WF: Medicare

COPY

November 30, 1962

Mr. L. F. Detwiller
Health Sciences Centre
Faculty of Medicine
The University of British Columbia
Vancouver 8, Canada

Dear Mr. Detwiller:

In the absence of Senator Humphrey who is travelling in Central America, I would like to acknowledge receipt of your letter and the numerous enclosures concerning medical care developments in Canada.

I know the Senator will be extremely interested to study this material when he returns to Washington later in December. As you know, this again will be a major issue in the Congress and these facts and figures that you have brought to the attention of the Senator will be extremely useful to him.

Best wishes.

Sincerely yours,

John G. Stewart
Legislative Assistant to
Hubert H. Humphrey

Leg: WF: Medicare
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THE UNIVERSITY OF BRITISH COLUMBIA

VANCOUVER 8, CANADA

November 19, 1962.

FACULTY OF MEDICINE
OFFICE OF THE DEAN



Honourable Hubert H. Humphrey,
United States Senate,
Committee on Foreign Relations,
Washington 25, D. C.

My dear Senator:

It was very thoughtful of you to write to me concerning my letters and the articles on medical care developments in Canada which I had sent to Judge Loevinger.

Having been privileged to develop and administer the government sponsored hospital insurance program in British Columbia, financed first under a prepayment system and later through general revenues, has provided an opportunity of viewing the hospital and medical care fields from the point of view of government sponsorship, as well as that of the hospital and medical professions. (This latter experience I gained during my association with the Medical Center at the University of California in Los Angeles). During my yearly trips to the University of Minnesota, where I give a course in medical economics in the Schools of Medicine, Public Health, Hospital Administration, and Nursing, I have found developments in the medical care field in our two countries to be paralleling each other, even although they are following different channels. Perhaps then, the experience in Canada may be of assistance to those planning medicare programs in the United States.

The objectives and goals of the American medical and hospital fields, which emphasize the retention of local autonomy and individual initiative, are identical with those which have been developed in Canada over the years, and which we are attempting to retain under our government sponsored medical and hospital care programs. Unfortunately, the basic professional policies are usually so far overshadowed by the immediate fiscal problems of government plans that they are not recognized until sometime after the plans have been in operation. By this time, the patterns of operation often appear to be so strongly entrenched that it is difficult to modify them, with the result that it may not be possible to retain some of the basic policies in the plans which were

laid down in the beginning.

There is no doubt that the Federal-Provincial hospital insurance programs across Canada have been very successful. They are well received by the population, as well as the professions involved, with some reservations by the latter insofar as autonomy and freedom of action are concerned. At the present time, one of the basic conflicts (and perhaps the most important one) is finally coming to light, and it is to be hoped that we may be able to resolve this problem in the future. Specifically, in Canada, we are attempting to retain the local autonomous hospital operated at the local level, and yet finance it with government funds. Because of the obvious controls that are necessary in spending public moneys, it is difficult to allow the hospitals the autonomy which they enjoyed in the past, although this is the goal that we should like to achieve. Some form of compromise is obviously required, and it is to be hoped that this may be achieved in the not-too-distant future.

Because of the interest of your Government in this field, I am taking the liberty of enclosing articles on the concepts referred to above, which may be of assistance in formulating future programs. Some of the articles are repetitious but, in the main, contain some new approach to the problem of integrating government into the hospital and medical care fields.

As you know, Canada has established a Royal Commission to study the health needs of the country, and this is the body to which two of these submissions were made.

I do hope this material may be of assistance to you. If there is anything upon which you would like to have comment, I should be pleased to write you further at any time.

Yours sincerely,

L. F. DETWILLER.

LFD:GD
Enc. 8

L. F. DETWILLER
Consultant-Administrator,
Health Sciences Centre

Need Control Stifle Initiative?
How Are They Paid Who Pay the Piper?
Be Prepared for the Bubble to Burst
Brief to the Royal Commission on Health Services - Larry Fraser
Area Planning of Hospital Facilities
Hospital Facilities and Community Needs
Brief to the Royal Commission on Health Services -
Metropolitan Hospital Planning Council
Local Hospital Autonomy vs Centralized Prepayment Control

c.c. Judge Loevinger

November, 1962.

# LOCAL HOSPITAL AUTONOMY VS CENTRALIZED PREPAYMENT CONTROL

Perhaps the most important problem facing the provincial hospital programs in Canada is that of reconciling the desire to retain the local autonomous hospital at the community level with payment for its operation from a central provincial authority. Federal and provincial governments, as well as hospitals and other groups in the health field, have, without exception, stated that the concept of the local autonomous hospital should be preserved and that they have no wish to enfringe on the autonomy of hospital boards. (For example, see Exhibit I). Unfortunately, this policy is in conflict with the other basic principle involved in our provincial hospital insurance plans; namely, that the expenditure of governmental funds must be directed and accounted for by the people's representatives. This will, therefore, involve some form of governmental control to effect this responsibility. The existence of these two conflicting ideaologies has given, and is continuing to give, rise to basic problems in the hospital programs across Canada. A solution to this problem must be found before many of the difficulties now being encountered can be eliminated.

There is no doubt that the Federal-Provincial Hospital Insurance Plan has been a tremendous success, and both the federal and provincial governments may well be proud of the programs in operation across the country. The position of the Federal Government, in providing advice, counsel, and financial assistance rather than direction and control, has been accepted by all concerned, as has the position of the provincial governments in being directly responsible for the operation of the plan in their respective provinces.

In the early years of the operation of these programs, financial matters invariably received a great deal of attention, usually at the expense of professional problems which could well prove to be the more important in the long run. Legislation, such as provincial Hospital Acts, which governed the operation of hospitals prior to the implementation of these plans, may not, in some instances, have been amended sufficiently to recognize the changed role of the hospital in the new environment of governmental prepayment. The shortcomings of some of this legislation are now coming to light, and are beginning to give rise to serious problems.

Under certain sections of Hospital Acts, typical of that of British Columbia as contained in Exhibit 2, it is provided that hospitals are to have full control of their revenues and expenditures. It is also stated that they are responsible for the administration and management of their institutions and the standard of care and treatment of their patients. On the other hand, the Hospital Insurance Acts, again typified by that of British Columbia, see Exhibit 3, usually include provision whereby the prepayment agency sets the per diem rate of the hospital and states that the hospital

may not make any additional charge for services rendered, since the payment from the payment agency is to be considered as full payment.

While there has been no test case to date, both lay and legal opinion has been expressed that it is difficult to see how the Board of Trustees of a hospital can be held responsible for the standard of care in the hospital and the administration of its affairs when, in fact, it no longer has control of its revenue and expenditures, even although required under the Hospital Act, since these are now determined by the prepayment agency. The suggestion has been made that, if hospitals are to accept the directives of the government and the central prepayment agency, the hospital board should no longer be held responsible for the conduct of the hospital, and this should be assumed by the provincial government. If it were decided that this new policy should be adopted, this would require an amendment to the Hospital Act, and would likely result in hospital boards becoming even less interested in the operation of their hospitals than is the case at the present time.

On the other hand, if the autonomy of hospitals is to be preserved, and boards are to be held responsible for their actions, an amendment should be made to the Hospital Insurance Act, whereby the boards may once again assume control of a portion of their revenues and, in this way, may be held responsible for the affairs of the hospitals. They would then have gained back sufficient autonomy and authority to accomplish this.

In British Columbia, certain events have transpired this year which have brought to light this conflict between the Hospital and Hospital Insurance Acts, which govern the operation of the government prepayment hospital insurance plan in this Province. The basic issue of local autonomy and central control has also been highlighted as a result of these occurrences.

A summary of the situation is contained in a statement by the B. C. Hospitals' Association (Exhibit 4). This was replied to by the Minister of Health Services and Hospital Insurance in an open letter to the editors of the newspapers of British Columbia. (Exhibit 18).

During this controversy, visits were made to hospitals experiencing financial difficulties by representatives of the Government and the B. C. Hospital Insurance Service. The hospitals were informed that they would have to live within their budgets, as reported in Exhibit 5. Comment on the reduction in staff at one hospital is reported in Exhibit 6, pointing out that, in the opinion of the medical staff, this would be a rather difficult thing to do since, in its opinion, minimum requirements were being met at the present time.

Exhibit 7 indicates that, in the final analysis, the board did reduce staff and that this would probably result in a "reduction in service

to patients". Here then is a situation where a hospital board, which under the Hospital Act is held responsible for patient care, has acted contrary to its own wishes in the operation of the institution. The question then arises as to whether or not this Board of Trustees should still be forced to act contrary to its wishes.

The situation came to a head when one hospital did not meet its payroll because of a shortage of funds (Exhibit 8). Comment from an employee point of view is presented in Exhibit 9, as is that of the Minister in Exhibit 10.

The Board Finance Chairman resigned his post because of charges (Exhibit 11), and since that time a second director has left that board (Exhibit 12). This is a pattern which could be followed in many other hospitals if the financial picture continues to deteriorate.

At the annual meeting of the B. C. Hospitals' Association, reference was made to the financial situation, which was the main subject of discussion at the conference. (Exhibit 13).

Exhibit 14 reports the Minister's remarks, in which the suggestion is made that hospitals are being used for political purposes by certain board members.

Exhibit 15 is a reply to this charge by the Minister by the Administrator of one of the hospitals involved in this crisis.

The Hospital Employees' Union undertook research in the hospital finance field and prepared two documents (Exhibits 16 and 17), putting forth their arguments in the hospital finance controversy.

Exhibit 18 is self-explanatory, and presents the Government's point of view in the discussion.

Exhibit 19 is a comment of one of the papers on the Minister's letter (Exhibit 18), presenting one point of view, and Exhibit 20 reports an editorial from another newspaper presenting another viewpoint.

Exhibit 21 reports the provision of an extra $800,000.00 for hospitals for the advance account. While the Minister states that this is not in response to the representations of the hospitals concerning the financial situation, hospital authorities think otherwise. Whether or not the advance was the result of pressure by the hospitals is a matter of opinion, but only two weeks prior to the B. C. Hospitals' Association conference and its attendant protestations, the Minister had stated that hospitals must hold the line on costs.

Exhibit 22 (page 18 of the British Columbia Hospital News - excerpts of the theme of the 45th Annual Conference of the B. C. Hospitals' Association) indicates the problem as hospitals see it.

This summary of events serves to illustrate the basic conflict between the desire to retain hospital autonomy at the local level and the

apparent necessity of central prepayment control. This problem is the subject of a brief which the B. C. Hospitals' Association has prepared and wishes to discuss with the Premier and Minister of Health Services and Hospital Insurance but has not, as yet, been able to obtain a hearing. It is to be hoped that the proposal which the hospitals have developed to solve this problem will be heard by the Government and will prove to be acceptable to all concerned. Unfortunately, this proposal is still of a confidential nature and, therefore, cannot be discussed here. *

It would appear that the mechanism which has been developed should make it possible to retain the local community hospital as we know it to-day, with its advantages of local initiative and control, and yet provide the financial support necessary for the efficient operation from provincial and governmental sources. If this can be achieved, a very significant contribution will have been made to the hospital field, which will enable our Federal-Provincial hospital insurance programs to steer a course somewhere between the state control of Great Britain and the free enterprise concept of the United States. We may perhaps reap the benefits of both, without suffering the inadequacies of either.

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* attached herewith as Exhibit 23

EXHIBIT I

**EXCERPT FROM A SPEECH BY THE BRITISH COLUMBIA MINISTER OF HEALTH AND WELFARE**

"This government believes that it is of paramount importance to encourage administration of hospital affairs, to say nothing of other such endeavours, as much as possible on the municipal or local level. This government re-affirms its stand by replying that it is not the intention of the government to encroach upon the autonomy of hospital boards."

# CHAPTER 178

## Hospital Act

[*Consolidated for convenience only, May 1st, 1961.*]

Title.

**1.** This Act may be cited as the *Hospital Act*. R.S. 1948, c. 152, s. 1.

Interpretation.

**2.** In this Act, unless the context otherwise requires,

"board of management" means the directors, managers, trustees, or other body of persons having the control and management of a hospital;

"Chief Inspector" means the Chief Inspector or the Assistant Chief Inspector appointed under this Act;

"day's treatment" means necessary medical or surgical treatment in a hospital of a patient for a complete period of twenty-four hours commencing and ending at midnight, but the hours of necessary treatment in a hospital of a patient during the day of his admission and the day of his discharge shall be counted together as one day's treatment;

"hospital," except as otherwise defined in Parts II and III, means a non-profit institution operated primarily for the reception and treatment of persons suffering from the acute phase of physical illness or disability which has been designated as a hospital by the Minister;

"Inspector" means any person appointed as Chief Inspector or Inspector pursuant to this Act;

"Minister" means the Minister of Health Services and Hospital Insurance. R.S. 1948, c. 152, s. 2; 1951, c. 37, s. 2; 1955, c. 35, s. 2; 1959, c. 41, s. 2.

Division of Act into parts.

**3.** This Act is divided into four parts, as follows:—


| PART | SECTION |
|---|---|
| I.—Requirements | 4–6 |
| II.—Private Hospitals | 7–24 |
| III.—Chronic and Convalescent Hospitals | 25–29 |
| IV.—General Provisions | 30–43 |


R.S. 1948, c. 152, s. 3; 1951, c. 37, s. 3; 1955, c. 35, s. 4; 1958, c. 21, s. 2.

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## PART I

### REQUIREMENTS

Requirements.

**4.** (1) Every hospital as defined under section 2, except hospitals owned by the Government of Canada, shall

(*a*) make provision for the representation of the Provincial Government and municipalities upon the board of management of the hospital to the extent and in the manner provided hereunder;

(*b*) have full control of the revenue and expenditure of the hospital vested in its board of management;

Constitution and by-laws, etc., not effective unless approved by Minister.

(*c*) have a properly constituted board of management and such by-laws, rules, or regulations as may be deemed necessary by the Minister for the proper carrying-out of the administration and management of the hospital's affairs and the provision of a high standard of care and treatment for patients, and the constitution and by-laws, rules, or regulations of a hospital shall not become effective until approved by the Minister;

(*d*) comply with any further conditions prescribed by the Lieutenant-Governor in Council.

(2) For the purposes of this section, the Lieutenant-Governor in Council may from time to time appoint a person to represent the Provincial Government upon the board of management of any hospital for a term not exceeding two years.

(3) For the purposes of this section, every municipality in which a hospital is situate may appoint a person to represent it on the board of management. In addition to all other appointments provided for in this section, the Lieutenant-Governor in Council may, if he considers it advisable, appoint a person to represent the municipalities situate in the vicinity of a hospital upon the board of management thereof. R.S. 1948, c. 152, s. 5; 1955, c. 35, ss. 3, 6; 1959, c. 41, s. 3.

Treatment of communicable diseases.

**5.** No person suffering from a communicable disease who is required to be isolated by the regulations under the *Health Act* shall be admitted to a hospital unless it can be established to the satisfaction of the Minister that there is in the hospital accommodation and facilities for the isolation of persons suffering from communicable diseases, and such a person shall not be housed or treated elsewhere in the hospital but in such accommodation during the period in which he is required to be isolated as aforesaid. R.S. 1948, c. 152, s. 6; 1955, c. 35, ss. 3, 7.

Indigency no bar to admission.

**6.** No hospital shall refuse to admit a person on account of his indigent circumstances. 1955, c. 35, s. 8.

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## PART II

### PRIVATE HOSPITALS

Interpretation for purposes of Part II.

**7.** In this Part, unless the context otherwise requires,

"house" includes any building, tent, or other structure, whether permanent or temporary, intended for human habitation; and where there are two or more such structures in the occupation of the same person, and situate on the same piece of land, they shall be deemed to constitute a single house within the meaning of this Part;

scriptions, drugs, dressings, cast materials, and other services as are prescribed by the regulations; and

(*c*) In respect of qualified persons requiring treatment or diagnostic services as out-patients: Such out-patient treatment or diagnostic services as are prescribed by the regulations;

but shall not include transportation to or from hospital or the provision of services or treatment in respect of any illness or condition excluded by the Lieutenant-Governor in Council.

No benefits unless certified necessary and application for benefits made.

(2) No person is entitled to receive any of the benefits provided under this Act unless

(*a*) it has been certified in the manner provided in the regulations that he requires such services; and

(*b*) he proves to the satisfaction of the Deputy Minister that he is a beneficiary by making an application for benefits in the manner and form prescribed by the Deputy Minister upon being admitted to hospital; and if the person requiring admission to a hospital is unable to make such an application, or if he is a dependent, it shall be made on his behalf by a member of his family or some other person having knowledge of the facts required to be stated in such an application.

(3) If a person does not obtain certification as provided in subsection (2), he shall have no claim against the Hospital Insurance Fund for any general hospital services provided to him.

Payments to hospitals by beneficiaries.

(4) Subject to the approval of the Lieutenant-Governor in Council, the right of a beneficiary to receive the benefits provided under this Act may be made subject to the payment by or on behalf of the beneficiary of a portion of the cost of providing any treatment or services rendered to the beneficiary by a hospital, and the Province shall pay, on behalf of any person who is certified by the Deputy Minister of Social Welfare to be a person entitled to health services, any charge levied under this subsection against such a person. R.S. 1948, c. 151, s. 5; 1950, c. 29, s. 8; 1953 (2nd Sess.), c. 11, s. 5; 1954, c. 16, s. 6; 1957, c. 26, s. 3; 1958, c. 20, s. 4; 1959, c. 40, s. 5.

Premiums.

