ASSOCIATION OF DALHOUSIE RETIREES AND PENSIONERS
QUARTERLY NEWSLETTER
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NOTICE OF GENERAL MEETING.

The next General Meeting will be held at **2 pm on Thursday, December 5, 2002 in the Senate Hall, Macdonald Building on the Studley Campus.** Following the General Meeting, Members are invited to a Seasonal Gathering at 4 pm in the University Club.

MEDICARE AFTER KIRBY COMMISSION

Tarun Ghose, President

All retirees are justifiably concerned about the future of our healthcare. The hiatus between the Kirby (i.e. Senate) Commission's report and the expected publication of the Romanow report towards the end of this month may be an appropriate time to initiate a debate among ourselves on the future of Canada's healthcare. My comments on Kirby Commission's report are based on the conclusion (after living in the UK, Australia, Sweden, Japan and India) that Canada's health care system, Medicare, is one of the best in the world. This is also an opportunity to dispel some of the myths which impede rational dialogues on Medicare.

I shall start by reassuring that contrary to what has been widely publicized, Medicare is not terminally ill. Medicare has its problems but their seriousness and the level of public disaffection are exaggerated. For example, Statistics Canada's July, 2002 report shows that about 80 percent of Canadians are satisfied with the present level of Medicare service. Medicare also does not have an "out of control" spiralling cost. The cost of Medicare has been around 10 percent of our gross domestic product (GDP). Germany and France spend the same amount on healthcare. Medicare's present crisis was created by cuts in transfer payment by the federal government which forced the provinces to spend 35 percent or more of their budget for healthcare and also led to a real cut in healthcare budgets during 1992-1997.

I disagree with the Commission's enthusiasm for privately delivered hospital-care in the guise of introducing competition, efficiency and fiscal accountability into the system. Private (for-profit) healthcare systems are neither more efficient nor qualitatively better than our exclusively publicly funded Medicare. For-profit health-insurers and their chain of satellites (e.g. insurance brokers, consultants, system analysts, lawyers, etc.) skim off their administrative costs and profits so that less than half the amount is left for patient care. For-profit healthcare in the US has left 40 million people, including 10 million children, uninsured. Rising rates of premium (average of about 13 percent) deprived another 1.5 million people of health coverage in 2001. Unfortunately, the uninsured die more frequently than the insured. Thus about 18,000 people died prematurely in the US in 2000, because their for-profit health insurance failed them. The Commission is aware that parallel for-profit hospitals are unlikely to improve Medicare. They cherry pick the very profitable, low risk, high volume diseases leaving the more serious (and expensive) conditions and emergencies for the publicly funded hospitals. Moreover, these hospitals cut corners to generate profit. A study on 38 million patients in US reveals a 2 percent higher death rate in for-profit hospitals than in non-profit hospitals. In Canada this translates to 2,200 additional deaths per year (about same number of deaths as in traffic accidents).

I am glad that Mr. Kirby has backed away from users' fees. Small "barrier" users' fees are supposed to discourage "frivolous overuse" but there is no evidence of such overuse. However, such fees do discourage healthcare use by the lower-income groups (who fall ill more frequently, more seriously and in larger numbers than upper income groups) and make patients seek help when disease is advanced, necessitating more extensive (and expensive) treatment. Other models of users' fees such as charging for services not included in "basic core medical services" (?) or Medical Savings Accounts or MSAs (in which the government annually allocates a lump

some of money for individuals and families for purchasing healthcare services) do not save much but shift scarce healthcare resources from the sick to the healthy and from the poor to the relatively affluent. All users fees breach the Canada Health Act. Unfortunately, at present, only about 70 percent of healthcare is publicly funded in Canada (in contrast to 80 percent public funding in the OECD countries). Every province has hidden user fees (e.g. ambulance fees) which make access difficult especially for the lower income groups.

Polls show that Canadians realize that universal and high quality healthcare in an aging society will be expensive but they are ready to pay the cost which may need 2.5 percent of real increase per year. But the Commission is right that it will be a folly to throw money at Medicare without resolving its root problems i.e., i) budgetary shortfall resulting from cuts and rising costs, and ii) organizational inefficiency. Medicare needs changes to control costs and improve the quality of care.

