be referred to a committee of some kind.

There is already an advisory committee on medical statistics which is to be reconstituted to some extent because of the recommendations made by the World Health Organization. I wonder whether the question of morbidity statistics might not be part of the work of that advisory committee instead of the work of the continuing committee which we are to form as the result of this Conference?

MISS A.E. SCOTT: I would like to speak briefly on that question.

It seems to me that the discussions in our Committee on Morbidity and Movement of Patients really involved three types of things. First was the revision of an annual return dealing with movement of patients; second was the question of the desirability of obtaining supplementary statistical data from some type of individual record; and the third item concerned problems associated with morbidity data as such.

The first question was one to which we gave very little attention. It is an enormously complicated matter and we were concerned primarily with the question of procedure and with recording our support for the principle of extending the use of standard means of recording morbidity data and classifying morbidity data.

I feel that the second of the two things which the group considered were functionally distinct in a sense.

There is a great deal of information concerning hospital utilization which is quite distinct from the morbidity question as such and I feel if we are to consider the desirability of having a medical advisory committee deal with these matters rather than the continuing committee, a distinction should be made between the two types of work.

I think it is desirable in the extreme that the question of hospital utilization data, hospital population, the standard divisions of age and sex, standard methods of calculation of rates, should be within the field of hospital utilization statistics. It seems to me, however, that one of the things the continuing committee might very well do is to consider the problem of establishing uniform methods of tabulating and classifying hospital utilization data as such. The question of morbidity as such might very properly be referred to a technical provincial group and I would like to make that suggestion.

THE CHAIRMAN: I think that is a very good suggestion. I think we should refer this question of morbidity statistics to the continuing committee and they can decide upon what aspects should be handed to the medical advisory committee.

MISS A.E. SCOTT: In the committee I opposed the use of the term morbidity including also hospital utilization statistics because I think there is a great deal of information which concerns other fields.

THE CHAIRMAN: Are we in agreement that we shall leave this question to the continuing committee which will decide the aspects which should be handed to the medical advisory committee? (Agreed.)

Report of the Committee on Terminology and Classification (Cont'd)

THE CHAIRMAN: I believe that Dr. Wride now has a definition of a new-born.

DR. WRIDE: Mr. Chairman, ladies and gentlemen, after an arduous labour your committee gave birth to the following definition:

"A new-born for statistical purposes is an infant newly born in the hospital who receives new-born care only, either in the obstetrical service or in the pediatric service."

We finally avoided time limits entirely.

THE CHAIRMAN: How does that definition appeal to the Conference?

MR. McGILP: I think Dr. Wride and his co-workers should be congratulated on the excellent definition.

(Applause).

DR. WRIDE: It is only fair that Dr. Reed and Dr. Stalker should receive acknowledgement for their contributions.

THE CHAIRMAN: The next item of business deals with the continuing committee.

It has been suggested that we should have two forms of continuing committee. There should be a continuing committee which will deal with the subject generally and in addition to that there ought to be some sort of a committee composed of financial people. It was thought that it would not be necessary to make the financial committee meet very often because there are a lot of things the necessity for its meeting often is not so great.

Are you in agreement with the suggestion that we should have two separate committees? (Agreed.)

I would like to have suggestions from the Conference as to how we might constitute those committees.

Shall we name the representatives on the committees now?

It was thought that on the continuing committee there ought to be a representative from the Maritimes, one from Quebec, one from Ontario and Manitoba, one for Saskatchewan and Alberta and one for British Columbia. Of course, there would have to be power to add to the committee as it was deemed necessary. There would in addition require to be some delegates from Ottawa.

DR. E.R. RAFUSE: I believe that it might be agreeable to have one representative from Manitoba and Saskatchewan and another from Alberta and British Columbia.

THE CHAIRMAN: Yes, perhaps that might be more advisable.

Would you like to suggest names for the committees now?

MR. A.R. DAVEY: Could you not name as Chairman of the Continuing Committee one of the representatives from the Bureau and then let him pick his own committee?

THE CHAIRMAN: Would it meet with your approval if in the Bureau we drew up a slate and corresponded with the provinces requesting approval or alternative suggestions?

DR. RAFUSE: I think that selection would be the best.