**7.** (1) Upon the coming into force of this section, the Minister of Finance shall pay a premium in respect of the remainder of the current year on behalf of every resident who has lived in British Columbia during the immediately preceding period of time which shall be prescribed by the Lieutenant-Governor in Council. In the case of a person who becomes a resident during the said period of time or on any date after the expiration thereof, a premium shall be so paid on his behalf on the day upon which he has lived in British Columbia as a resident for a term equivalent to the aforesaid period of time prescribed by the Lieutenant-Governor in Council. Every resident on whose behalf such a premium payment is made shall be a beneficiary.

Payment for special services.

(4) Where a person receives hospital services or treatment other than those authorized pursuant to this Act, payment of a sum computed by the hospital shall be made to the hospital by or on behalf of that person in respect of the cost of such other special services or treatment, in addition to the payment of other sums to which the hospital is entitled in respect of any general hospital care which the hospital has rendered to that person. 1954, c. 16, s. 12; 1959, c. 40, s. 10.

Persons who may be excluded from benefits.

**14.** The Lieutenant-Governor in Council may by regulation exclude, in whole or in part, from the benefits provided under this Act any person who is entitled to receive hospital care or treatment under any Act of the Parliament of Canada or of the Legislative Assembly of British Columbia specified in an agreement entered into between the Governments of British Columbia and of Canada, or any person who is entitled to receive hospital care or treatment from any government other than the Government of the Province or of Canada. 1954, c. 16, s. 13; 1958, c. 20, s. 6; 1959, c. 40, s. 11.

Payments in full.

**15.** (1) Where a hospital has been paid out of the Hospital Insurance Fund for any services rendered by it, such payment, subject to the provisions of subsection (4) of section 6 or section 16, shall be deemed to be payment in full for such services, and the hospital shall not seek to recover any additional payment from any other person.

(2) Any person wilfully rendering an account or causing an account to be rendered to a beneficiary for hospital services that are provided, and to which the beneficiary is entitled under this Act, is guilty of an offence against this Act and liable, on summary conviction, to a fine not exceeding five hundred dollars. R.S. 1948, c. 151, s. 16; 1951, c. 35, s. 20.

Other than public-ward care.

**16.** (1) Where a person entitled to the benefits provided by this Act requests and receives care in addition to public-ward care, or where such additional care is provided for a patient upon the order of his physician, the hospital shall be paid from the Hospital Insurance Fund on the basis of public-ward care as provided in this Act, and the hospital may collect from the patient and retain the difference in rates between the public-ward care and the actual care provided.

(2) A proportion of all such sums collected and retained by the hospitals shall be applied towards the cost of providing care in addition to public-ward care, and the proportion of such sums to be so applied shall be in accordance with the directions issued by the Deputy Minister from time to time. R.S. 1948, c. 151, s. 17; 1950, c. 29, s. 17; 1953 (2nd Sess.), c. 11, s. 12; 1959, c. 40, s. 12.

*Finances*

Hospital Insurance Fund.

**17.** (1) For the purpose of this Act, a fund to be known as the "Hospital Insurance Fund" shall be established and maintained in the manner hereinafter provided.

PROV -14/9-

EXHIBIT 4

# A STATEMENT

on

# Hospital Finances in B.C.

**Prepared for the Information of the Public**

**by**

**The B.C. Hospitals' Association**

Many hospitals in British Columbia are at this moment in grave financial trouble. This statement is issued to give the public the background of the present financial situation.

A crisis has been building up for several years. For one reason or another many hospitals have been progressively hard pressed for working capital. It required only a delay in anticipated payments from the provincial government—their chief source of revenue—or credit restrictions, to precipitate a crisis. Now both have happened together.

Substantial amounts of working capital are normally provided hospitals by a system of advances which is a credit to the B.C. government and has up to now been fairly satisfactory. At approximately the middle and end of each month, the B.C. Hospital Insurance Service makes advance payments on a formula related to the budget approved by the government.

The system of advances was undoubtedly started by the Service to assist in the desperate financial plight of the hospitals prior to the inception of hospital insurance. Whether or not the provincial government is under an obligation to make such advance payments, nevertheless it has done so for the past decade. Hospitals have come to rely upon working capital assistance thus provided.

The formula used for the first several months of the year is that based on the previous year's approved cost. Labor negotiations, which the hospitals are compelled, by provincial law, to pursue, commonly result in increased salary costs dating from January 1. The cost of other supplies too is increasing. Money for the Insurance Service is not voted in the Legislature until March. Commonly, it takes the Insurance Service another three or four months to reconcile the competing claims on the funds voted and issue approved budgets to individual hospitals. This year many hospitals did not know what their acceptable costs for the year would be until some time in July.

To the extent that rates are increased, the Hospital Insurance Service has made a retroactive adjustment in its payments. Hospitals can and have been financing the increases in costs for six or eight months, but have arranged their affairs in anticipation of the monies being refunded.

Yet over the years a number of hospitals were never able to clear their bank accounts even after they received retroactive payments. Rightly or wrongly, wisely or unwisely, but **in all cases with no interest but that of better patient care,** year after year they have provided a level of care which costs more than the government is willing to approve. All agree that close control of hospital expenses is necessary, but many feel that in the last ten years the government has applied its controls too rigidly. The human needs that press daily and intimately upon them have been most important, and their financial reserves have suffered accordingly.

The potential crisis thus building up was touched off by a recent change in government policy, or in its practical application. For many of its members this Association hears that their customary mid-summer retroactive payments have been substantially reduced, or delayed. Other evidence indicates that in many hospitals the normal end of August advances were also drastically cut. These two blows fell, as it happened, at the very time when many hospitals were just beginning to feel the effect of new restrictions on bank loans.

Foreseeing this crisis, on May 4 the Association sent a letter over its President's signature to the B.C. Minister of Finance, alerting him to the danger ahead, urging him to give immediate consideration to the working capital problem, offering to meet and discuss it with him. To date this letter has been merely acknowledged. With growing alarm, the Association has continued its studies of the problem, and its search for the solution. It has had prolonged discussions with Insurance Service officials, and it stands ready for discussions at any time, and at any level.

The shortage of working capital is the problem, the root of the present crisis. A solution to it will be found, because it **must** be found, acceptable to the government, hospitals and people of this province.

Whatever that solution may be, this Association and all its members may be relied upon devotedly to follow it through. In issuing this statement, as in all other matters, they have no interest other than ensuring good patient care for the people of this province.

**Inserted by B.C. HOSPITALS' ASSOCIATION**

EXHIBIT 5

TRAIL DAILY TIMES TRAIL, B.C., FRIDAY, SEPTEMBER 7, 1962 Not More Than .06 Daily. EST

# HOSPITAL FINANCIAL CRI
# BLAMED ON OVERSPENDI

By DENNIS WILLIAMS
Editor, The Times

**The financial troubles of the Trail-Tadanac Hospital are directly traceable to the installation by the trustees of costly unauthorized services; and the hospital now will have to enter a period of austerity, health minister Hon. Eric Martin told this editor today.**

**The minister, here for a meeting Thursday evening with the trustees, said he did not contemplate an increase in BCHIS operating grants, to get the hospital over a possible $90,000-odd deficit this year.**

**And, he said, the board should prepare itself for an outcry, particularly from the doctors, as it moved to adjust its spending rate to match its revenues.**

The following is the text of a prepared statement read to this editor by Mr. Martin:

"The financial problems of the Trail-Tadanac Hospital result from the fact that the hospital has spent greatly beyond its income.

"The budget approved for the hospital by the hospital insurance service, takes into account the patients referred to the hospital by doctors from elsewhere.

"The standard ward patient day rate of $21.20 for 1962, is considerably greater than that of comparable hospitals in other parts of the province.

"A full and frank discussion was held with the hospital board.

"It is the responsibility of the board to make certain that the hospital operates within its income.

"It is my opinion that the board will make every effort successfully to place the hospital on a sound financial basis."

In the course of a general review of the hospital's finances, the minister asserted: "We have been extremely generous to this hospital."

He said that the placing of the hospital on a sound business footing did not involve a reduction of services.

Earlier, the hospital board itself had predicted that staff cutting would be inevitable if the per diem grant by BCHIS were not increased.

"It isn't a case of reducing services," insisted the minister.

"The board has added unauthorized services which, of course, places us in an impossible position, because we can't grant special privileges to any hospital.

## "Unnecessary Position"

**"If these added services have been put into operation without first ascertaining whether or not the legislature has voted the necessary supply ("supply" in parliamentary terms means funds), it places us in a very difficult position and, I maintain, an unnecessary position."**

Mr. Martin said he had found the board to be "sincerely concerned" over continuing serious operating deficits.

"I also find they are men of integrity, and they have ability.

"This discussion last night was very lengthy and thorough.

"As a result, a very considerable degree of understanding has been reached.

"I anticipate the usual thing will occur: the odd adjustment will be made which might produce an outcry in this area.

"The doctors will probably object.

"On the other hand, they must face the economic facts of life: the taxpayer can stand only so much."

Mr. Martin spoke of the "splendid efforts" of everyone involved at T-TH, in establishing in Trail an institution offering a "very high level" of treatment and service.

For this, he said, board and staff were to be commended.

**"All in all," said the minister, "I am well satisfied with the outcome of this meeting.**

**"Real progress has been made."**

Mr. Martin was accompanied here by Donald M. Cox, deputy minister, hospital insurance service; and W. J. Lyle, BCHIS hospital finance manager. Mr. Cox and Mr. Lyle participated in the discussion with T-TH trustees and staff. Rossland-Trail MLA Donald L. Brothers also attended the talks.

## "Belligerent At Start"

"I was a bit belligerent at the start," the minister went on.

"But I came to realize these men are very sincere.

"They are not hospital experts, and many of them are new and are feeling their way around.

"But there was a great deal of intelligence shown."

The minister said the hospital was embarking upon a "new era" of administration, and he implied its growing pains on the road to economic adulthood might be prolonged.

But, he said, the hospital must put itself on a sound business basis.

He said whether or not a hospital district was formed here was for local decision.

**"I do think," said Mr. Martin, "that planning for the future could proceed while the deficit is being wiped out by administrative adjustments within the present hospital framework.**

"The hospital board has a plan to expand, I know, and I would want to take a close look at it.

"But over-expansion has been one of the troubles with hospitals in this province today."

Concerning the T-TH cost-revenue picture, Mr. Martin noted that the BCHIS-approved $21.20 per diem grant, compared very favorably with the Vancouver General Hospital rate of $24.

"The rate set for Trail is already extremely generous," he said, discounting the possibility that BCHIS might be persuaded to increase the T-TH grant in the interests of balancing its budget.

EXHIBIT 6

*Kootenays*

# Nurse-cut suggestion opposed by hospital

TRAIL—The Trail-Tadanac Hospital Board has reacted strongly to a proposal from the B.C. Hospital Insurance Service which suggested hospital staff be cut by 17 nurses.

Dr. A. F. Alvarez, medical chief of staff, said: "Don't touch the staff. We are already stretched to the minimum requirements. It is very unfair that we are not going to be allowed to give as high a standard of medical care as those on the coast."

The BCHIS has cut the hospitals' $1,030,783 budget by $99,000 and said that if the revised budget is to be met the nursing staff will have to be cut by 17.

Trustees said the new budget now faces the hospital with an $85,000 deficit and have concurred that the BCHIS proposal could not be met without seriously jeopardizing the safety of patients. They will discuss the situation with the local municipalities.

EXHIBIT 7

# Hospital layoffs 'forced'

TRAIL—The Trail-Tadanac hospital board has been "forced" into its recently-announced staff layoffs, Ald. Harold S. Dixon told city council.

The layoffs, he said, undoubtedly would result in a reduction in service to patients.

"But we have no recourse," he said, "other than to live within the budget.

"I doubt if this can be achieved.

"That is a personal observation and not held by the board as a group.

"The consequences of this reduction are going to be found out in the new year, and I certainly hope there will not be serious consequences.

"We have been forced into this situation . . ."

EXHIBIT 8

# Hospital Unable To Meet Payroll

Vernon 8/9

VERNON (Staff) — Vernon Jubilee Hospital board has informed employees it cannot meet the semi-monthly payroll due to shortage of funds. More than 130 employees should have received salary cheques yesterday.

Lawrence Muirhead, administrator of the hospital told the Daily Courier today that because of inability to pay the board has breached a contract with nurses and lay staff.

"It was certainly not intentional, but we simply do not have the money," he said.

Part of the reason for nonpayment of salary to employees, Mr. Muirhead said, was a retroactive rate adjustment amounting to $17,400 which the B.C. Hospital Insurance Service has not paid. The money was promised when nurses' salaries were increased retroactive to January 1, also the board is limited to $15,000 in bank loans and the banks' refusal to now disallow overdrafts, has caused the embarrassing situation, Mr. Muirhead said.

The administrator said the payroll would be met by Sept. 15, but at the same time payment must then be deferred on trade accounts and suppliers.

"Our first obligation is to our staff and they must be paid. All other outstanding accounts will be paid as money arrives," he said.

Mr. Muirhead said the situation was extremely serious and admitted the hospital board was "quite incapable" of coping.

Meanwhile it is expected the week late pay day will cause a serious burden on many employees.

A member of the administrative staff said employees in the lower wage bracket would be hard hit as monthly charge accounts, as well as food and lodging bills must be met, despite the board's inability to meet the pay deadline.

EXHIBIT 9

Vernon 10/9

# 'No Pay—No Work' Hospital Staff Says

## $20,000 Payroll Not Met —No Money, Board Claims

**Members of the Hospital Employees Union at Vernon Jubilee Hospital will leave their jobs immediately if no pay cheque is received Saturday.**

William Black, secretary of the union, told Health Minister Eric Martin Sunday the employees "won't work", if there is any recurrence of the failure to meet the payroll here.

Jubilee Hospital administrator L. T. Muirhead notified the local union representative Albert Tetz last week, the hospital could not meet the payroll until more money was received from the provincial government.

**Without Pay**

Pay day arrived Friday and 150 employees went without pay, 80 being members of the Hospital Employees Union, and the majority of the remainder affiliated under the Registered Nurses Association. Nurses' representative Miss Hazel Sullivan was unavailable for comment this morning on any action the association might take. Administrator Muirhead said there was a high level of co-operation between the hospital and the nurses.

In an interview with The Vernon News this morning Mr. Tetz said many employees were suffering great hardships because of the failure to pay. "This is a hard time of the year, especially with school resuming. Most of our workers are mothers too, and have certain commitments to keep."

Mr. Tetz said no further statement on union plans would be made until after a special meeting Wednesday at which secretary Black will be present. "I'll only say this, it's not good, and shouldn't happen again."

Meanwhile back in Vancouver Mr. Black said there would not be a strike, but simply a walkout. "We're not being caught in a government squeeze," he stated.

Health Minister Eric Martin was unavailable for comment, but North Okanagan MLA L. Hugh Shantz said he expected a phone call from the minister today, and would report his conversation to hospital board chairman David Howrie Sr.

**$20,000 Payroll**

Jubilee Hospital finance chairman A. W. Howlett told the News that a total payroll of $20,000 should have been paid Friday covering wages until the end of last month.

He said the hospital had a borrowing limit of $15,000 laid down under the constitution of the hospital association, and of this amount $5,000 had already been borrowed leaving $10,000.

Besides the payroll, the hospital owes $34,000 to suppliers to the end of July, making a total of $54,000 in liabilities, not counting August accounts which come due at the end of this month.

Mr. Howlett said the shortage was due to the $70,000 cut in the hospital budget

(Continued on Page 7)

From Page 1

## No Pay

announced recently by the B.C. Hospital Insurance Service. No reason was given, he claimed.

"The situation has been building up for some time," Mr. Howlett went on. "As the government constantly cuts hospital operating expenses, we are forced to dip into our reserves."

"Now the reserves are gone," the finance chairman disclosed.

The hospital's promise to pay September 15 is based on hopes that a government grant in the neighborhood of $25,000 will be received this week.

**Reduced Payments**

Several other hospital administrations in the province said Sunday they had received reduced payments from BCHIS.

Though they are meeting the payroll first, some say they would have to keep creditors waiting and increase their overdraft or make special loans.

Others said the system of payments was so complex they could not tell whether they were short of regular payments or the special half-yearly retroactive payments for cost increases.

They just know they received or expect two-thirds less than they budgeted for in retroactive payments.

"We're never sure we're doing the same arithmetic as the BCHIS," said one administrator, while another claimed "the system was so complicated that no one understands it but Bennett."

EXHIBIT 10

Sun 11/9

# 'Maladministration' Blamed For Vernon Hospital Crisis

VICTORIA (Staff) — Health Minister Eric Martin charged Monday that maladministration by hospital officials was to blame for the financial crisis at Vernon Jubilee Hospital.

Martin said the provincial government had no intention of helping the hospital meet its overdue payroll by increasing advance payments to it under the B.C. Hospital Insurance Service.

He said the only solution was for the federal government to co-operate with provincial authorities by paying part of its share of hospital costs in advance.

He added that otherwise he didn't know what could be done for Jubilee Hospital.

**WAGES NOT PAID**

The hospital's 128 employees were told Friday that their pay cheques due then wouldn't be available until Sept. 15.

Lawrence Muirhead, hospital administrator, said it could not meet the $20,000 payroll because it did not receive the money it expected from the BCHIS.

The B.C. Hospital Employees' Union has warned that its members won't work if the situation occurs again at Jubilee or any other hospital in B.C.

A. W. Howlett, finance chairman at Jubilee, said the hospital has a total of $54,000 in liabilities as a result of a recent $70,000 cut in the hospital budget by the BCHIS.

**'RESERVES HAVE GONE'**

"The situation has been building up for some time," Howlett said. "As the government constantly cuts hospital operating expenses, we are forced to dip into our reserves. Now our reserves are gone."

Howlett said the hospital's promise to pay its employees their back pay by the end of this week is based on the hope that a government grant of about $25,000 will be received shortly.