The cost of prescription drugs is the fastest growing and also the single most expensive item in Medicare's budget. The most important cause of soaring drug price is patent protection which allows monopoly drug-pricing based on whatever the market can bear. The majority of prescription drugs used in Canada are manufactured by multinational patent drug manufacturers. Only a small number of Canadian manufacturers produce the lower priced generic drugs which are no longer patented. The Mulrooney government extended the duration of patent protection to a minimum 20 years and also ended the unique compulsory licensing which enabled Canadian licensees to provide low-priced patented drugs. Federal Liberals, vocal in protest when in opposition, further strengthened patent protection when in power. There is no doubt that patent protection is essential for cost recovery and as incentive for research and development (R&D). But for how long does a drug need to be protected? Multinationals do not open their books but estimates indicate that the average rate of return on equity before taxes for pharmaceuticals during 1988-1995 was about 3 times higher than that of all other manufacturing industries. The cost of basic R&D after tax write-offs, is only about 90 million dollars per year, a relatively small fraction of their profits.

Because patients (or insurers) fully pay for their prescription drugs when not hospitalized, about 3.5 million Canadians without any drug insurance, have to be content with an expensive diagnosis but no treatment. Only in this context the Commission's recommendation for a catastrophic drug programme makes sense but this is not a definitive solution. According to the Prime Minister's National Forum on Health, drug prices can be controlled best by introducing universal pharmacare, bulk purchasing of drugs, eliminating over-prescribing (which costs Canadian hospitals about 250 million to1 billion dollars per year) and introducing reference-based pricing (i.e., use of the lowest priced but equally effective drug). As regards the cost of universal pharmacare, the Forum has pointed out that the public sector already pays for about 40 percent of prescription drug costs and various types of existing drug insurance programmes cover a sizable proportion of the remaining. Let us hope that the multinationals and their patent protector, the World Trade Organization, will be persuaded to lower drug prices by popular and political pressure, as was done with the pricing of anti-AIDS drugs in Africa.

In our healthcare budget, the cost of prescription drugs is closely followed by the costs of hospital services and physicians remuneration. The Commission is right that the present fee-for-service method of doctors remuneration is inefficient because it is geared to generate adequate income for doctors. A system of capitation fee or a salary system with performance-enhancing incentives will allow planning of long-term budgets, and introduce into the system accountability, quality control and impetus for continuing education. Evidence-based evaluation of doctors services will save costs by eliminating unnecessary consultations and procedures. However, it is surprising that after denouncing the fee-for-service method of payment for doctors, the Commission recommends the same method for paying hospitals.

The Commission is right in recommending that the Federal government should provide funds for increasing the intake of students in medical schools. The present physician shortage is the result of cuts in the intake of medical students and trainee residents that started in 1992. (Emigration of doctors is almost fully compensated by medical immigration). However, medical education has to be affordable and accessible to all income groups. Physician

shortage has distorted physicians' remuneration and impeded the development of healthcare. Canada has about 60,000 doctors at present but the optimal number of doctors that the country needs is not known. Moreover 40 percent of our doctors are older than fifty years and will be retiring in approximately 15 years. Because a new medical graduate needs about another 3 years to become a family physician and five to eight years to become a specialist, current doctor shortage is likely to persist. Pressure on physicians' time can be reduced by forming healthcare teams consisting of doctors, nurses, pharmacists, psychologists and others. Nurse practitioners can be a relief in busy practices and can also work solo in outlying areas. It is a pity that at a time when patients are being turned away from understaffed emergency facilities, qualified immigrant doctors can not obtain a license to practice even though they were allowed to immigrate because of their medical expertise. Toronto area alone has about 4,000 such immigrant doctors who are ready to work under supervision. It is disappointing that Mr. Kirby did not look into this waste of trained individuals.

Kirby Commission's recommendation for guarantee for timely access to care is commendable because this is the single most common complaint against Medicare. However, long waiting periods are not due to workforce shortage alone. For cutting down waiting, we have to decide how much resources can be allocated to create the reserve capacity for dealing with fluctuating demands.

The most serious structural problem of Medicare dates back to *The Constitution Act, 1867,* which gave the provinces jurisdiction over healthcare. As a result, Canada does not have a single national Medicare: every province has its own Medicare. The federal government uses the provisions of the *Canada Health Act, 1984* and transfer payments to have its input into the healthcare policies of the provinces. For an efficient Medicare and setting up national standards, it is imperative to create a truly national Medicare capable of long-term planning (based on expected economic growth and competing demands) and effective execution of such plans. Long-term planning is difficult now because federal and provincial governments change every four to five years. Unfortunately, Canada's provinces are not likely to hand over healthcare to the federal government and constitutional amendments for consolidating Medicare nationally are also unlikely. One way of overcoming this, will be to create a national Healthcare Corporation with appropriate representations from federal, provincial and territorial governments; professional organizations of healthcare workers; patients' rights groups; healthcare economists; social workers and the public. At the political level, this organization would be overseen by a parliamentary committee and would report to parliament while staying at arms length from all levels of government. As recommended by the Commission, this entity should have stability of funding based on a clearly dedicated part of the national revenue. It can also nationally coordinate health and education policies and train adequate numbers of doctors, nurses and other health professionals.