THE CHAIRMAN: Is it agreed that the constitution of the committee will be a representative from the Maritimes, one from Quebec and Ontario, one from Manitoba and Saskatchewan, and one from Alberta and British Columbia?

(Agreed.)

Then, when the committee meets, it may choose its own chairman.

MR. McGILP: I am not convinced as to the necessity of having two committees? Is it the unanimous feeling of the Conference that there should be two committees?

THE CHAIRMAN: It was suggested by a delegate from one of the provinces that the better plan might be to have the two committees because the membership might then be composed of those who are well versed in the two aspects.

DR. E.R. RAFUSE: They are special fields.

THE CHAIRMAN: How many are in favour of having two committees rather than one?

I declare the Conference in favour of having two committees.

Report of the Committee on Resolutions -Dominion-Provincial Conference on Hospital Statistics

THE CHAIRMAN: I will now call on Dr. Sellers for the report of the Committee on Resolutions.

DR. SELLERS:

"Resolution No. 1

WHEREAS the holding of this Dominion-Provincial Conference on Hospital Statistics has been made by the Right Honourable C. D. Howe, Minister of Trade and Commerce for Canada;

AND WHEREAS this Conference has made possible the presentation and discussion of nation-wide problems respecting statistics describing the organization and operation of Hospitals in Canada, thus assuring the continued development and improvement of the Hospital Statistics of the Provinces and Canada;

BE IT RESOLVED that this Conference requests Mr. Herbert Marshall, Dominion Statistician, to transmit to the Right Honourable, the Minister of Trade and Commerce, a unanimous expression of its appreciation." (Agreed.)

"Resolution No. 2

WHEREAS the success of this Dominion-Provincial Conference has depended, in a large measure, on the efforts of the Dominion Statistician, Mr. Herbert Marshall, who has so ably presided over the deliberations;

BE IT RESOLVED that the delegates to this Conference express their cordial appreciation." (Agreed.)

"Resolution No. 3

WHEREAS great benefit has been derived by the Conference from the presence at its sessions of the following visitors: Mr. Graham L. Davis of the W.K.Kellogg Foundation, Michigan, U.S.A.; Dr. Louis S. Reed, U. S. Public Health Service, Washington, D.C., U.S.A.; and Mr. D.L. Butler, Department of Health and Welfare, Newfoundland;

BE IT RESOLVED that this Conference expresses its thanks to the Right Honourable C. D. Howe for inviting these visitors to the Conference, and requests the Dominion Statistician, Mr. H. Marshall, to convey the appreciation of this Conference to the W. K. Kellogg Foundation, the United States Public Health Service, and the Commission Government of Newfoundland, for making possible the attendance of these visitors at this Conference." (Agreed.)

"Resolution No. 4

WHEREAS this Conference has reviewed and adopted the reports of the Committees on

(a) Terminology and Classification

(b) Standards of Care

(c) Movement of Patients and Morbidity and

(d) Finance and Administration

as amended in Plenary Session;

AND WHEREAS these reports have formed the basis of the discussion at the Conference;

BE IT RESOLVED that this Conference recommend that the Right Honourable, the Minister of Trade and Commerce, be requested to transmit the reports to the several provincial Ministers for their consideration and approval."

MR. McGILP: May I be recorded as opposing the resolution on grounds which I have stated during the meeting yesterday afternoon and this morning.

THE CHAIRMAN: Very well.

With the exception of Mr. McGilp does the resolution meet with the approval of the Conference?

(Agreed.)

"Resolution No. 5

WHEREAS the Conference, having in mind the fact that the control and supervision of hospitals is a matter of provincial concern;

AND WHEREAS the most effective channel for obtaining accurate information on hospitals is through the provincial authority;

AND WHEREAS present methods of collecting statistical information do not completely permit the securing of comparable statistics;

AND WHEREAS many mutual benefits would accrue by the clarifying of such information through the appropriate authority;

BE IT RESOLVED that all hospital statistics be channelled through the appropriate provincial authority under the provisions of the Statistics Act of Canada."

(Agreed.)

"Resolution No. 6

WHEREAS the holding of this Dominion-Provincial Conference on Hospital Statistics has effectively demonstrated the value of inter-provincial co-operation;

AND WHEREAS there is need for machinery to provide continuous exchange of ideas;

BE IT RESOLVED that a Continuing Committee be set up to give effect to the work of the Conference;

AND BE IT FURTHER RESOLVED that this Conference recommend that another Conference be convened, when necessary, to review the progress and plan for the future."