But Martin, in blaming the trouble on maladministration, stated flatly that the hospital was already over its budget.

**'NO RIGHT TO BLAME'**

"The hospital has simply spent more money than it was authorized to spend and it has no right to blame the provincial government for its troubles," Martin said.

"It's the hospital's responsibility to meet its payroll. It's probable that the banks put their new system of no overdrafts into effect and this allowed the hospital no flexibility in its financing.

("But) they should have had some flexibility. We've paid Vernon more money this year than ever before."

He added that many other hospitals are in a good position because they are well administered. He cited as examples Victoria's Jubilee and St. Joseph's.

Martin agreed that all hospitals could manage their finances more easily if the provincial government increased its advance payments under BCHIS.

**PAYMENTS INCREASE**

"But where are we going to stop?" he asked. "We've already increased the advance payments from $3.5 million a month in 1949 to $5.9 million at present.

"Sometimes I wish we had never brought in the advance payment system. We don't have to do it."

Martin said the problem would be solved easily if the federal government agreed to co-operate in the advance fund system by paying part of its share in advance.

But, he said, the provincial government has to pay the full cost of hospital insurance before it can claim the share owed by the federal government.

"We've got to limit the advance payment fund somewhere," he said. "We have no intention of increasing it at present. It's up to the federal government to co-operate."

Provincial officials explained that under the involved hospital financing formula the provincial government pays about 53 per cent and the federal government about 47 per cent of claims on the BCHIS.

These claims are based on the individual hospital's estimated set costs for the year, plus an estimate of the number of patients it will treat per day.

A hospital cannot exceed its set operating costs, but adjustments are made before the end of a year if it handles more patients than expected, the officials said.

Neither the provincial nor federal government is legally bound to make any payments to hospitals before claims for individual patients are submitted to them.

**HELPING FINANCES**

But the provincial government instituted the advance payment fund to facilitate hospital financing and distribute twice monthly amounts which should be equivalent to about one twenty-fourth of the hospital's annual budget.

If a hospital spends more one month than it expects, the advance payment does not increase, but adjustments are made eventually if the increased spending is due to an increase in the estimated number of patients.

While these adjustments are being made, a hospital could become temporarily short of funds and normally this shortage would be carried by bank overdraft, the officials said.

H. L. Wilson, administrator of the hospital at Summerland, announced that no relief nurses will be employed in future in an attempt to stay within the budget ordered by the BCHIS.

EXHIBIT 11

# Hospital Official Quits Over Charge

VERNON (Staff)—Vernon Hospital Board finance chairman A. W. Howlett has resigned his post.

His resignation was submitted Thursday in the wake of a charge from Health Minister Eric Martin that there is maladministration in the hospital.

Howlett refused to speak to reporters today, but hospital administrator L. T. Muirhead said Howlett "just wouldn't accept the health minister's charge."

"He believes it's completely hopeless to continue," Muirhead said.

Bitterness flared between hospital officials and the government over payments to the institution by the B.C. Hospital Insurance Service.

Employees at the hospital received their pay cheques one week late this month because the hospital failed to get as large a payment from the service as it expected.

The hospital claims it is entitled to $17,400 retroactive to Jan. 1 becuse of a cost increase caused by salary increases.

Muirhead expected the money in a lump sum last week which would have allowed the hospital to meet its payroll, but the BCHIS informed him it would be held back indefinitely.

This action also affected Howlett's decision to resign, Muirhead said.

The administrator said a new finance chairman will be appointed to the board until regular hospital trustee elections are held this fall.

The appointment will likely be made at the board's Sept. 26 meeting.

EXHIBIT 12

*Okanagan*

# Second director quits Vernon hospital board

VERNON—A second member of Jubilee Hospital board of directors has resigned as a result of the hospital's quarrel with Health and Welfare Minister Martin and the B.C. Hospital Insurance Service over finances.

Murray A. Gee, a member of the finance committee headed by A. W. Howlett, has followed his chairman into retirement.

Mr. Howlett resigned following a quarrel with Victoria over BCHIS payments to the hospital, amid charges on the one hand of delayed payments and on the other of poor management. The crisis developed when the hospital was unable to pay wages due to employees.

Mr. Gee said Thursday he was resigning for the same reason as Mr. Howlett, and that he is in sympathy with his views.

EXHIBIT 13

Sun 18/10/62

# Hospitals Denied 'Basic Costs'

PENTICTON (Staff)—President H. R. Slade of the B.C. Hospitals Association charged Wednesday that the provincial government isn't providing enough funds to meet the basic costs of hospitals in B.C.

Slade told the Association's annual conference here that unless the government agrees to meet full basic costs and allow hospitals other forms of revenue the standard of care will drop sharply.

He said the present BCHIS method of setting per diem rates had no true relation to the quality of care or of individual hospital needs because it didn't have the staff or time to make a true assessment.

He said the standard should be set by the individual hospital boards in compliance with the minimums prescribed by the Canadian Council on Hospital Accreditation.

He said local autonomy is a must.

"All the hospitals are interested in — and virtually so — is to receive from the provincial government sufficient funds to meet the true costs, which must include rising costs of wages, services, and other commodities," he said.

"The premier made a recent statement that hospitals would have no trouble if they did as the provincial government did and live within their budgets.

"We agree, if hospitals were allowed to use their own budgets and not the provincial government's, the hospitals would have no trouble."

ish Columbia, Wednesday, October 17, 1962 12 Pages Not more than 7¢ per copy

EXHIBIT 14

# ealth Minister Hits ome' BC Hospitals

## End Of BCHIS Threatened In Disregard Of Budget

PENTICTON (CP)—Health Minister Martin today charged some hospital trustees with financial irresponsibility and said a few hospital boards are "deliberately pursuing a policy detrimental to the hospital and the community."

The minister said he has been greatly "saddened and disappointed" by indications that a few hospital trustees do not understand their responsibility to keep costs down to a level the taxpayer can afford.

Mr. Martin made the remarks in a hard-hitting speech to the 45th annual conference of the B.C. Hospitals Association here.

**OPENED ROUND**

The speech opened the latest round of a running battle between the BCHA and the government on hospital financing.

The minister said the financial records of the few hospitals which have not lived up to their responsibilities show "constant deficits and a seeming disregard for shrinking cash reserves."

"This is most distressing, since this attitude could spell the end of hospital insurance if it were to become the accepted behaviour pattern of hospitals."

## Reference To Vernon?

Mr. Martin did not name any trustees or hospitals but it was obvious his remarks referred partly to Vernon Jubilee Hospital, which was unable to meet its payroll for several days last month. The hospital blamed a delay in its budget payment from the B.C. Hospital Insurance Service.

"These few hospitals which insist upon plunging heavily into over-expenditures ask for government funds to bail them out of their difficulties," the minister said.

"Why should government funds be provided in greater proportion to those boards who have. . . . allowed costs to be increased over the levels maintained by the majority of hospital boards This would be unjust and rewarding to the inefficient and discriminatory against the efficient."

Most hospital boards took appropriate measures to correct an off-balance financial picture.

"However, occasionally it is found that a board is deliberately pursuing a policy detrimental to the hospital and the community.

"I sometimes suspect that politics might be a motivating force in some board members, but I hesitate to say this directly, since such a charge would be the worst thing that could be made against anyone. To think that anyone would play politics with the health of the people is almost unthinkable."

**BCHA President Told:-**

VERNON NEWS 22/10/62

EXHIBIT 15

# Hospital Denies Political Motivation In Crisis

A sharp denial of any political inspired motives in last month's financial crisis at Vernon Jubilee Hospital was given to the B.C. Hospitals' Association in Penticton.

Writing to association president H. R. Slate on behalf of the local hospital board, administrator L. T. Muirhead said that he had not observed any "politics" in board decisions with regard to hospital business. "The board itself takes strong exception to any such inference, which I understand, has been made by the Minister of Health Services," Mr. Muirhead wrote.

Parts of Mr. Muirhead's letter were used by the hospitals' president in his report to the convention. Text is as follows:

Mr. H. R. Slade, President
B.C. Hospitals' Association.
Prince Charles Motor Inn,
Penticton, B.C.

Re: Vernon Jubilee Hospital Payroll Difficulty.

Dear Mr. Slade:

"When the Minister of Health Services visited our hospital, towards the end of September, to speak with our board, it was apparent that he was very much interested in trying to find out just what disposition had been made of our August 31 cheque from the B.C. Hospital Insurance Service. This cheque amounted to $27,717, which was sufficient to cover our month-end payroll, but we owed the bank slightly more than that amount. In accordance with our regular borrowing arrangements, the bank deposit was applied against our overdraft and borrowings. The board did not (at that time) have authority to borrow sufficient funds to permit payment of the full amount of the payroll, and decided it had no alternative but to notify the staff that the payroll could not be met until September 15.

"Mr. Martin insisted that the $27,717 payment was intended to cover the month-end payroll and indicated that he could recover the payment. He implied that the board had misused the funds.

"As of August 31, the B.C. Hospital Insurance Service was withholding $12,500 in retroactive rate adjustment payments, which, if received by the hospital by September 8 or 10, would have enabled the hospital to release the payroll cheques on Friday, September 7, the regular pay date. The board innocently believed, until September 3, that it was likely the hospital would receive payment of this amount, especially under the circumstances. On September 3, however, a letter arrived from B.C. Hospital Insurance Service which indicated that further payment of the retroactive adjustment would not be possible.

"On Thursday, September 6, the board's executive committee met to review the situation finally before payday. The situation at that time was that $20,000 additional credit would be required from the bank to meet the payroll, but only $10,000 additional borrowings could be authorized under the hospital's by-laws. It was not practical to pay a part of the payroll only. The cheques had been prepared and were ready for signature. On Friday, September 7, the staff were notified that the pay cheques would not be released until September 15, or possibly the 17th, at which time funds would be available from the B.C. Hospital Insurance Service.

"On Monday, September 10, the board's executive met again, at which time it was decided that an extraordinary meeting of the Vernon Jubilee Hospital Association should be held to consider an amendment to the by-laws in regard to borrowing powers. Such a meeting required 14 days notice. The meeting was held on September 28, and the by-laws were amended to extend the board's borrowing powers to $30,000 from the present $15,000.

"The situation in regard to the payroll difficulty was eased considerably September 11 when word came that the mid-month cheque from B.C. Hospital Insurance Service would be expedited. It arrived on September 13, and the delayed pay cheques were released immediately. The knowledge that this would be possible helped considerably in a meeting on September 12 with the officers of Local 180.

"The following is a summary of what happened from August 31 to September 28, some of which has already been explained in this letter:

"1. A telegram and letter were sent to B.C. Hospital Insurance Service August 31 requesting financial assistance and warning them that payment of the month-end payroll depended on their assistance. A reply received September 3 offered no possibility of help.

"2. The month-end B.C. Hospital Insurance Service cheque arrived and was deposited forthwith. This amounted to $27,717, and included about $1,500 on account of the retroactive rate adjustment. From a letter received September 8 it was clear that B.C. Hospital Insurance Service was retaining $12,500 which the hospital had expected to receive.

"3. On September 6 it was certain that the pay cheques could not be released on September 7 (the regular pay date). The "book" overdraft at that date, including payroll cheques, amounted to $26,048. This exceeded the hospital's borrowing limit by $11,048. Employees and others were notified accordingly. Cheques were released to employees going on vacation, or otherwise leaving.

"4. Receipt of a cheque from B.C. Hospital Insurance Service, in the amount of $25,000 on September 13, enabled the hospital to release the pay cheques. This cheque was deposited in the bank forthwith and was automatically applied against the hospital's borrowings. Under arrangements made with the bank, demand notes in denominations of $5,000 are given to the bank periodically. These notes are used to cover overdrafts, and are retired automatically when deposits to the hospital's bank account make this possible.

"5. On September 26, Mr. Martin, Mr. Cox, and Mr. Lyle met with the hospital board in Vernon. The meeting was arranged by Mr. Martin. The board was charged with maladministration over the years in permitting the hospital's operating expenses to exceed income. It was made clear to the board that the hospital must keep within its approved budget. It was also indicated that until the hospital demonstrated its ability to operate within the approved budget, authority would not be given for any new construction. The obvious need of working capital was mentioned.

"6. The Vernon Jubilee Hospital Association met September 28 to consider an amendment to the by-laws. A motion to increase the board's borrowing power to $30,000 to meet operating expenses was adopted.

"I would like to say on behalf of the board, that I have not observed any politics in board decisions with regard to hospital business. The board itself takes strong exception to any such inference, which I understand has been made by the Minister of Health Services."

EXHIBIT 16

# THE HOSPITAL GUARDIAN

HOSPITAL EMPLOYEES' UNION, 180, N.U.P.E., C.L.C

## SPECIAL BULLETIN

# MR. MARTIN CAN'T DENY THESE FACTS:

## A Special Report on the Continuing Crisis in British Columbia Hospitals

On September 18, B.C. Health Minister Martin sent an open letter to the editors of B.C. newspapers. He asked them to reprint material contained in his letter regarding financing and operation of our acute general hospitals and the B.C. Hospital Insurance Service.

A province-wide survey shows that very few newspaper editors complied with the minister's request.

The minister then used government facilities to send a second letter to many thousands of persons in B.C. complaining that the newspapers did not reprint the material he had sent them.

One could come to the conclusion that the government is more concerned with public relations than with the provision of good hospital service.

Why did the newspaper editors not utilize Mr. Martin's material?

Newspapers have a responsibility to their readers. They have to deal with facts. Naturally, the editors contacted their local hospital boards. The facts they learned bear witness to a crisis that has been building up for several years.

### It's Not New

This is no new crisis. It is only accelerating. The "hold the line" policy, the "tight budget" policy — with the Minister directing letters to the Chairmen of Hospital Boards — has been in existence for years.

Mr. Martin claims that there is a limit to the extent to which the taxpayers of this province can provide funds for the operation of their hospitals. We agree.

But, there is also a limit to which the government can siphon off hospital insurance funds. This amounts to approximately $27 million in the last four years — money which the public provided for the insurance scheme.

There is a limit to the over-drafts which the banks will furnish to the hospitals.

There is a limit to the length of time hospital suppliers will wait to be paid.

There is a limit to what the hospital worker is going to take.

We say to the Honorable Minister that the hospital care which the public has paid for, and is paying for, is starting to be denied.

### Here is Evidence

The trend is clearly established.

Public notice has been given that the hospital in Cranbrook, owned and operated by the Sisters of Charity of Providence, will not operate after December, 1965. The residents of this section of B.C. will then be without hospital facilities.

The Castlegar and District Hospital Board of Management is taking steps to reduce the number of beds in the hospital to cut down their operating deficit.

### *HOSPITAL DEFICITS . . . THE HARD FACTS*

Health Minister Martin claims adequate funds are being provided for B.C. Hospitals. But the financial records — reproduced here in approximate round figures — show this picture for those hospitals which have come to our attention:

| | |
|---|---|
| Castlegar | $ 14,000 |
| Trail-Tadanac | 102,000 |
| Vernon | 48,000 |
| Kamloops | 19,000 |
| St. Paul's, Vancouver | 35,000 |
| Van. Gen., Vancouver | 500,000 |
| Mt. St. Joseph, Van. | 24,000 |
| N. Vancouver ('61) | 32,000 |
| Prince Rupert (4 mo.) | 5,000 |
| Surrey | 25,000 |
| Royal Columbian, New West'r ('61) | 40,000 |

The Trail-Tadanac hospital has been directed by non-professional persons connected with the government and BCHIS to cut 17 nurses from the staff. Dr. A. F. Alvarez, a physician who sits on the hospital board, said this would make it impossible to carry out present levels of treatment. Dr. Alvarez added, significantly: "We are already taking chances."

Salmon Arm Hospital is unable to meet $3,500 in trade accounts; the long-planned new hospital at Fort Nelson has been cancelled due to the government's austerity program.

If more evidence is needed, it can be found in the financial statements which must be made public by organizations receiving government funds. The box at the bottom of this page shows the deficits reported by a few of those hospitals which have come to our attention. There are also some hospitals in B.C. which show balanced budgets. But there are few indeed that do not have to resort to bank overdrafts or deficit financing.

### No Cinderella Role

Hospitals deal with human health and human life. Surely, human health and human life deserve a major role in any government's operation. They don't deserve to be relegated to the Cinderella role they are now being asked to play in B.C.

Tables 1 and 2 on the reverse side of this page show the steadily decreasing importance placed on this vital service by the government and BCHIS.