Other structural changes in Medicare for cutting costs and improving care include shifting care from expensive tertiary centres to intermediate and community-based healthcare units and finally to homecare. The present load on emergency facilities can also be reduced by round-the-clock services in community health centres managed by salaried physicians and nurses or by family physicians in group practice. At present we spend only about 4 percent of the healthcare budget on homecare. This is not adequate even for any decent homecare service let alone for further extending homecare to replace institutional care. Thus the Commission's recommendation for additional allocations of 550 million dollars for homecare and 250 million dollars for palliative-care appear to be inadequate. However, the recommendation for fresh annual infusions of 5 billion dollars into the system to compensate for the long underfunding may be of help.

REPORT ON THE FINANCIAL HEALTH OF THE RTF
Paul Huber, Vice-President

Six months ago, in our joint report to the DFA, Faye Woodman and I refused to speculate whether a further special distribution of surplus to retirees might occur during this academic year. Our caution proved warranted. Financial markets had partially recovered from their post-Trade Center crisis when we drafted our report, but the

two quarters since then have been disastrous.�� Funds with the asset mix of the Dalhousie Retirees' Trust Fund [RTF] lost about six percent of their value in the period from April through June and a further seven percent in the subsequent period through to the end of September.�

The RTF did slightly better than this at -4.5 percent and -6.5 percent respectively.� Since the RTF needs to earn over one percent per quarter-year just to maintain its level of surplus (measured at market values) in the absence of any indexation, its overall underperformance from 1 April through 30 September amounted to about -13 percent.� Consequently, the RTF surplus (at market value) shrank substantially and now (30 September) amounts to about only about 4 million dollars, i.e., about three percent of liabilities.� This disappearance of surplus clearly implies that there will be no special distribution to retirees this year.�

Although financial markets sometimes change direction abruptly, you should not at this point plan on any further surplus distributions ever.� Prudent Pension Advisory Committee Members will not recommend a special distribution to retirees when there is little or no genuine surplus to be distributed and financial markets are trending downward; nor will conservative Governors of the University agree to such a recommendation.� And should -- in some ecstatic rave -- such a proposal go forward to the Provincial Superintendent of Pensions, it would not be approved.

The Pension Trust Fund's [PTF] situation is much graver than that of the RTF.� Its 84 million dollar deficit (at market value) as at 30 June 2002 increased by September-end to over 100 million dollars, more than one quarter of the PTF's liabilities.� The Pension Benefits Act of Nova Scotia will require the Board to increase its pension contribution rates to overmatch those of employees if a deficit prevails in the Dalhousie Pension Plan on 30 June 2003.

Indexation of pensions in January for those eligible has been approved by the RTF Trustees at the rate of 0.305 percent (except for those who are being indexed for the first time), which is less than the increase in the cost of living of 1.2766 percent.� This under-indexation is driven by the three-year average RTF return of 5.355 percent less the indexation threshold of 5.05 percent.� This marks the fifth occasion and the first time since 1996 when the RTF was unable to index pensions completely to the rate of increase of consumer prices.� Previously �missing� indexation was made good in 1997; it cannot be predicted when � if ever � the new �missing� indexation of 0.97 percent will be made good.� Indeed, because negative returns have prevailed in each of the last two years and RTF returns are averaged over a three-year period, indexation may be incomplete in 2004 and 2005.

Indexation arrangements at Dalhousie have thus far worked much better than ever anticipated in 1982 and have cost relatively little.� You have had the good fortune that your pension funds participated in one of the longest (18 years!) bull markets in history and so earned returns up to 2000 that well exceeded historical norms.� Surpluses in the RTF cannot generally be expected to arise; they came about in recent years because investment returns were unusually high relative to inflation.