(Agreed.)

"Resolution No. 7

WHEREAS the type and amount of statistical information recommended by this Conference departs from that obtained under the existing system;

AND WHEREAS there is considerable detail in relation to the Conference resolutions, which have to be worked out to give effect to the principles recommended by this Conference;

AND WHEREAS time is required to prepare new schedules embodying the recommendations of this Conference;

BE IT RESOLVED that the Conference recommend that, with the co-operation of provincial and hospital authorities, the new schedules shall be used for the preparation of hospital statistics for the year 1950."

MR. McGILP: Again, Mr. Chairman, may I record my opposition?

THE CHAIRMAN: Shall the Resolution carry?

(Agreed.)

MR. D.W. SIMMONS: In connection with the last Resolution will it be permissible to drop statistics on the movement of population, which item is being deleted on the new form, for the current year?

THE CHAIRMAN: What are the views of the Conference?

MR. D.W. MYERS: Could the question be repeated?

MR. D.W. SIMMONS: With respect to the statistical side of the picture and the movement of population being dropped on the new form, can we discontinue that for 1949?

MR. D.W. MYERS: I believe at a Conference a couple of years ago part of that information was discontinued.

MISS A.E. SCOTT: The birthplace was discontinued but it came back.

THE CHAIRMAN: As far as the Dominion Bureau of Statistics is concerned we are perfectly prepared to drop it unless some province wishes to keep it.

DR. E.R. RAFUSE: I think we could look after that ourselves.

MISS A.E. SCOTT: Does the Dominion Bureau of Statistics use that information? If you do not use it for compilations of a dominion nature then it doesn't really matter whether you get it and it could be left to the discretion of the provinces?

THE CHAIRMAN: Yes.

DR. A.G. SELLERS: May I, for the record, move the adoption of the complete report of the Committee on Resolutions?

MR. A.R. MOFFAT: I would second that motion.

THE CHAIRMAN: Is the Conference in favour of accepting the complete report of the Resolutions Committee?

(Agreed.)

THE CHAIRMAN: Are there any other items of business?

MR. McGILP: I would like to say a few words before we adjourn, and I imagine that we are adjourning now.

I do not want to appear as an obstructionist or as a nuisance but I believe I would be derelict in my duty if I failed to say a few words about the entire Conference.

Mr. Chairman, your remarks this morning made it clear that the purpose of the Conference was to get opinions from the various provinces as to what statistics are required at the dominion level and at the provincial level and in addition it is to assess the value which can be derived from those statistics.

As I mentioned before, in Alberta last year we held a series of schools throughout the province to which small groups of hospital administrators were invited. The purpose of those schools was to educate, clarify the minds of, and render assistance to the small hospital administrators in this matter of the preparation of statistics.

I was appointed to conduct those schools and after having conducted some thirteen of them throughout the province I feel I am qualified to speak on their behalf. As Dr. McCallum has mentioned, in Alberta about ninety-six

per cent of our hospitals are small rural hospitals. From the administration point of view the work is largely done by part-time secretaries and certainly in very few cases is there an accountant employed. To them the problem of preparing Hospital Statistics looms so large that it is amazing that they have been able to complete the reports which they are asked to complete now.

The schools, however, were very successful. We were able to help those people and to clarify a lot of points which had been causing trouble. At the conclusion of the schools I was convinced that to gather statistics from those small hospitals we would of necessity have to be as brief as possible.

I found that these part-time administrators in the small hospitals were most anxious to be accurate in their reporting but they could not be accurate sometimes by reason of lack of time and lack of experience.

Speaking from Alberta's viewpoint I am not convinced that the extra information which will ber requested by these new schedules is in fact required. I would like to ask the question, generally speaking, if the Conference considers more valuable or more necessary, the statistics we have now which are inaccurate or no statistics at all.

I have my own thoughts on the subject and I would prefer no statistics at all because other statistics can be and are misleading. I am also of the opinion that we should draw a line between the large and the small hospitals. At the present time we have statistics which are being compiled by our large hospitals and which are accurate. The accuracy can be guaranteed and we could use those figures at the provincial or dominion level to give us information which I agree we should have. At the same

time I think we might leave the small hospital on the old system of reporting.