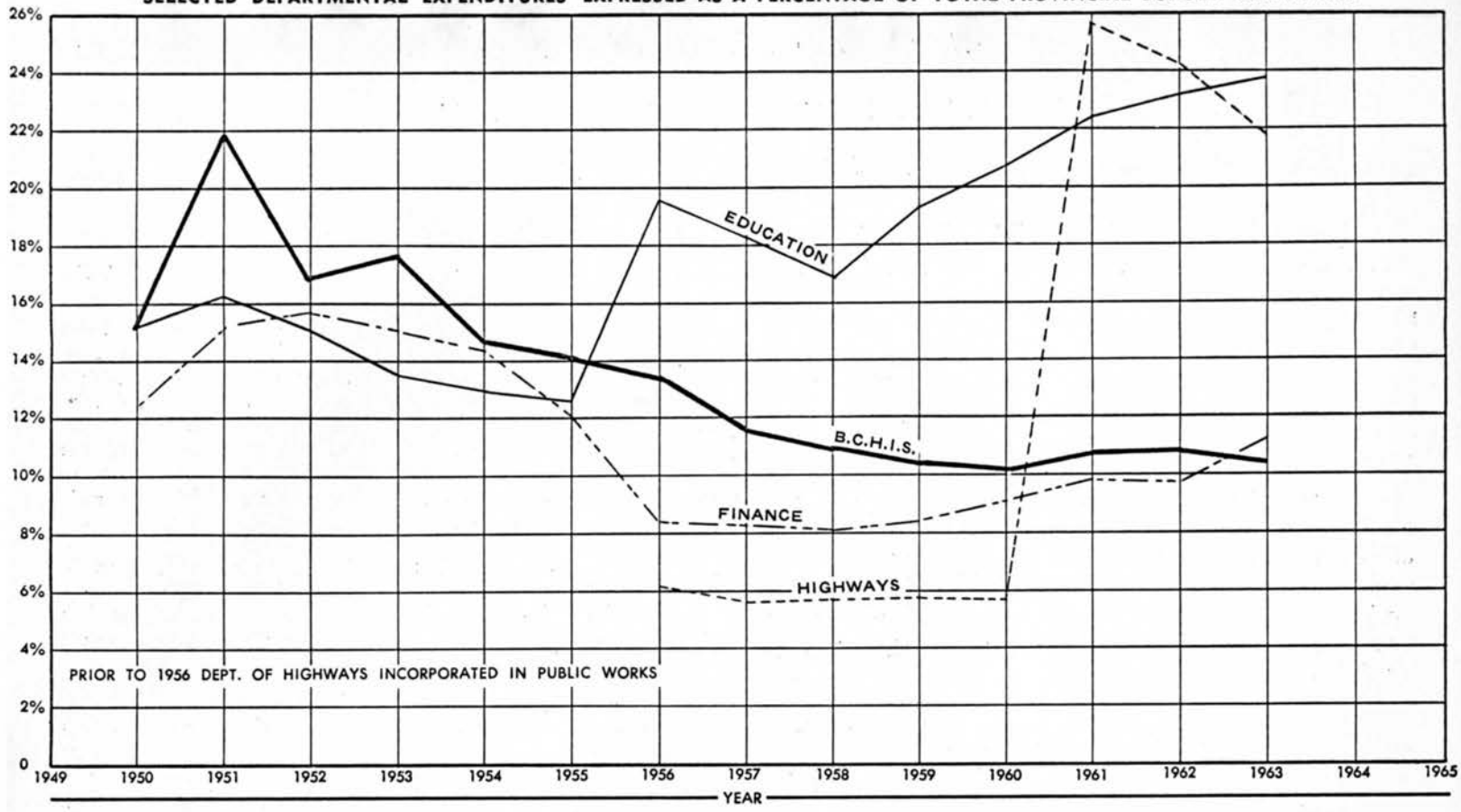
The problem of financing our general hospitals is not one which is going to be resolved by public debate, or by the sending out of thousands of leaflets.

We cannot afford to play around with our hospitals in this dangerous fashion.

Before there is complete anarchy — and surely no one has anything to lose by putting his cards up on the table — we suggest, as responsible members of the community, that a thorough examination of the financial policies of the B.C. Hospital Insurance Service should be undertaken by a Royal Commission, with instructions to put our hospital care scheme on a sound financial basis.

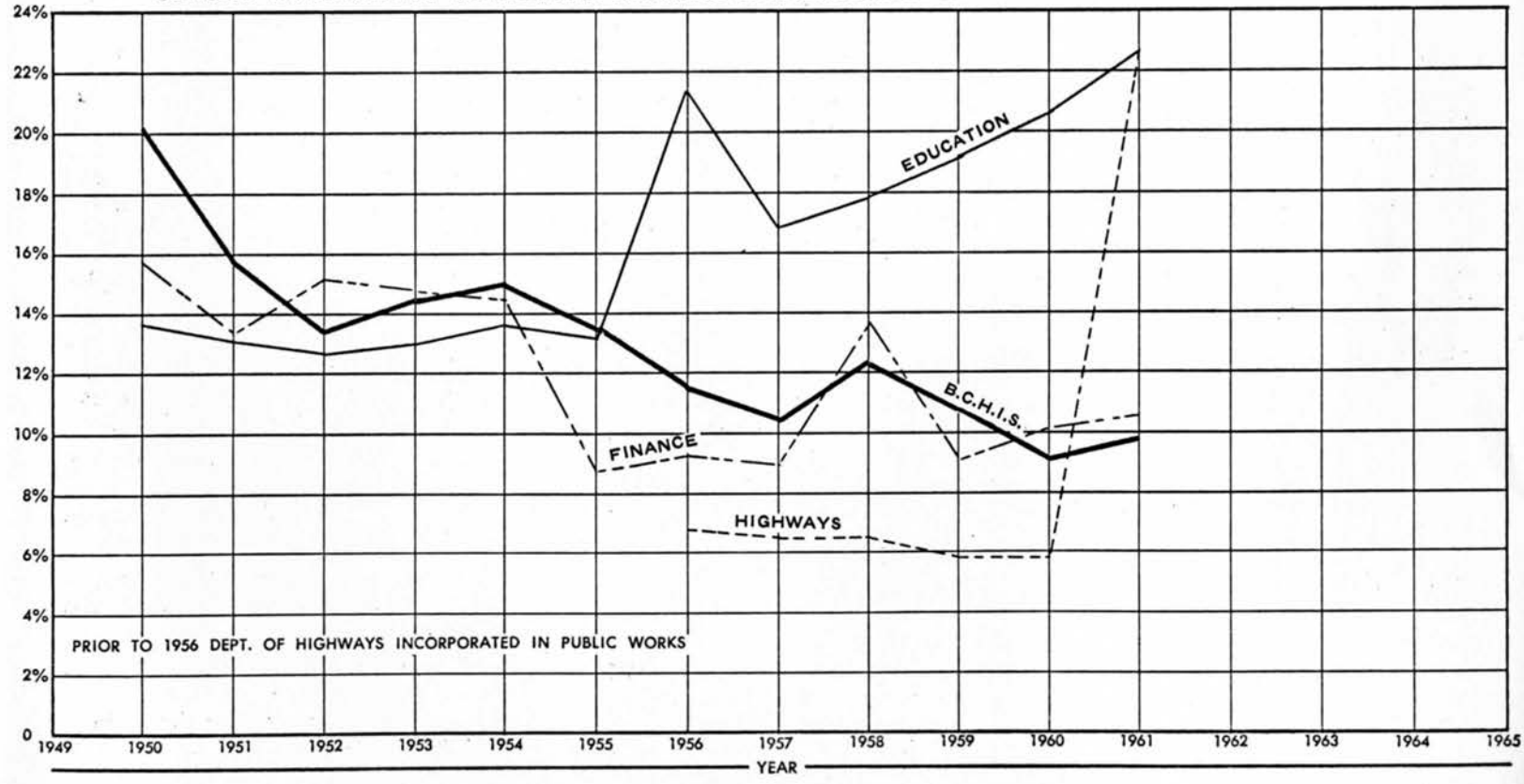
## TABLE 1

**SELECTED DEPARTMENTAL EXPENDITURES EXPRESSED AS A PERCENTAGE OF TOTAL PROVINCIAL BUDGET (ESTIMATED)**




## TABLE 2

**SELECTED DEPARTMENTAL EXPENDITURES EXPRESSED AS A PERCENTAGE OF TOTAL PROVINCIAL BUDGET (ACTUAL)**




In an effort to present a clear and factual picture, without conflict or confusion the percentages utilized in the above charts are based on Net Provincial Costs. The statistical source is based on net costs. Gross cost figures incorporate Federal Government subsidies; however, even if the gross figures were used the pattern of expenditures by provincial department would remain relatively unchanged.

STATISTICAL SOURCE:

Table 1. Adapted from "Estimates," Province of British Columbia, 1950-1963.

Table 2. Adapted from "Public Accounts," Province of British Columbia, 1950-1961.

EXHIBIT 17


# THE HOSPITAL GUARDIAN

HOSPITAL EMPLOYEES' UNION, 180, N.U.P.E., C.L.C.

VOL. III. VANCOUVER, B.C., OCTOBER, 1962 No. 2


# HOSPITAL FINANCE PROBE DEMANDED; 'SICKNESS' IN BCHIS MUST BE CURED

Hospital Employees' Union Local 180 today declared that the acute general hospital system in B.C. is suffering from a dangerous sickness.

The Union demanded a Royal Commission to investigate the operation and financing of hospitals and find a remedy before it is too late.

Officers and employees of the Union have penetrated a smoke screen of propaganda and untruths surrounding the operation of B.C. Hospital Insurance Service, the agency which is charged with providing hospital care.

They found indisputable proof that over the past four years at least $27 million gladly provided by the people of B.C. for hospitals has been diverted to other government projects.

This amount has been kept from the hospitals by a prolonged system of installment plan starvation. The result — complicated by other unhealthy factors — is a growing fever chart of symptoms. Among them:

- One hospital has failed to meet its payroll; others are merely squeezing by, thanks to the indulgence of their banks and suppliers.
- Long hidden conflicts in BCHIS operating procedure are coming to light.
- The provincial minister of health, Mr. Martin, has issued a long public statement which is either cynical or the result of poor advice. It does not jibe with the facts.
- It is an open secret among administrative and medical authorities that due to the above factors, the standard of care given patients in B.C. hospitals must soon suffer — if indeed the deterioration has not already started.

It would be unfortunate if these events took place anywhere in Canada.

In B.C. it is tragic, because it is a matter of record that the B.C. Hospital Insurance Scheme is second to none, and the hospitals of B.C. are among the most efficient and the most economical in America.

Consider these accomplishments, in which hospital employees have been proud to play a part:

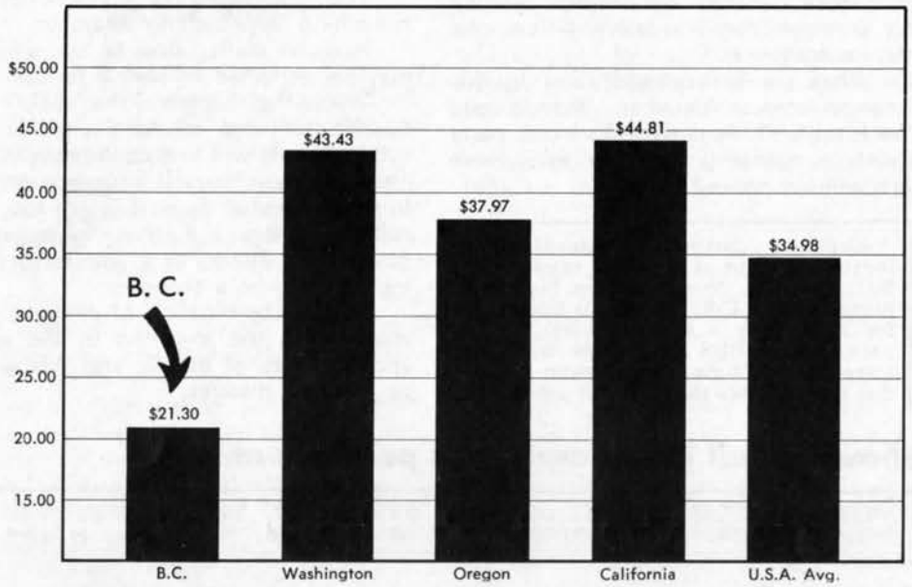
- The ratio of hospital expense per patient day in B.C. is strikingly below that of comparable hospitals in the U.S. (See chart page 1).
- The number of full time employees per 100 patients in B.C. hospitals is well below the Canadian average, far below that of neighboring hospitals in the U.S. (See chart page 2).
- The increase in hospital personnel per patient day — an unavoidable trend due to a revolution in treatment techniques — is nevertheless lower in B.C. than in other comparable hospitals. (See chart page 3).

These facts are true and are well known within the industry, if not by the general public. In addition, the taxpayers of B.C., through both federal and provincial governments, make enough money available to operate hospitals for all with efficiency and dignity.

Why then do we see an atmosphere of crisis and wild-eyed penny pinching

(Continued on Page 2)

**Comparison Total Expense per Patient Day — Pacific Northwest**




*STATISTICAL SOURCE:* Journal of the American Hospital Ass'n, Aug. 1, 1962; B.C. Hospital Statistics, year ending Dec. 31, 1960.

HOSPITAL CRISIS 1962

## The Situation in Brief

1. Hospitals are in deep financial trouble, although taxpayers are putting up adequate millions through the federal government and the provincial two percent sales tax.
2. Over the years, more than $27 million in taxes raised for hospitals has been diverted into other projects.
3. The government hints that the financial trouble stems from inefficiency by hospitals, but this isn't true.
4. The trouble lies in installment plan starvation — plus a basic lack of communication between BCHIS and hospital boards.
5. If this crisis isn't solved, patient care will suffer.

# PROBE DEMANDED

## From Page One

that can do nothing but impair efficiency and detract from public confidence?

The answer lies primarily in the financial operation of the provincial government and its agent, BCHIS.

There is this fact which no amount of press releases can deny: Hospitals are not getting the money that an enlightened public is making available. In the past four years, the difference between the yield of the two per cent sales tax in B.C. and the amount expended on general hospitals amounts to $27 million. (For details drawn from the Public Accounts of B.C. see table upper right).

It is conveniently forgotten today that before the advent of the two per cent sales tax, many people escaped paying premiums altogether. The provincial government picked up the tab, amounting to many millions. But since the advent of the sales tax, BCHIS has been a source of revenue, not expense, to the financial wizards of Victoria.

This is especially true when you consider the further contribution of the Federal Government.

And despite the remarks of Premier Bennett and Health Minister Martin in recent days that the two per cent sales tax was not hitched directly to hospital costs, the fact remains that the tax was "sold" on that basis, and people have paid it all these years under the impression that at least they were financing a sound hospital scheme.

The financial policy of BCHIS in its dealings with hospitals has always been a deliberate one. "Too little and too late" seems to have been the motto.

| | Payments for Services and Grants in Aid | Federal Contribution | Provincial Portion | 2/5 Sales Tax and Amusement Tax | Amount of Sales and Amusement Tax Unspent |
|---|---|---|---|---|---|
| | | (IN MILLIONS) | | | |
| 1959 | $43,814 | $12,784 | $31,030 | $35,617 | $4,587 |
| 1960 | 48,330 | 20,406 | 27,924 | 37,868 | 9,944 |
| 1961 | 53,318 | 22,590 | 30,728 | 36,846 | 6,118 |
| 1962 | 58,018 | 25,697 | 32,321 | 39,013 | 6,692 |
| | | | | | Total $27,341 |

The following table of figures, computed from the financial reports of the provincial government, show clearly that more than $27 million which the public believes is earmarked for hospitals has in fact been diverted to other projects.

(Note: The provincial government now says that two per cent of the provincial sales tax was never directly tied to hospitals. However, a policy statement in the August, 1962, issue of the official B.C. Government News states: "On April 1, 1954, the collection of premiums was discontinued and the social services tax was increased from 3 to 5 per cent to provide the funds formerly raised by premium collections for the (Hospital) Insurance Service.")

The result came to public attention on the morning of Sept. 8 of this year, at which time the impossible happened, and Jubilee Hospital at Vernon failed to meet its payroll.

The immediate reason has been well documented elsewhere. In brief, BCHIS payments were so small and so late that the hospital exhausted its bank credit. It could happen to other hospitals.

But behind this bizarre event there are more general questions which must be answered:

What is the basis of an accounting procedure in which no hospital can tell for sure whether it is solvent from one day to another?

What are the ground rules in this strange contest between Victoria and the hospitals? And why does one party insist on changing whatever rules there are without notice?

Canadian government figures show the true picture of the staff situation in B.C. hospitals. Note that the high employee rate in U.S. hospitals is accounted for in part by a shorter, more intense patient stay. DBS figures are used for Canadian hospitals because some provincial governments use different yardsticks.

Why is there a chronic lack of communication between the hospital boards and BCHIS? Why is there no sensible formula for settling disputes that are bound to arise in a project of this magnitude?

Hospital administration is one of the most complex operations on earth. Members of this Union do not pretend to have all the answers. But the answers must be found, and we submit this can best be done by a Royal Commission with full power to unravel mysteries wherever they may occur.

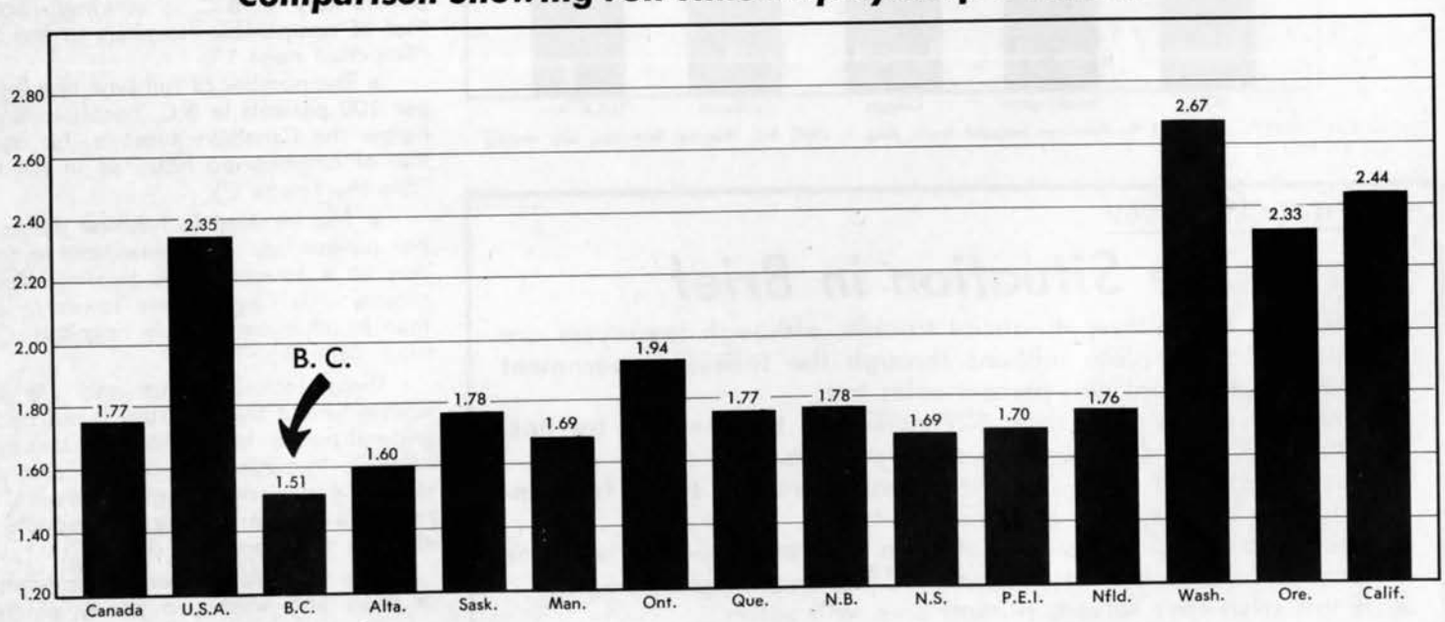
The alternative is continuation of something approaching anarchy.