DALHOUSIE BLUE CROSS PLAN COVERAGE FOR RETIREES

Philip Welch, Chair Benefits Committee

In the last newsletter we brought to your attention the fact that the Dal Blue Cross Plan provided for reimbursement to Dal retirees (over 65) for 80 percent of their Pharmacare drug co-payments. Although this was an accurate and correct interpretation of the Blue Cross/Dalhousie contract, it now seems that this apparent provision was due to a mistaken interpretation of changes made in the Plan by Blue Cross authorities (or their advisers) in 1995.� Dr. Ghose and I met with Mr. Roughneen and Mr. Crowell on November 12, 2002 regarding this matter.� Some important points were clarified.

First, this Blue Cross error came to attention because in 2002 a few perceptive retirees realised that the Plan appeared to offer this benefit.

Second, Dal retirees have not been paying an increased premium over the past seven years for this inadvertent "benefit", of which most retirees were unaware.

Third, retirees will not be asked to reimburse Blue Cross for any monies received under this "benefit".

Fourth, it will be apparent from all the above that this "benefit" is no longer available!

A New Drug Plan? We explored with the Dal representatives whether a drug reimbursement plan could be considered in conjunction with Dal and Blue Cross. The latter have quoted on a plan which would provide coverage for 100 percent of the 20 percent Pharmacare co-pay to an annual maximum of $400 reimbursement. The premiums would be $19.04 per month for singles and $44.35 for families.

My own immediate reaction was that retirees would find this plan unappealing. However, we would appreciate feedback from our readers. (I should add that Blue Cross would likely require the participation of 75 percent of those retirees presently in the Dal/Blue Cross Plan as a condition of offering this drug plan.)

Dal/Blue Cross Travel Health Insurance? It appears that such a plan may be feasible, if certain important considerations are met.

First, that at least 75 percent of ADRP members, who are currently in the Dal/Blue Cross Plan must elect to join the Travel Plan.

Second, certain important limitations would apply, viz:

1. Coverage is limited to expenses incurred as a result of a sudden illness or accident, which occurs outside the participant's province of residence, during the term of the policy.
2. Blue Cross will not pay any benefit or accept any liability for claims relating to a medical condition /illness /injury which, within the six-month period immediately prior to the date of departure from the participant's province of residence, has:

    ******* - deteriorated; or
    ******* - been diagnosed; or
    ******* - required medical consultation; or
    ******* - required hospitalisation; or
    ******* - required a change in medication.

My present understanding is that if the exceptions listed in 2 do not apply to you or your spouse/partner, coverage would be essentially complete as in 1. Further, note that coverage is not dependent on age, nor would the premiums increase for older retirees, (e.g., over 70), nor is there any limit on the number of trips per year, provided no single trip exceeds 180 days.

And The Premium? $5.70 per month for single coverage, $11.43 for family. If my understanding and assumptions about this potential plan are correct, I believe this to be a good plan. Note that if there is a reasonable consensus (75 percent or more) of those potentially involved, to add on a drug plan and/or travel plan, then Blue Cross would insist that **ALL** participants in the Dal/Blue Cross Plan would pay the extra premium and would have the benefit of the additional coverage (drugs, travel or both) as voted by 75 percent or more of

participants. Note also that there is **NO** intention at the present time to offer the Dal/Blue Cross retirees plan to any retiree who did **NOT** elect to continue their participation at retirement.

We hope to identify those ADRP members, who currently participate in the Dal/Blue Cross Plan and will seek their opinion. Please let us know your opinion, and state whether you are presently in the Dal/ Blue Cross Plan by filling out the following brief questionnaire and returning it by e-mail to adrp@is.dal.ca or by post to ADRP Office, Room 2831, Life Sciences Centre, Dalhousie University, Halifax, N.S. B3H 4J1.

Your name:
 Are you currently a Member of the Dal/Blue Cross Plan? Yes
 No
 Are you interested in the Drug Plan as presented above? Yes
 No
 Are you interested in the Travel Plan as presented above? Yes
 No

SOCIAL COMMITTEE REPORT
Mary Simms, Co-Chair

Expenses - Please note the annual fee -- our only source of revenue, covers the coffee supplied at meetings. To defray costs we are asking members who enjoy our coffee to make a contribution of their own choosing.

Neptune Theatre presents Preview Nights -- First three nights of any new play (Tuesday, Wednesday and Thursday) at 8 p.m. Tickets: $25 Main Stage, $18 DuMaurier Theatre
Flat rate only **BOOK EARLY** (429-7300)

Symphony Nova Scotia presents four Open Rehearsal Series in their Celebrity Series at 10:00 am Rebecca Cohn Theatre: Oct. 8, Nov. 5, March 4, April 22. Tickets: $14. Each or $56 for all 4 Flat rate only **BOOK EARLY**

General Information - A Program for seniors booklet prepared by the N.S. Senior Citizens Secretariat may be obtained free at drugstores, Sobey s, municipal libraries and Access Nova Scotia government offices.