If we ask a small hospital to supply a staff in order to complete these detailed schedules we are simply adding to the cost of hospitalization which I am sure you agree is getting out of reach for the average man. That conclusion is inescapable.

A Continuing Committee is being appointed and I believe that these thoughts should be put before that committee in order that it may attempt, during the next year or two, to reach a compromise whereby a division will be made between the large and the small hospitals.

In conclusion I would thank you for allowing me to express my dissenting vote to the two Resolutions affecting this matter.

THE CHAIRMAN: I am quite convinced that none of us have the opinion, Mr. McGilp, that you are a nuisance to us. You are anything but that.

I think we have a great deal of sympathy for the views you have expressed and it is for just such reasons that we have decided to appoint a Continuing Committee. Your views are well put forward and I am sure they will receive careful scrutiny by the committee.

DR. A.G. SELLERS: I would like to make a further comment.

Mr. McGilp has given expression to a fundamental concept which it seems to me underlies this whole field. I was of the opinion that we had in a sense cleared away his apparent objections because is it not the situation that we have decided there are varying degress of intensity in the requirements for Hospital Statistics. The first

degree of intensity is that which exists at the federal level; another degree is that represented by requirements in the provincial field; and the third requirement is that of the hospital administrators themselves.

I would suggest that the Continuing Committee give considerable thought to that basic idea--that what we should be concerned with fundamentally is the basic, necessary, and minimum elements which are nationally required.

I should think there would be no difficulty among the provinces in agreeing to the contribution of such basic minimum requirements. It is also clear that the requirements of the individual provinces will vary for many reasons--in the first instance depending on the hospital administration activity and in the second instance there will be variation, as Mr. McGilp has well pointed out, in the degree of reliability and the value of the data supplied for use within the province.

I think it is an excellent thing, Mr. Chairman, that Mr. McGilp has risen to his feet to raise this topic and it may be that in our deliberations we did not give sufficient thought to the aspect which he mentioned.

THE CHAIRMAN: Are there any other comments on the matter?

Chairman's Concluding Remarks

I think the situation is clear. We have had a very good Conference and we have become well acquainted with the needs of the government at various levels and we have set up an objective. If we attain the whole of the objective it will be fine.

Some difficulties have been mentioned and some doubts arise as to the possibility of the attainment of the objective in full and the whole question cannot be settled

The Chairman

here. We have adopted general principles concerning the objective and now the problem goes to the Continuing Committee. The committee which we have set up will take steps to find out what the practical bases are and if some of the things we have recommended are not basically and essentially practical they can be eliminated. There is nothing final about any decision made here.

We will, in the future, have another Conference at which the report of the Continuing Committee will be presented. No one's hands are tied and there is still plenty of opportunity for all sections to present their various points of view. I think by following such a procedure we are eventually going to arrive at a workable basis which will give us statistics so badly needed now.

Is there any other business for discussion?

I would like first of all to thank our visitors, Mr. Davis, Dr. Reed, and Mr. Butler, who have taken of their time to come here and sit in at this Conference. These gentlemen have been a great help to us and we appreciate their attendance.

I would also like to thank the representatives of the Canadian Hospital Council and say to them that they too have been of great assistance to us in our deliberations. I would like to thank the Provincial Delegates for the part that they have played.

You gentlemen came here, we gave you various memoranda and set you to work. The material was new to you because of the impossibility of producing it an earlier date but you did a splendid job in assimilating it. You were divided into various committees and then the real work began. The committees produced good reports and we are very grateful for them.

I must also say that I appreciate indeed the work done by other departments in Ottawa which have co-operated with the Dominion Bureau of Statistics in preparing the agenda for this Conference. I do not know whether the Provincial Delegates are aware of the great amount of time that is required by way of preparation of the memoranda supplied to you.

To the Chairmen of the various committees I would again thanks for on their shoulders rested most of the burden of preparing the final reports.

I understand that a verbatim report will be prepared of the discussions which have taken place in plenary session of the Conference and such reports will go out to you on a confidential basis. The reports will be transmitted through the regular channels, that is from our Minister to your Minister but I am sure that arrangements may be made now for the odd extra copy if any are desired.

I now declare the Conference closed.

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