Hospital staffs, already overworked, may be expected to shrink further.

When that happens, the quality and quantity of care afforded patients will suffer. People will lose confidence in hospitals and their hospital insurance scheme. In these peculiar days, it is not too difficult to foresee a further tightening of government funds, or a general tightening of the whole economy.

Such a combination of circumstances could mean the lowering of the ideals and purposes of BCHIS, and this would be a public disaster.

## *Comparison Showing Full Time Employees per Patient*




*STATISTICAL SOURCE:* Journal of the American Hospital Ass'n, Aug. 1, 1962; D.B.S. Hospital Statistics.

## IN THE SPOTLIGHT

**Ian Manning**

This issue of the Hospital Guardian turns the spotlight on Ian Manning, administrator of Surrey Memorial Hospital and a man of varied background and talents.

Mr. Manning was born in Kirkcudbrightshire, Scotland, and can still pronounce the place of his birth.

He was a radio officer during the war in Europe, then served in Egypt and Palestine as a sergeant-instructor (education). He remarks that this phase included an illuminating period attached to a Guards battalion. The spit and polish guards regarded him as a curiosity because of a certain lack of interest in polished boots, and hair that persisted in growing longer than the regulation two inches per bristle.

From 1947 to 1952 Mr. Manning studied economics and personnel work in Glasgow, and also in Cleveland, Ohio, on a Fulbright travel scholarship. It was here he met his future wife, whom he says was then disguised as a sophomore. During summer holidays he worked in the fields, and as manager of international student farm camps in Scotland.

There followed a "mercifully short" period as a printer's devil, followed by work with the Ontario Hydro in selection, placement and related personnel matters.

At this juncture, Mr. Manning decided on a career in the hospital field, and bridged the gap by setting up a job analysis at the 700-bed general hospital in Indianapolis. Later, he took graduate studies in hospital adminstration, which included a "very full year" as administra-

(Continued on Page 6)

## THIS WE CHALLENGE

# Health Minister's Statement Comes Under Union Attack

On Sept. 18, 1962, there appeared in newspaper offices across the province an "Open Letter To the Editors of the Newspapers of B.C." It was signed by Eric Martin, minister of Health Services and Hospital Insurance.

This document contains information which the Hospital Employees' Union can and must challenge here and now:

Mr. Martin claims there is no foundation in reports that cuts have been made in hospital budgets.

We wish he hadn't said that. For one thing, it's a well known fact that the budget of almost every hospital in B.C. has been cut for one reason or another, sometimes legitimately. It would be strange indeed from a taxpayer's point of view if BCHIS, the paid agent of the public, were to accept holus-bolus every budget submitted by every hospital board in B.C. Mr. Martin must mean something else. The question is, what?

Mr. Martin states: "In the fiscal year 1958-59, the actual payments made by BCHIS to hospitals for hospital care amounted to $37,683,000. In the current fiscal year, the funds voted by the legislature to cover these payments total $57,240,000, an increase of $19,557,000, or about 52 per cent."

Mr. Martin should know full well that the federal government contribution — which he chooses to ignore — was $12,784,000 in 1958-59, and increased to $25,697,000 in the current year. The contribution by Mr. Martin's government was $31,029,542 in 1958-59, which remained relatively static in the current year at $32,320,603. And during that time, Mr. Martin's government showed a surplus of over $27 million on its hospital operations.

Mr. Martin states that although his government does not hitch hospital service to the sales tax yield, "anyone who studies the official estimates for 1962-63 would see that 40 per cent of the sales tax revenue is approximately a quarter of a million dollars below estimated payments to hospitals. Would it be suggested that hospitals cut their budgets this year to provide for this? Of course not."

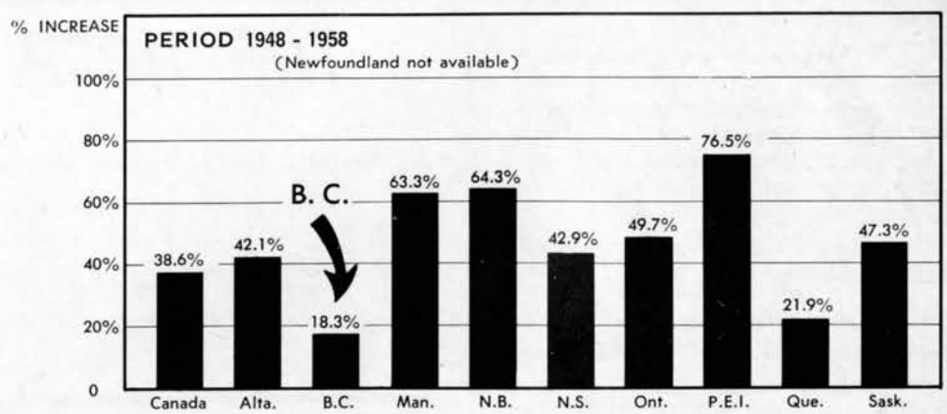
The clear inference here is that the provincial government is going to dig into some special fund to bail the hospitals out. Is that a fact? Of course not! This bit of free-wheeling fails once again to take into consideration the contribution of the federal government, which last year amounted to $25 million.

The open letter winds up with a backhand blow at all those hospitals which are having financial troubles at the moment. It says: "Since 1958-59 increases of 52 per cent in payments to hospitals have been provided, and there is no reason at all for a hospital to be short of funds if prudent management had insisted that developments take place only within the financial means of the hospitals."

The inference to any casual reader is that hospital management must have been imprudent.

We commend to Mr. Martin the wealth of statistical material in this publication which shows that hospital management is prudent indeed — often to a point where it hurts.

### *Increase in Ratio of Personnel to Daily Average Number of Patients*




*STATISTICAL SOURCE:* Adapted from D.B.S. Annual Report of Hospitals, 1948, 1950 and 1952, and Hospital Statistics, Vol. 1, 1954, 1956, 1957 and 1958.

# Across the Business Manager's Desk

In the *Guardian* of December, 1961, we wrote an article entitled "Fair Warning — Hospitals Must Obey Contracts."

In some areas there has been little or no improvement.

Contracts are still being violated and workers are still being intimidated. These violations have been catalogued and when we reach the bargaining table we will have something to say about these situations.

It may be that the hospital trustees are not informed. They may be unaware of the internal operation of their labour relations policies.

In other articles in this *Guardian*, we have demonstrated the ratio of employees to patients. We know that staffing is tight. We appreciate that the majority of departmental heads are fair, but as usual, there is an ignorant minority which condemns the majority.

### Ignorant Minority

It is this minority, which we refer to as the "little corporals", or the "little Hitlers" if you like, who lay the wood on the workers. They take out all their own personal frustrations, expose their own weaknesses by statements like this: "If you don't like working here, you know what you can do."

The creation of an atmosphere of fear within the hospital institution is a poor substitute for good, sound labour relations policies.

In some areas we hear a great deal about social justice. In fact, lectures are given on the topic. Our concern is not at the top management level where we can negotiate reasonably and fairly with the various members of hospital boards and trustees. Our problem is with the "little corporals," who do not appear at the bargaining table.

### Suit Own Whims

Apparently they have adopted the principle of divine right. They have set themselves up to interpret the various contract provisions to suit their own whims.

In other sections of this publication we have pinpointed a basic weakness in the B.C. Hospital Insurance Service — the lack of communication. The same weakness is perpetuated by many of our hospitals in the province of B.C.

At the conclusion of contract negotiations we have yet to hear of an administration that has called together the various administrative teams and explained the ramifications of the agreement and its interpretation.

We have attempted to develop Supervisors' Manuals — a standard interpretation of our Agreement, and the various labour policies of the hospital institution. But apparently we have failed to get that off the ground.

### Contract Violations

There have been contract violations and statute violations, right, left and centre. We intend to see that there is fair administration of our agreements and some social justice injected into labour administrative techniques.

If this is not so, then hospital workers will "work to rule"; the provisions contained in our Agreements and in the various labour statutes will be strictly enforced and adhered to.

Let this be fair warning.

# *Hospital Care Has Weak Link*

The public need for uninterrupted, skillful, and efficient care of the sick, created hospitals.

In British Columbia, orderly and efficient hospital planning, expansion, and extension of services has been made possible through public support and financing of the British Columbia Hospital Insurance Service.

As British Columbians we take pride in the advances we have made in the matter of hospitalization, but, just as we are able to pride ourselves on our accomplishments, we recognize also our shortcomings.

It is the shortcomings of our B.C. Hospitalization scheme, coupled with reports of accelerated construction of 50 and 75 bed, profit making private hospitals that are now causing us deep concern.

There is no doubt that the chronically ill patient, the aged patient, and the convalescing patient all present problems to our public acute care hospitals. But these people have two things in common with those patients who are free to use the complete facilities of the publicly sponsored hospitals. They are sick, and they finance the hospital scheme on an equal basis.

Our hospitalization system was devised to take care of the sick and injured. Not just the acutely sick, not just one or another type of easy to handle sick or injured person, as may suit the desire of the institution; but to provide the necessary needed care for all of our citizens.

Many in the medical profession are so absorbed in the pressing problems of purely physical disease, and in the maintenance of their public image or status in the community that they appear to have little sympathy for the rehabilitative and convalescent need of their flesh and blood patients.

Also, the Provincial Government, through B.C.H.I.S., by consciously or unconsciously sidestepping the need for total public hospital care, because it happens to present unusual and perhaps a

**(Continued on Page 7)**


# THE HOSPITAL GUARDIAN

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*All submissions and correspondence to be sent to:*

W. M. BLACK, *Business Manager*

335 West Broadway Vancouver 10, B.C.

*"In humble dedication to all of those who toil to live."*

BROADWAY PRINTERS LTD.

## OUR SCHOLARSHIP WINNERS

# Local 180 Invests In Education

Four young people have begun their university careers with the assistance of the scholarship program of Hospital Employees' Union Local 180.

Winners of the 1962 scholarships, each valued at $250, are:

SYBIL SMITH-GANDER, 16, whose mother works at Burnaby General Hospital;

ELIZABETH DEMCHUCK, 18, whose mother is a nurse aide at St. Joseph's Hospital, Victoria;

CAROL JOLING, 17, whose mother is a hospital aide at Nicola Valley Hospital, Merritt;

DON HOWARD, 16, whose mother is a nurse aide at Royal Columbian Hospital, New Westminster.

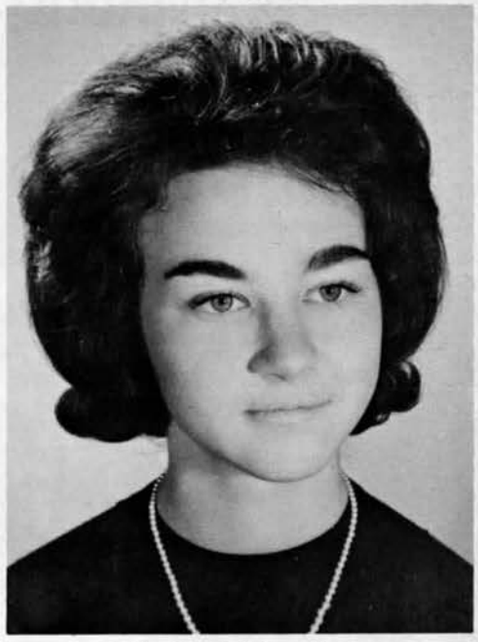
The scholarship program was established at the union's 1960 convention. Last year two scholarships were awarded, and this year the Vancouver General unit established two additional scholarships.

All are awarded students entering UBC or Victoria College for the first time. Candidates must write government examinations and achieve 70 per cent or over. They must also be sons or daughters of active members of the Hospital Employees Union.

SYBIL SMITH-GANDER, whose home is at 4584 Gilpin St., Burnaby, is at UBC working towards a BA. She may follow this up with a master's degree in social work — or perhaps a career in journalism.

Sybil's favorite subject is English; she is also studying world history, zoology, psychology and Chinese, a subject which she believes would be an asset to a social worker in Vancouver. She makes her own clothes, attends the theatre whenever possible, and with four others has written and produced a play.

**Sybil Smith-Gander**



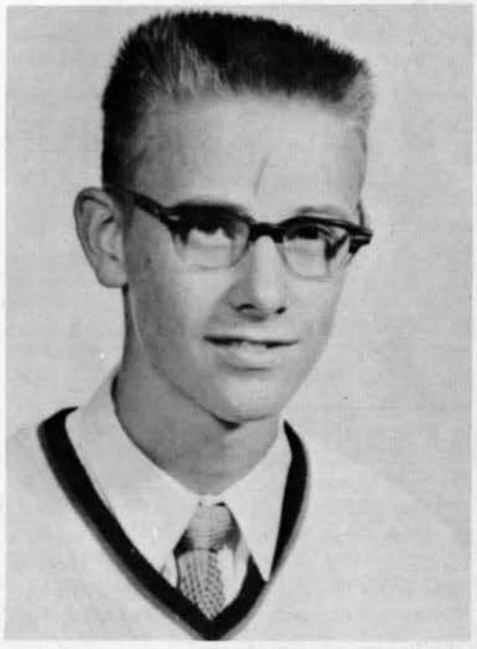
**Elizabeth Demchuk**

ELIZABETH DEMCHUCK, now a student at Victoria College, hopes to attend UBC next year and work towards a degree in Home Economics. She is interested in the food section of the course, and may find employment on the experimental staff of a food firm. In high school she was president of the Home Economics Club and co-ordinator of the annual school fashion show. Her hobbies are reading, cooking and sewing.

CAROL JOLING is now in residence at Anne Westbrook Hall, UBC, and is working towards a BA, specializing in French and German. Eventually she may become an interpreter, or a secondary teacher here or abroad. She is a sports enthusiast, and like the other two girl scholarship winners, finds it "handy and usually much cheaper" to sew her own clothes.

DON HOWARD, the only male scholarship winner this year, lives in North Surrey, is enrolled in Arts and Science and will probably follow a career in science. His chief hobby is sports and he plays baseball in the Connie Mack League.

**Carol Joling**



**Don Howard**

## *The Sales Tax Argument*

The provincial government is well aware that a significant amount of the money paid by taxpayers in the hospital portion of the sales tax has not been spent in the hospital field.

That is why government spokesmen are now saying that the sales tax increase was never tied to hospital finance.

But even if we were to accept Health Minister Martin's version of this dispute, the fact remains that no reserve fund has been set up with the excess money. Common sense would indicate that this should have been done, because should sales tax revenues be decreased by recession or depression, it is obvious that other sources of revenue would also dry up.

# CONVENTION AT PENTICTON





**A SUCCESSFUL CONVENTION** has one vital ingredient — people who are interested, active and responsible. Local 180 had scores of these at the Penticton convention, some of whom are shown here. No. 1 shows (from left) acting mayor of Penticton Perley McPherson, guest speaker Harry Slade of B.C. Hospitals' Association, and business manager Bill Black; No. 2 a group of delegates as they go about convention business; No. 3 shows the newly-elected provincial executive and regional representatives; No. 4, constitution committee chairman Wally Fedak (at right) and members of his committee report to convention.

# DELEGATES CHART FUTURE POLICY

PENTICTON — More than 100 delegates from all parts of B.C. met this summer as Hospital Employees Union Local 180 held its third biennial convention at Prince Charles Motor Hotel here.

For a week, delegates met to review union activities for the past two years and to formulate new policies and procedures for the next two years.

Delegates approved a resolution calling for removal of discriminatory clauses in the Municipal Superannuation Act. They also asked that free medical coverage for unemployed workers and their families be extended until such time as the worker is re-employed.

Delegates unanimously condemned the practice followed by some public bodies of "contracting out" jobs held by union members. This, delegates found resulted in deterioration of service to the community and generally resulted in higher costs.

A resolution calling for the union to provide an annual grant of $500 to assist in technical and vocational education was referred to the incoming provincial executive to make a study of factors involved in its implementation.

A number of constitutional amendments were given convention approval, including a proposal setting forth qualifications for table officers in established units of 250 members or more.

To ensure experienced "trusteeship" at the unit level, the constitution is to be amended to provide that one trustee will be elected at annual elections for a two year term, and the other two trustees will be elected to serve one year terms.

## IN THE SPOTLIGHT

(Continued from Page 3)

tive resident with preceptor Leon Hickernell at Vancouver General Hospital.