Walking - Keep fit by joining the twice a month walks organized by the Chebucto Hiking Club. The walking club runs all year and walks are 10km in length. Walks are held in various localities throughout HRM. Organized walking tours in the Canadian Rockies and Portugal are also planned. Call Ruth or Bill at 477-7142 for scheduled walks.

UPCOMING EVENTS

December 5, 2002 2 pm GENERAL MEETING Senate Hall, MacDonald Bldg.
 4 pm Seasonal Gathering University Club.

January 21, 2003 7 pm Theatre C Tupper Building.
 Speaker from Canada Customs and Revenue Agency.
 Topic: Income Taxes, RRSP s vs. Annuities, plus other tips.

January 25, 2003��� ������ 2-5 pm.� Scotia Bank Theatre, McCain Building � opposite the ������������������������������ Rebecca Cohn Theatre on University Ave:� An afternoon with Charlie ������������������������������ Chaplin.� The film �Limelight�.� Discussion and coffee following.

������������������������������ Next golden oldie movie:� Saturday May 31, 2003.�
������ This series is organized by Sid Sodhi.

The ADRP wishes to receive feedback regarding activities of interest to Members.� Please check off the following in which you would participate.� Feel free to add suggestions.� Reply by e-mail: adrp@is.dal.ca Or mail to ADRP Office, Room 2831, Life Sciences Centre, Dalhousie University, Halifax, N.S.� B3H 4J1.

Art Gallery Tour_____ _____

Book Reading Group_____ _____

Bus Tour_____
_____

Exercise Group_____ _____

Harbour Boat Tour_____ _____

Neptune Theatre_____ _____

Old/Classic Movies_____ _____

Pot Luck Dinners_____ _____

Shut In Visits_____ _____

Social Gatherings_____ _____

Symphony Orchestra_____ _____

Walks � Nature/Historical_____ _____

Other:_____
_____

Your name:_____�� Phone number: _____

Your response will help the Social Committee plan for ADRP activities.
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REPORT FROM THE KEEPING IN TOUCH SUB-COMMITTEE
Dorothy Moore, Chair

This Committee was recently formed to respond to the concerns voiced by several ADRP members about our lack of knowledge of those Dalhousie retirees who have not, so far, joined the Association. The ADRP is the vehicle which can bring us all together for betterment of our retirement circumstances; it can also foster ways in which we can contribute to the life of the University and the community.

After years of dedicated service to the University, the intellectual capital represented by all of the retirees can continue to benefit Dalhousie. We can also benefit each other and enrich our retirement with a continuing awareness of the accomplishments and changing circumstances among those who have retired.

This Sub-Committee of the Communications Committee would like to learn of important events in the lives of all retirees, which can be inserted in this Newsletter. So we invite everyone to submit brief notes on news items such as:

- awards and recognitions
- major accomplishments during retirement
- milestone birthdays (80, 90, 95, 100, etc.!)
- wedding anniversaries (50, 60, etc.)
- recovery from a serious illness or surgery
- bereavements

Since the number of retirees is large, we also depend on the cooperation of others to pass on news of retirees to this Sub-Committee; and we also solicit information from Departments, Schools, Faculties and any other Dalhousie employees. You may contact us by leaving a brief message (including your own telephone number), on the answering machine in the ADRP office; or alternatively on mine; ADRP Office (902) 494-7174 or e-mail adrp@is.dal.ca, Dorothy Moore (902) 494-1185 or e-mail dorothy.moore@dal.ca

We are looking for more volunteers to serve on this Sub-Committee, so please contact either of these if you wish to participate.

PENDING CHANGES TO NOVA SCOTIA PENSION LEGISLATION

Rosemary MacKenzie, Editor

Retirees who removed their contributions from the Dal Pension Plan and invested the locked-in portion in a Life Income Fund will find the following, quoted from Davies Diary by John Davies, Investors Group, of interest.

On July 25, 2002, the Nova Scotia government released amendments in draft form to the Regulations under the Pensions Benefits Act of Nova Scotia. It is intended that the changes to the pension legislation will become law as of January 1, 2003.