In the summer of 1958, Mr. Manning bounced and clattered 6,000 miles through Europe on a small overloaded motorcycle, his wife wedged between himself and a tall pile of camping gear tied onto the machine at the rear.

While serving as assistant director of the 300-bed McLaren Hospital in Flint, Mich., his family expanded in the form of two redheads, Gavin and Fiona. While in Flint, the family had a memorable camping trip to the Windward Islands, where he visited two hospitals and also climbed a remote trail to visit the few remaining Carib Indians.

Mr. Manning took up his duties as adminstrator at Surrey Memorial in March, 1962.

## *Death Takes Phil Forsha and Wife*

**A motor accident this summer took the life of Brother Philip Forsha, one of the pioneer builders of the Hospital Employees' Union, and his wife, Ermie.**

**Brother Forsha came to Vancouver General in 1940 from the Marpole Infirmary and worked at VGH for four years. He took employment elsewhere for a time, then in June, 1947, returned to Vancouver General and immediately became most active in union affairs.**

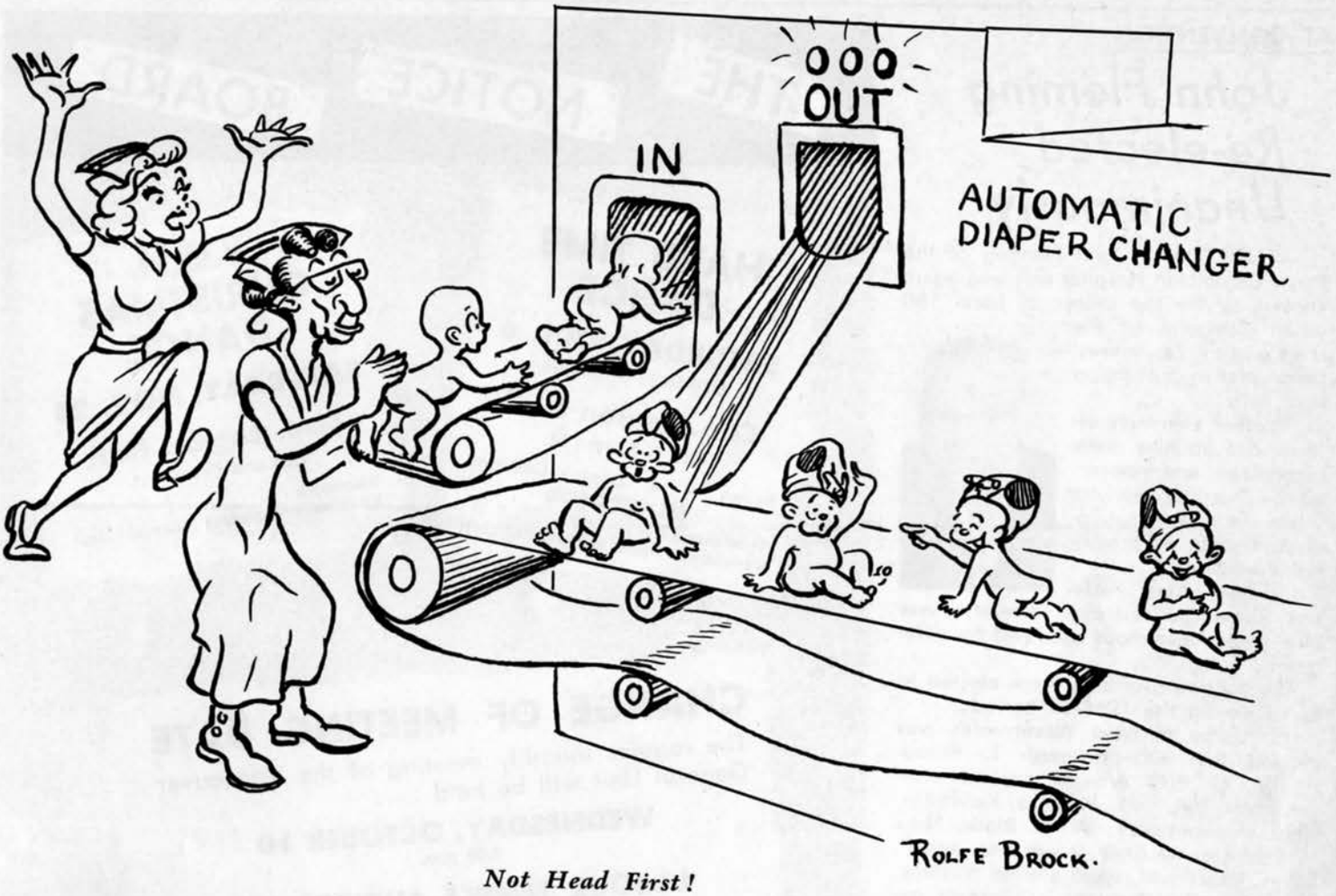
**He served on the provincial executive from 1953 to 1959. In 1956 he was elected first vice-president by acclamation. For the remainder of his term as an executive member, he was a trustee.**

**During the whole period he helped make the decisions which led to the building of this union as a strong provincial organization.**

**In his own local unit he served for nine years as secretary, and during that whole time missed only one meeting. That was due to serious illness.**

**In his final year he was chairman of the Vancouver General Unit sick committee.**

**Brother Forsha will be missed throughout the province, both as friend and as a worker in Local 180.**




*Not Head First!*

**BUSINESS MANAGER'S REPORT:**

# Events of Two Big Years Come Alive

How do you compress the events — big and small — of two momentous years in the life of a big province-wide organization into the space of a few hours?

Normally, it can't be done. But delegates to the Penticton convention of Local 180 agreed that business-manager Bill Black had apparently accomplished the impossible.

Brother Black's report occupied 53 manuscript pages. But in the hours he was on his feet before the convention he managed to transform a vast mountain of facts into a living documentation of 24 months — a never-ending series of decisions and battles involving every member of the union.

The report, too long to be summarized here, encompassed every field of union activity, and should be required reading for those individuals who balk at paying dues to the union which fights their battles.

Brother Black made these major points:

• The strength of Local 180 lies in the fact it is the unified voice of hospital workers. Divisions or splinter groups could cause trouble.

• The concept of regional bargaining is developing well, although there are pockets of resistance to the idea and a great deal of ground work remains to be done.

• Local 180 is the inspiration — and often the envy — of hospital workers across Canada.

• Nurses, experiencing long and frustrating negotiating sessions this year, may have to take a new look at their bargaining position.

• The Local will require additional high calibre headquarters staff if the present rate of growth is to be maintained.

At the end, it was moved by Brother Sevin of VGH and seconded by Brother Weisgerber of St. Paul's that the report be accepted with the greatest appreciation for the work of Brother Bill Black.

# Hospital Care Has Weak Link

(Continued from Page 4)

difficult variety of social as well as medical problems, plays into the hands of groups in our midst who believe that profit can, and should be extracted from those individuals who are unfortunate enough to become ill, from those who are bedridden, and from those patients who require periods of convalescence.

That we should allow profit seeking groups to enter the hospitalization field is morally indefensible, especially so when you consider that we have the necessary finances, and have demonstrated that publicly supported and financed hospitalization has brought the finest low cost acute hospital care in North America to the citizens of British Columbia.

We now urge the provincial government to implement a custodial nursing care program in conjunction with the existing acute and rehabilitative hospital care scheme.

**AT CONVENTION**

# *John Fleming Re-elected Unanimously*

PENTICTON — John Fleming of the Royal Columbian Hospital unit was again chosen as the top officer of Local 180 when delegates of the Hospital Employees' Union met in convention here.

Brother Fleming's efforts and abilities were recognized and rewarded by hospital workers when he was unanimously chosen as Provincial President.

Brother Alex Paterson, provincial financial secretary, was also given unanimous approval by delegates.

The following officers were elected to serve during the 1962-64 period:

J. Darby of New Westminster was elected first vice-president; L. Woodthorpe, of Port Alberni, second vice-president; Mrs. C. E. McInnes, Kamloops, third vice-president; W. D. Black, New Westminster, H. Duff, Vancouver, and P. Sevin, Vancouver, were elected trustees. W. Fedak of Vancouver is alternate executive member.

Regional area representatives were elected as follows:

Fraser Valley: L. Moore of Langley.

Lower Mainland: J. Weisgerber, St. Paul's, Vancouver.

Okanagan: A. Tetz, of Vernon.

Kootenays: R. Cole, of Nelson.

Vancouver Island: W. Power, of the Victoria Solarium.

## Closed Session Sets Precedent

The Penticton convention included one unprecedented feature — an eight-hour closed session in which delegates let their hair down for the good of the union.

The object: to formulate major organization and negotiating policy.

Bargaining procedures and structures were changed, streamlined and strengthened. Selection of regional bargaining teams was reviewed, and the basis of representation improved.

Delegates also tightened up bargaining techniques.

---

The *St. Louis Post-Dispatch* said: "The FCC is going to look into deep necklines on TV. It isn't often government investigators get an assignment like that."

# THE NOTICE BOARD

**HARD TIME DANCE**
**SATURDAY, OCT. 6**
8:30 to 12 Midnight
**Can. Legion Hall**
49th & Fraser St.
Prizes ★ ★ Door - Costume
TICKETS $1.00
Sponsored by
Vancouver General Hospital Unit

**V.G.H. CHRISTMAS DANCE**
**SATURDAY, NOV. 24**
**Can. Legion Hall**
49th and Fraser St.
Sponsors . . .
Vancouver General Hospital Unit

**CHANGE OF MEETING DATE**
The regular monthly meeting of the Vancouver General Unit will be held . . .
**WEDNESDAY, OCTOBER 10**
8:00 p.m.
**LABOUR TEMPLE AUDITORIUM**
307 West Broadway

*Annual*
**SMORGASBORD DINNER DANCE**
**SATURDAY, NOVEMBER 24, 1962**
8:00 P.M.
**STRY HALL, 8th & Main**
Sponsored by St. Paul's Hospital Unit

ROYAL COLUMBIAN HOSPITAL UNIT
**CHILDREN'S ANNUAL CHRISTMAS PARTY**
**KNOX CHURCH HALL**
**MONDAY, DECEMBER 17, 1962**
7:30 P.M.

EXHIBIT 18

TELEPHONE EV2-6111
LOCAL 2220

THE GOVERNMENT OF
THE PROVINCE OF BRITISH COLUMBIA

MINISTER OF HEALTH SERVICES AND HOSPITAL INSURANCE

VICTORIA

September 28th, 1962.

Dear Sir:

During the past few weeks, many newspapers and other news services have given considerable publicity to claims of shortages of funds for hospital operation and even of deficits. There have also been contentions that hospital employees are being unfairly dealt with and that a good standard of patient care in hospitals is being made possible only because it is subsidized by hospital employees. Because of this misinformation, I wrote an open letter to the editors of all newspapers in the Province pointing out the facts which clearly show the great increases in payments to hospitals and, while I cited the figures for the past three years, I can assure you that the figures since the start of the Hospital Insurance Service are equally revealing. For your personal information, I am attaching a copy of my letter to the editors.

Unfortunately many editors, particularly the metropolitan daily newspaper editors have not seen fit to bring to the attention of their readers the information in my letter. I know that this matter has been the subject of discussion in a great many communities and I felt that it might be of interest to you to have an accurate summary of the great improvements in hospital income over the past few years. I hope this information will be of value to you whenever you have occasion to discuss this matter.

Yours very truly,

ERIC MARTIN,
Minister of Health Services
and Hospital Insurance.

Encl.

TELEPHONE EV2-8111
LOCAL 2220

THE GOVERNMENT OF
THE PROVINCE OF BRITISH COLUMBIA

MINISTER OF HEALTH SERVICES AND HOSPITAL INSURANCE

VICTORIA

September 18th, 1962.

AN OPEN LETTER TO THE EDITORS
OF THE NEWSPAPERS OF BRITISH
COLUMBIA

Gentlemen:

It is a matter of great importance that the following information be made available to the readers of your newspaper.

Recently, news accounts stemming from hospital officials have resulted in a totally erroneous impression regarding the provision of funds to the hospitals by the Provincial Government. Statements that "cuts have been made in hospital budgets" have appeared several times, and yet these statements are completely without foundation. They are false and if allowed to go unchallenged will mislead the people. Other statements claim that payments to the hospitals are inadequate and this too is misrepresenting the facts.

In the fiscal year 1958/59, the actual payments made by the B. C. H. I. S. to the hospitals for hospital care amounted to $37,683,000. In the current fiscal year, the funds voted by the Legislature to cover these payments total $57,240,000, an increase of $19,557,000 or about 52%.

Another way of looking at this matter is to compare the hospitals' calendar year 1959 with 1962. This shows that staffing has been increased by 12% while patient days were increased 10%. In this same period of time, gross salary costs went up by 27%.

References are also being made to the revenue of the sales tax. Obviously, it is most unwise to hitch a vital service such as hospital insurance to the yield from any tax, since in poor times the hospitals would be required to cut their operating costs to fit the tax yield. However, even though the Provincial Government does not operate on that basis, anyone who studies the official estimates for 1962/63 would see that 40% of the sales tax revenue is approximately a quarter of a million dollars below estimated payments to hospitals. Would it be suggested that hospitals cut their budgets this year to provide for this? Of course not!

There is not a hospital in this Province which has not enjoyed substantial increases in revenues from the B. C. H. I. S. during the past



few years. The majority of hospitals have been able to do very well indeed within the revenues provided by the Provincial Government. Many wind up the year with surpluses, which they use to increase their cash reserves. Many finish up the year in a stabilized position without incurring either surpluses or deficits of significant size, while a few plunge heavily into overexpenditure which results in sizeable financial losses.

It is quite evident that even after allowances are made for the increased number of beds and increased level of patient days, the operating costs of the hospitals and the salaries and wages paid to hospital employees have increased at a much more rapid rate than have the average incomes of the people of the Province. In addition, hospital employees have within the past two years been given superannuation coverage at a cost of almost $1,500,000 per year, and one-half the cost of medical insurance at a cost of $250,000 per year. The charges for these benefits have to be paid by the taxpayers of this Province, many of whom do not enjoy these benefits.

Obviously, there is a limit to the extent to which the taxpayers of this Province can provide funds for the operation of their hospitals. The standards of hospital care and treatment in the hospitals of B. C. are very good and comparable to those found anywhere, and we all have good reason to be very proud of this degree of excellence. It is natural that conscientious hospital boards want to further improve the services they provide. The Provincial Government recognizes and encourages this attitude, and proof of this is the substantial increases in funds which we have provided during the years. However, it is common sense to acknowledge that this progressive development can only take place within the ability of the taxpayer to meet the costs involved.

Hospital budgets have not been cut--they have been increased every year, and this year stand at the highest level in the history of British Columbia. Since 1958/59, increases of 52% in payments to hospitals have been provided, and there is no reason at all for a hospital to be short of funds if prudent management had insisted that developments take place only within the financial means of the hospitals.

Yours truly,

ERIC MARTIN,
Minister of Health Services
and Hospital Insurance.

Authorized as second class mail, Post Office Department, Ottawa, and for payment of postage in cash.

Authorized as Second Class Matter by the Post Office Department, Ottawa, and for payment of postage in cash.

# BRITISH COLUMBIA Government News

VOLUME 10, NO. 7 VICTORIA, B.C., OCTOBER, 1962 Published the third week of each month.

# Hospitals to Receive Payments of $57,240,000 in Current Fiscal Year

In recent weeks several newspapers have given considerable prominence to what some sources have referred to as the "dire financial problems of hospitals" brought about by "cuts in hospital budgets." The Honourable Eric Martin, Minister of Health Services and Hospital Insurance, in an open letter to the editors of the newspapers of British Columbia stated that these claims are without foundation. "Hospital budgets have not been cut, they have been increased every year, and this year stand at the highest level in the history of British Columbia," Mr. Martin said. In support of his statements on hospital financing, Mr. Martin pointed out that the funds voted by the Legislature in the current fiscal year to cover payments made by the British Columbia Hospital Insurance Service to hospitals total $57,240,000, exclusive of grants for hospital construction. "This represents an increase of $19,557,000 or 52 per cent over payments made to hospitals in the fiscal year 1958/59," he continued. Mr. Martin further stated that a comparison of hospital statistics for the year 1959 and those estimated for 1962 shows that while patient-days have increased 10 per cent, the number of hospital employees has increased 12 per cent and gross salaries are up 27 per cent during the four-year period. "This shows that the operating costs of hospitals and the salaries paid to hospital employees have increased at a much more rapid rate than the average incomes of the people of the Province," the Minister said. "As a matter of fact," he continued, "since the start of hospital insurance coverage in British Columbia in 1949, the number of patients in the general hospitals of the Province has increased approximately 80 per cent, whereas the total number of full-time employees has more than doubled, and gross hospital salaries in 1962 are more than four times what they were in 1948. Added to these costs is the fact that within the past two years hospital employees have received superannuation coverage at a cost of almost $1,500,000 a year to the Government, plus another $250,000 representing one-half the cost of medical insurance."

Mr. Martin said that he is satisfied that the majority of hospital board members and hospital administrators are most conscientious in keeping their hospital expenditures within reasonable limits, and that he had no doubt also that hospital employees realized that they had very fair treatment. "However," he said, "some hospitals that were overspending and found themselves in a deficit position complained vigorously to the press, giving the people of the Province a misleading impression of the general good conditions. For example, here is what happened to one of the hospitals that has run into financial difficulties because their spending exceeded their revenues. In 1959 this hospital spent $565,000. The budget approved by B.C.H.I.S. for 1962 is $686,000, which allows them an increase of $121,000 or 21.4 per cent in three years. However, this hospital actually proposed to spend $753,000 in 1962, *despite the fact that a slight decrease was expected in the number of patient-days to be provided.*"

When Mr. Martin was asked to comment on news items which referred to statements by hospital officials that "hospitals are not receiving their two-fifths share of the sales tax," he replied, "A fluctuating tax is an extremely hazardous foundation on which to build a sound business, and I know it is the last thing any responsible board of management would want the Government to do."

Another factor which Mr. Martin said must be considered in this question of just how much can the taxpayer stand, is the contribution made by the Provincial Government to hospital construction. In the present cost-sharing formula, the Provincial Government pays one-half the approved cost of acute, rehabilitation and convalescent bed construction, one-third the costs of equipment and improvements, and one-third the costs of the construction of nursing-home type beds by non-profit organizations. "Since the inception of the hospital insurance plan in 1949, more than 6,100 acute, chronic, and nurses' beds have been built in over fifty-two separate centres at a cost to the Provincial Government of $33,600,000. A further $4,800,000 has been given to hospitals for the purchase of equipment."

***Hon. Eric Martin.***

One of the Province's newspapers, in an editorial written in reference to Mr. Martin's letter, said, "While private business has been trimming its sails for three years the hospitals have been proceeding unaware of any such economic changes outside their doors. Payments to hospitals by B.C.H.I.S. have increased 52 per cent since 1958/59. Well might people ask, how much longer can this sort of increase continue? Mr. Martin should have come out flat-footed and said that budgets and revenue must be brought into line. If he does not, then the normal operation of economics will take care of the situation. The results will cost us dearly."

In summing up the situation, Mr. Martin said, "There is not a hospital in the Province which has not enjoyed substantial increases in revenues from B.C.H.I.S. during the past few years. The majority of hospitals have managed extremely well and at the same time maintained a high level of patient care. Many of the hospitals, through sound administration, are able to finish the year with a surplus. It is natural that conscientious hospital boards of management want to do everything they can to further improve their services, and the Provincial Government has encouraged this attitude by providing increased grants each year. However, common sense dictates that progressive development must take place within the ability of the taxpayer to meet the costs involved."

***Illustrative of the Province-wide hospital construction programme is the new 160-bed Nanaimo Regional Hospital, being built at an estimated cost of $3,500,000, and now in the final phases of construction. Provincial Government grants will exceed $1,750,000.***

# PREMIER OPENS ROGERS PASS

The speeches made, the ribbon cut on the hot afternoon of July 30, and one of the most spectacular motor routes in North America became part of British Columbia's highway system.

The Honourable W. A. C. Bennett cut the ribbon at 3.15 p.m. and in a few minutes motorists filled the new Rogers Pass portion of the Trans-Canada Highway.

A line of cars nearly 6 miles long had waited on the highway near Revelstoke solely to be among the first to use Rogers Pass. As the awed travellers passed over the faultless black-top they marvelled at the great mountain structure of snow and rock rising almost from the edge of the roadway, which without question is a masterpiece of engineering skill and practical foresight.

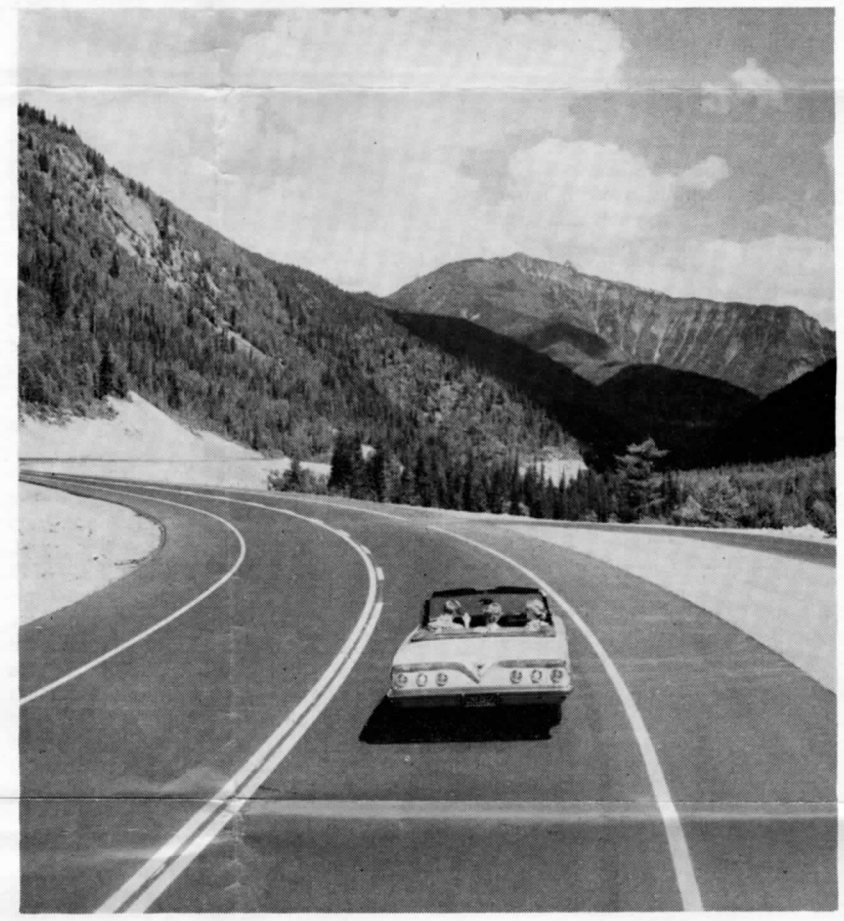
### ECONOMIC ADVANTAGES

Because it will cut 100 miles and three hours off the original Big Bend route between Revelstoke and Golden, the new Rogers Pass has tremendous value as well as beauty. Strawberries from the Shuswap area can reach the Calgary-Edmonton markets in 8½ hours instead of two nights and a day, the former time required. Hence, with the inevitable increase in commodity movement, plus reduction in the transportation costs that would otherwise have been the case, the economy of the whole area is bound to improve. As well, tourists can now make a complete circle tour of British Columbia via Highways No. 95 and No. 3. Rogers Pass provides the shortest all-Canadian route from the Pacific Coast to the Canadian prairies.

### WORLD'S TOUGHEST

Hon. P. A. Gaglardi, Minister of Highways, told the large crowd assembled for the opening ceremony that no highway project had been more challenging for Provincial and Federal engineers. The route, said Mr. Gaglardi, traversed some of the world's toughest road-building country.

Laid among giant timber and thick brush, passing towering bluffs and sheer rock faces, skirting deep ravines and chasms and hurrying streams and rivers, close to huge snowfields and in the shadow of great mountains, the new road is a combination of magnificence and breath-taking beauty.



*Rogers Pass.*

# *Major Export Study*

Market opportunities for Canadian goods in twelve areas of the Far East are outlined in a recent report prepared by Provincial research staff.

The publication "Export Opportunities in the Far East" is obtainable, free, from the Director, Bureau of Economics and Statistics, Department of Industrial Development, Trade, and Commerce, Parliament Buildings, Victoria, B.C.

# Time and Terrain Alter Bridge-building Methods

Over the past twelve years about 300 bridges have been built in British Columbia. Of these, thirty-six are of semi-permanent creosoted timber construction.

Though most replaced obsolete structures, the total number in the Province dropped from some 3,300 to less than 2,900, because many were replaced by culvert and fill. This is indicative of the change in construction techniques in recent years. Whereas formerly it was cheaper to build a timber trestle over a gorge, now with modern earth-moving equipment use of culvert and fill is cheaper. From Hope to Lytton in the reconstruction of the Trans-Canada Highway the total number of bridges has dropped from forty-eight to twelve, but the over-all footage of bridges has dropped only from 9,266 to 6,500 feet.

The Alexandra Bridge is five times the length of its forerunner. Similarly, Yoho Bridge east of Golden is more than three times the length of the bridge it replaced.

Rivers in British Columbia are the prime barriers to Provincial highway construction, and in 1961 three bridges were being built over each of the two major rivers, the Fraser and Columbia. These were completed last year, while an additional bridge across the Fraser River has been started at Prince George.

### AVERAGES DIFFER

During three years of the past decade, the number of bridges constructed was seventeen per year, considerably below the average of twenty-five. However, between 1957–58 the average was more than doubled with a total of sixty-two bridges built. Fifteen of these were railway-grade separation structures to replace existing structures, others to eliminate level crossings. Railway-grade separations and overpasses and underpasses of minor roads in the past five years have become a major part of bridge-construction programmes. Fifteen out of twenty-two structures in the 1959–60 programme, and twenty-six of forty-five in the current programme, are this type.

While most major bridges have steel superstructures, the Department of Highways has recently completed three reinforced concrete arch bridges: Capilano (main span 345 feet), Elk River (main span 300 feet), and Mosquito Creek Bridge (main span 213 feet). Prestressed concrete also has established itself as a construction product for short-span structures. Of the sixty bridges completed in the past two years, twenty-five have been at least partially of prestressed concrete.

# Ministers Discuss Common Policy

The Minister of Lands, Forests, and Water Resources, Hon. Ray Williston, represented the Province of British Columbia at a meeting of the recently formed Resource Ministers Council, held in Toronto, September 20 and 21. The meeting, under the chairmanship of the Hon. J. W. Spooner, Minister of Lands and Forests for Ontario, comprised one Minister from each of the ten Provincial Governments and one Minister from the Government of Canada.

The Council was set up following the Resources for Tomorrow Conference that took place October, 1961. The Conference emphasized the need for a high measure of co-ordination and co-operation in resource-management policies among the eleven senior Governments of Canada.

### EFFECT ON EXPLOITATION

It was recognized that establishment of resource-management policies had an important effect upon the economic and social welfare of the people of Canada, and at the same time many of Canada's fiscal monetary and trade policies would exert an important effect on the exploitation of Canada's natural resources. Thus, the need for co-ordination of resource work among the various Governments became apparent.

The Resource Ministers Council deliberated in the field of government policy, and for this reason the meeting differed considerably from the Resources for Tomorrow Conference, a gathering of scientific and technical experts asked to exchange information on scientific techniques.

# *Government Scholarships Increase By 25 Per Cent*

A total of 380 students who obtained first-class standing of 80 per cent or higher in the University of British Columbia and Victoria College examinations of 1962 have qualified for Government of British Columbia scholarships.

The scholarships represent half the tuition fee of the Faculty in which the student will take training in 1962–63.

In addition to these first-class winners, approximately 1,300 University and Victoria College students with second-class standing will also qualify for scholarships representing one-third of their fees.

The Minister of Education, Hon. Leslie R. Peterson, said the first-class scholarships, as one-half of the fee, range generally from $161 in the Faculty of Arts to $264 in the Faculty of Medicine. The number of successful students this year was an increase of some 25 per cent over the past two years.

"This is a commendable achievement," said Mr. Peterson.

# NEW HOSPITAL FOR CARIBOO

The Minister of Health Services and Hospital Insurance, Hon. Eric Martin, opened the new Cariboo Memorial Hospital at Williams Lake during a special dedication ceremony August 24.

The five-storey hospital provides accommodation for seventy-two beds, and cost an estimated $1,470,000. Provincial Government grants toward the approved construction costs will be some $735,000. In addition, the Government will pay one-third the cost of equipping and furnishing.

The top floor of the reinforced-concrete building was left unfinished and will provide an additional thirty beds when required at a future date. Construction of a new eighteen-bed nurses' residence is expected to start in the near future.

The new Cariboo Memorial Hospital will provide a complete range of services, including diagnostic and laboratory facilities, major and minor operating rooms, an emergency department, a pharmacy, physiotherapy services, and a laundry. This replaces the old thirty-bed frame hospital built in 1918.

## Lakes Cleared Of Coarse Fish

Restocking Niskonlith Lake southwest of Little Shuswap Lake with 14-month-old six and eight-inch rainbow trout has been completed. Trout used came from the Kootenay Lake stock of the Lardeau River run. Fishing in the lake will be resumed later.

Also part of the fishery rehabilitation programme, Paul Lake some 16 miles north-east of Kamloops was cleared of coarse fish subsequent to later restocking with sports fish. Provincial fishery biologists in charge of the operation said the 60,482 acre-feet of water, plus Louie Lake and adjacent tributaries, were cleared without incident.

## Added Acreage

Foreshore reserve of 180 acres has been added to Sidney Spit Marine Park, bringing the total land and foreshore area of the park to 717 acres.

Sidney Spit, one of five completed marine parks, is situated on the northern tip of Sidney Island, about 3 miles east of Sidney village.

## New Road Into Waterfowl Area

First road built in British Columbia specifically to aid waterfowl hunters has been completed.

Near Tofino on the west coast of Vancouver Island, just less than a mile has been built through dense jungle-like bush to give hunters access to one of the finest waterfowl hunting areas on the coast. Prior to this, the area was accessible only by a risky sea route.

Begun last year in co-operation with the Fish and Game Branch, the project was built by a Parks Branch construction crew.

## *Big Game Had Good Winter*

British Columbia's big-game species have wintered well, according to Provincial biologists' reports.

Deer have increased in the Kamloops and Chilcotin areas, where the bag-limit has been raised from two to three animals, two of which may be antlerless. During the season, hen pheasants may be shot on a limited basis on Vancouver Island where previously closed, in the Creston area of the Kootenays, and during a short period on the Lower Mainland. Experience on Vancouver Island and also in many parts of North America has shown that regulated shooting of hens has no appreciable effect upon the following year's pheasant population. Nevertheless, results of the open season on hens will be carefully studied.

Moose hunters in northern regions this year will be able to shoot antlerless moose from October 20 to December 15, an extension of more than a month.

To curb wanton killing of black bears during the summer months, closed season was imposed in parts of the Okanagan, Princeton, and Kootenay areas. This closure in no way prevented farmers and ranchers from protecting their crops or live stock from troublesome animals.

In general, indications are that wildlife populations in the Province are staying at a very satisfactory level. Hence, sportsmen can look forward to a good 1962 hunting season.

# TOURISM BOOSTING PROVINCIAL ECONOMY

Tourism, British Columbia's fourth largest industry at the present time, could possibly climb to second place within the next five years.

The news was put before the British Columbia Tourist Association September 19 to 21 annual convention at Kelowna by the Minister of Recreation and Conservation, Hon. Earle C. Westwood.

Mr. Westwood said January–June 1962 mail inquiries to the Travel Bureau showed an increase of 38.5 per cent over the same period of 1961. In June alone this year, 7,189 over 5,472 inquiries for the same month last year represented a 31 per cent increase. From April to June 1962, 7,712 cars stopped at the Provincial Government Information Centre at White Rock to make for a 366 per cent increase for a similar period of 1961.

### PICTURE BRIGHT

"Regionally," said Mr. Westwood, "the picture presents the same bright aspect. In the Peace River district 1962 traffic has increased some 40 per cent. Motel bookings are up about 15 per cent. In the Kamloops district tourist traffic showed an increase of 35 per cent over 1961 even before the Rogers Pass was opened."

Nationally, the tourist industry has grown from $328 million in 1955 to $473 million in 1961, a condition that reflected favourably on Canada's present foreign-exchange picture. In British Columbia, there were signs of a record $145 million.

### CO-OPERATION NEEDED

A big factor in the year's success could have been the Provincial Government's Matching Grants system. Under this, eight Provincial regions will receive $150,000 this year instead of $50,000, last year's total amount. Mr. Westwood said this was positive proof of the Government's "tremendous interest in tourism and its resolve to encourage and support it." However, Mr. Westwood appealed to members not to become complacent. He stressed the need for co-operation at all levels, together with the continued effort to *create* co-operation.

"The Matching Grants scheme cannot work successfully," said Mr. Westwood, "unless all organizations in the regions create a regional spirit."

Mr. Westwood assured the convention that the Government worked to this same principle. Every day new ways and methods were sought whereby British Columbia could be made even more appealing to tourists and British Columbia citizens.

*During July and August 180,000 tourists visited the Provincial Museum in Victoria.*

# PARK SKETCHES

### STRATHCONA

Strathcona Park, almost geographically in the centre of Vancouver Island, is the oldest of our Provincial parks. Placed under reserve in 1911, the 530,319 acres of this park is a true wilderness area.

Mt. Golden Hinde, 7,219 feet in altitude, the highest mountain on Vancouver Island, is within the park, in company with several other lofty peaks.

### STAMP FALLS

Located nine miles north-west of Alberni, on the Beaver Creek Road, Stamp Falls Park is an ideal spot to observe migrating salmon as they struggle upstream to spawn. The fish gather and rest in a pool just below the falls before taking advantage of the fish ladder built to help them by-pass the swift water.

### BEAR LAKE

Bear Lake Park is on the John Hart Highway, about 45 miles north of Prince George, and midway between Prince George and McLeod Lake. Much of the soil in the area is sandy, including the beaches of Bear Lake. Nearby Crooked River is well known for fishing and moose hunting.

### GOLDSTREAM

The camping and picnic area of Goldstream Park straddles the Island Highway and Goldstream Creek, about 12 miles west of Victoria. This park is the gateway to the scenic Malahat Drive, the portion of the Island Highway traversing the shoulder of Malahat Ridge, high above Finlayson Arm and Saanich Inlet.

### BARKERVILLE

During the gold-rush period of British Columbia's history, Barkerville, 60 miles east of Quesnel, was the largest community west of Chicago. When the gold-rush subsided, Barkerville mouldered as a ghost town for many years. Restoration of this historic community began three years ago, and with the completion of this work, Barkerville will boom again as a museum.