Following is a brief summary of the changes to the Life Income Fund Rules:

- The requirement that a LIF must be converted to a life annuity contract by the end of the LIF owner's 80th year is being eliminated. The LIF will be able to continue for the owner's lifetime.

- The method of determining the LIF maximum annual payment has been revised. It will be very similar to the calculation of Quebec LIFs.

- A LIF owner who is between the ages of 54 and 65 will be able to receive "Temporary Income" from the LIF, which in most cases will provide a higher payment than the normal LIF maximum. The concept of Temporary Income is designed to allow more access to locked-in funds by retired individuals who are not yet eligible to receive Canada Pension or Old Age Security benefits.

- A LIF (or LIRA) owner who is at least 65 years of age will be able to withdraw all of the locked-in funds if the value of the client's locked-in assets is less than 40 per cent of the Year's Maximum Pensionable Earnings under the Canada Pension Plan. (In 2002, the YMPE is $39,000).

- The owner of a LIF (or LIRA) who wishes to withdraw amounts based on diminished life expectancy must now complete an Application Form which includes a Physician's Statement.

HAVE YOU WORKED IN ANOTHER COUNTRY?
YOU MAY BE ABLE TO CLAIM BENEFITS
Rosemary MacKenzie, Editor

ADRP organized a meeting on international benefits with Brian MacMillan from Human Resources Development Canada. The meeting took place on September 25, 2002 with about twenty-five retirees in attendance. This is a brief report of the meeting. Many countries have similar social security systems to Canada i.e. Canada Pension, and Old Age Security schemes. If you have ever worked in another country and made contributions to its social security system you may be eligible for social security benefits from that country. Many countries have agreements with Canada which can make you eligible for these benefits even if you did not work the full qualifying time in that country. These agreements allow you to transfer time from your employment in Canada without affecting your Canada Pension Plan entitlement. For example, if you worked in the United States for four quarters you may believe you are not entitled to US Social Security. However, the agreement between the US and Canada allows you to transfer time to allow you to qualify.. If you have worked in Great Britain which does not have such an agreement with Canada you may be able to claim the British benefits if you have also worked in a country which has an agreement with both Canada and Great Britain such as the United States. You would claim the British benefit through the US social security system.

Schemes such as Canadian Old Age Security usually have a residency requirement of some sort. For example, to claim the full Canadian Old Age Security at age 65 you must have lived in Canada for 40 years after age 18. If you move to another country, you may still receive Canadian Old Age Security if you have lived in Canada for at least 20 years after age 18.

In Canada, there are many people who are eligible for benefits who are not claiming them.. For example, 400,000 people who are eligible for Canada Pension are not receiving it because they have not claimed it. If you wish to verify your eligibility for Canadian or international social security benefits contact HRDC - see below.
The HRDC website lists the countries with which Canada has agreements. URL is www.hrdc-drhc.gc.ca. The phone number to call for information is 1-800-277-9914. Brian MacMillan can be reached directly at 426-4666.

VOLUNTEER OPPORTUNITIES.

Tarun Ghose and Alasdair Sinclair are looking for volunteers and donations to assist with the organization of the National Convention of Canadian University/College Retirees Associations to be held May 26, 2003 in Halifax.

There is an opportunity to volunteer your talents to reorganize a small library at the office of Canadian Pensioners Concerned NS, Suite 325, 7071 Bayers Road, Halifax, NS. Please contact Joan Lay or Pat Baker at 455-7684 or email cpc@ns.sympatico.ca
E-MAIL ADDRESSES.

We have e-mail addresses for less than half the ADRP Membership. To cut the cost of postage we would like to distribute this Newsletter to as many Members as possible by e-mail. If you have an e-mail address please let us know at adrp@is.dal.ca.

EDITORIAL POLICY.

The ADRP intends to publish the Newsletter every three months. It is hoped the Newsletter will serve the following purposes:

- **To provide pertinent information;**

- **To provide a forum for the free exchange of views on issues relevant to our Membership;**

- **To serve as a documentary record of matters relating to the ADRP.**

The Editorial Board, under the ultimate direction of the ADRP Board, takes responsibility for the contents of the Newsletter. Signed contributions will take the form of short articles and letters to the editor which will normally represent the opinions of the author and need not represent the views of the ADRP. Anonymous material will not be considered for publication. The Editorial Board retains the right to edit or reject contributed material and to elicit similar and opposing views surrounding any issue raised.

The Editors Rosemary MacKenzie
Dee Purvis

The Editorial Board Rosemary MacKenzie
Dorothy Moore
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