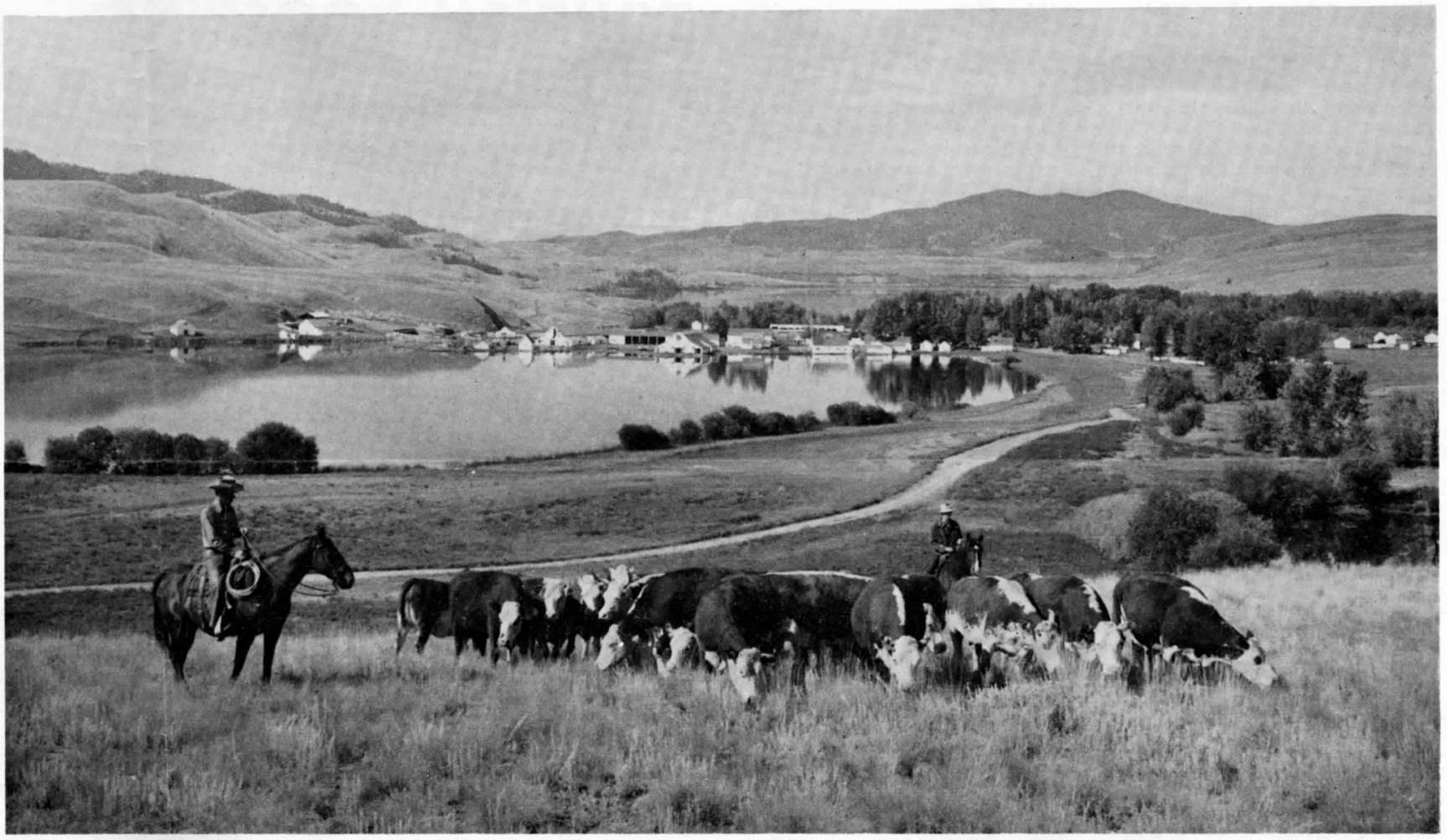
### NEWCASTLE ISLAND

Anyone looking for variety will enjoy Newcastle Island. Visitors can camp, picnic, hike, study nature, gather historical information, swim, or just laze on the grass. Just off shore from Nanaimo and accessible by ferry, the island is 750 acres in extent.

## *Ten Commandments of* Hunting Safety

1. ***Treat every gun with the respect due a loaded gun.***
2. ***Watch that muzzle!*** **Carry your gun safely; keep safety on until ready to shoot.**
3. ***Unload guns when not in use,*** **take down or have actions open; guns should be carried in cases to shooting area.**
4. ***Be sure barrel is clear of obstructions,*** **and that you have ammunition only of the proper size for the gun you carry.**
5. ***Be sure of target before you pull trigger;*** **know identifying features of game you hunt.**
6. ***Never point a gun at anything you do not want to shoot;*** **avoid all horseplay.**
7. ***Never climb a tree or fence or jump a ditch with a loaded gun;*** **never pull a gun toward you by the muzzle.**
8. ***Never shoot a bullet at a flat, hard surface or water;*** **at target practice be sure your backstop is adequate.**
9. ***Store guns and ammunition separately,*** **beyond reach of children.**
10. ***Avoid alcoholic beverages*** **before or during shooting.**

**KEEP SHOOTING A SAFE SPORT**



# 4-H Programme Sets Pattern for All Canada

Now in its third year, British Columbia's rural youth development programme bids fair to become an example of good 4-H Club planning in Canada. The project has proved its worth for young British Columbians who have chosen farming as their life career.

Laying the foundations for the programme was a major accomplishment for Provincial Agriculturists. This entailed the exchange of thousands of letters, conferences the length and breadth of the Province, ideas and suggestions to be sifted and carefully considered for their possible merit, plus the innumerable discussions that would mean so much to the future careers of young British Columbians. With these since completed, the 4-H Clubs of the Province are working to a well-laid framework of solid planning designed to produce maximum results.

### FOUR-FOLD OBJECTIVES

The four main objectives are intended to provide:

- Opportunities for farm boys to start early in life to acquire materials and resources necessary for them to undertake a career in farming.
- Training in the scientific and technical fields of agriculture.
- Training in the economic and managerial fields of agriculture and to encourage wise decision-making based on sound principles.
- Programmes that will recruit and train local leaders both for 4-H activities and for community affairs.

To meet these objectives, principles have been made sufficiently broad and flexible to allow for adaptation to the needs and resources of individual members, as well as fitting the programme in with the over-all district extension programme. In other words, the Department of Agriculture, realizing that hard and fast rules cannot always apply to a far-flung system, leaves the basic rules to a particular locality that is subject to a specific environment and conditions. This is done in the knowledge that subsequent results are more effective.

### IDEAS WELCOME

This attitude has shown its success in the number of ideas and suggestions leaders and members have contributed toward the Provincial mechanics of the programme. These, incorporated by Department officials, have resulted in a system that has been applied with advantage to young farmers wherever they may be in the Province. There is comprehensive group appeal, with no isolated pockets, and with members working together as a unified total. At the same time, the constant flow of ideas modifies the system progressively, making it still more adaptable and workable to members and officials.

### THREE PHASES

To reduce the system to its simplest terms, the programme was arranged to a three-pronged approach. The first includes junior members between the ages of 10 and 14, and gives the children an entirely free hand to pursue the projects already in hand. Emphasis has been placed on skills in husbandry practices, judging, and showmanship.

At 14 years of age the members undergo a comprehensive examination on the work done so far. A successful mark brings reward of a general proficiency certificate that entitles the holder to move into the senior phase.

Meantime, club leaders and junior leaders have been trained to do most of the work related to these clubs.

The second phase, slanted toward boys and girls between 15 and 21 years of age, is regarded as senior 4-H work. Boys are encouraged to expand their projects to the point where their investment will give them an easier start in farming when they decide to do so. For example, a live-stock herd consists of five to ten females in beef and dairy, up to twenty ewes in the case of sheep, and between five and ten sows in hogs.

Important points are stockmanship and economic management of the projects undertaken. Members who cannot afford to undertake these projects carry programmes such as farm-management studies, farm-woodlot operation, Christmas-tree production, farm mechanics and electrical projects, marketing studies, test plots, or special surveys for Provincial District Agriculturists.

Girls in Group 2 are encouraged to study planning complete wardrobes, food preparation and storage for entire families, home planning and decoration, and home beautification. This is intended to develop members almost to the point of self-sufficiency both on the farm and in the home. At the same time, District Agriculturists hold field days for older members, and discuss their projects. Here, the Department of Agriculture depends a great deal on successful local farmers and ranchers to act as consultants.

### SENIOR STATUS

The last phase, which is proposed, caters to young men and women between the ages of 18 and 30. Men concern themselves with the essentials of farm management on their own farm, and are given every encouragement to develop projects on a father-son basis. There is no limit or restriction on the extent of such projects. If they want to, they can take on public speaking or any other community activity that may appeal to them.

Young women study home management, budgeting, record-keeping, child care, needlework, or any kindred aspect of how to make the home better. They also are free to undertake leadership activities in 4-H and other farm groups.

Members of Group 3 may work by districts as study and discussion groups and not necessarily as clubs. Thus, the entire project is flexible and able to consider proposals and suggestions from any member in any age-group. The arrangement, however, does not preclude formation of clubs or associations should there happen to be enough people interested. Notwithstanding, aim of the Department of Agriculture is not so much to form clubs as it is to use the best possible means to assist boys and girls who will make farming their life career.

### AWARDS FOR ACHIEVEMENT

Youth showing the necessary ingredients to become successful farmers and ranchers do not go unrecognized. Awards made on the basis of achievement include trips to various club functions in Canada and the United States, together with the possibility of cash prizes for investment in breeding stock. In this regard the Department of Agriculture is always ready to extend utmost co-operation and assistance, for, like the members themselves, official outlook is that the greatest reward of all comes from a job well done.

***British Columbia's " bread and butter " industry will be in the spotlight October 21 to 27—National Forest Products Week.***

***Province-wide events and attractions are planned to focus attention on the industry which provides more than 73,000 jobs and $484 in purchasing power every year for every man, woman, and child in British Columbia.***

***The week will be launched with proclamations by both the Federal and B.C. Governments, and the theme of this third annual observation of N.F.P.W. is: " Live, Work, Build Better with Wood."***

EXHIBIT 20

# Mr. Martin Asked for It

18/10/62

It has been brought to our attention that Health Minister Eric Martin is circulating a form letter in which he accuses the press of suppressing his side of the argument with British Columbia's hospitals.

Our observation is that Mr. Martin's rebuttals to hospital association allegations have occupied considerable news space during recent weeks. However, it is true that we did not print the particular letter to which he refers.

We thought our restraint in this matter was a kindness to the minister.

The information contained in the letter is incomplete and misleading. It is difficult to see how its display can do other than embarrass him and confuse his readers.

However, since the minister is importunate, The Sun feels it has no choice but to publish the letter with an explanation of its misleading features.

In paragraph three of the letter on today's page, Mr. Martin says BCHIS payments to hospitals increased by more than half since 1958. But this is not the whole truth, and half truths are dangerous things.

What his letter fails to mention is that payments from Ottawa, not from Victoria, were responsible for by far the largest part of the increase.

In the 1958-59 fiscal year, $12,784,000 of the $37,683,000 cited by Mr. Martin came from Ottawa. But in the current year, BCHIS expects to recover a whopping $27,450,000 of the $57,240,000 hospital budget from Ottawa. The increase in provincial payments for which Mr. Martin can properly take credit is $4,891,000—a far cry from the 52 per cent he appears to claim.

In paragraph eight, Mr. Martin says most of our hospitals have been able to do "very well indeed" on the funds provided by government. He cites no figures to support this claim.

The record shows that last year more than half British Columbia's 87 general hospitals incurred operating deficits. These deficits totalled more than $1 million. Reported surpluses among the more successful hospitals totalled only about $150,000.

This year's figures, although not yet complete, are of the same depressing pattern. Of 55 hospitals which filed semi-annual statements for 1962 with the B.C. Hospitals Association, 36 had operating deficits totalling $447,000, 19 had surpluses totalling about $57,000.

It is surprising that some official of the health department did not advise his minister against such careless statements.

'PERFECTLY ROUTINE,' SAYS MARTIN

Times 30/10

# Extra $800,000 for Hospitals

Health Minister Eric Martin has been given an extra $800,000 for British Columbia hospital payments.

A cabinet order Monday increased his budget for hospital advances from $5,940,000 to $6,740,000.

The move follows loud complaints from hospitals across the province that the government is not giving them enough money to meet their bills.

But Mr. Martin said the money has "nothing whatsoever" to do with these complaints.

"It's unfortunate this came at this time, because it might arouse suspicions," he said, "but it's perfectly routine".

He said his revolving fund for advances is increased from time to time to ensure that all claims under the British Columbia Hospital Insurance Service are met. The hospitals get the money in advance of the actual claims in order to meet operational expenses.

Mr. Martin said that whenever there is an increase in revenues the advance fund is correspondingly increased.

"This increase is conforming to the supply voted in the Legislature," he said.

The hospital finance issue flared into controversy last month when the Vernon Jubilee Hospital said it was unable to meet a payroll.

This sparked complaints from other hospital boards that government advances were too little and too late.

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In Vancouver, the president of the B.C. Hospitals Association said the financial boost came just in time. "It's certainly an alleviation of what was becoming a very acute and very drastic situation," said J. V. Hughes.

EXHIBIT 22

# British Columbia Hospital News

Published by the B. C. Hospitals' Association




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INDEX

45th Conference Election Results - shown on this page
45th Conference Resolutions Pages 13 - 17
James L. Manz, In Memoriam Page 17
45th Conference Themes " 18
Minister's Address - Excerpts " 18 to 19
President's Report - Excerpts " 19 to 20
Hospital Finances - Part Report " 20 to 21
"Hospitals get extra $800,000" " 21
The B.C.H.A. Crest, adopted October 19, 1962 " 22
Convention - Conference Comparisons " 23
How many petals in a dogwood? " 23

## 45th Conference Resolutions

a. No fewer than 39 Resolutions were considered by the Assembly of this Association in Penticton on October 19th.. Of these, 31 have been previously printed in earlier issues of our News: 6 extraordinary resolutions recommended by the Board in Number I, pages 1 and 2; and 25 from various sources in Number 2, pages 6 to 11. The remaining 8 were new and did not have the benefit of review, revision and recommendation of the Pre-Conference Resolutions Committee which met in this office under chairmanship of Mr. J. V. Hughes on September 28th. In comparison, the new 8 fared poorly in Penticton: 2 were defeated, "no action" was voted on 1, 1 was tabled, and 4 were carried. By contrast, the recommendations of the Pre-Conference Resolutions Committee were substantially endorsed for all but 1 of the earlier 31.

b. Complete text of all approved or referred 45th Conference Resolutions is being readied for use of the Board,(and may be obtained by others on direct request to this office), but it seems pointless to reprint here those which have already appeared in recent issues of our News. In the following pages, therefore, only adopted resolutions which were not previously published,and accepted amendments to those so published,appear in full. For the remainder, reference to the appropriate pages and marginal identifications of earlier News is indicated in *script lettering*, so. For further ease of identification, the same numbers originally used are retained, preceded, however, by "C45/R" - meaning "Conference 45, Resolution number."

c. C45/R1. Extraordinary, setting October as month of annual meeting. *I, b, unchanged*. Carried.

d. C45/R2. Extraordinary, establishing a deadline for resolutions. *I, c, unchanged*. Carried.

e. C45/R3. Extraordinary, re enlarging requirements for signature for Association's Seal. *I, d, unchanged*. Carried.

f. C45/R4. Extraordinary, rewording procedure for By-Law amendments. *I, e, unchanged*. Carried.

g. C45/R5. Extraordinary, providing constitutional and organizational changes in the Board of Directors, particularly eliminating divisional representation and enlarging regional representation. *2, a to c, unchanged*. Carried (unanimous).

h. C45/R6. Requesting 5 year extension in retirement ages of female employees. *6, d, unchanged*. Carried.

i. C45/R7. Accepting the principle of uniform wages and benefits. *6, e, unchanged*. Carried.

j. C45/R8. Requesting recognition of Unemployment Insurance Costs. *6, f, unchanged*. Carried.

k. C45/R9. Requesting implementation of the Practical Nurses' Act. *6, g, unchanged.* Defeated.

C45/R10. Re standard formula of depreciation. *7, a, unchanged.* Carried. a.

C45/R11. Requesting that a statement accompany all government cheques. *7, b, unchanged.* Carried. b.

C45/R12. Requesting a survey of Stand-By rates. *7, c, unchanged.* Carried. c.

C45/R13. Requesting acceptance of the cost of interest on loans. *7, d, unchanged.* Carried. d.

C45/R14. Requesting maintenance of, and increased funds for, advance payments. *7, e, accidentally amended by typist's error in omitting words* for advances *in 5th line.* Carried. e.

C45/R15. Requesting Budget return information. *7, f, unchanged.* Carried. f.

C45/R16. Requesting provision for Budget approval appeals. *8, a, amended in committee by deletion of last 11 words and substitution therefor of the words* submitted by the hospital. Carried. g.

C45/R17. Requesting earlier Budget approvals. *8, b, amended in committee by deletion of last 15 words and substitution therefor of the words* release tentative budget estimates by February 28th. Carried. h.

C45/R18. Requesting uniform residence requirements for patient benefits. *8, c, revised overall, thus:* i.

WHEREAS all Provinces of Canada, except B. C., extend Hospital Insurance protection to a resident who is temporarily absent from his home province for a period of at least twelve months, and

WHEREAS British Columbia allows only a temporary absence for a period of three months before the resident is out of benefits and after twelve months temporary absence loses benefits until three months residence is again established, regardless of how many years a person may have been a resident prior to the temporary absence, and

WHEREAS the B.C.H.I.S. only pays $12.00 per day for Acute and Chronic patients and $4.00 per day for New Born patients when hospitalized outside of Canada and all other provinces pay higher rates, on various formulas, and up to $25.00 for Acute and Chronic days by the Prince Edward Island plan, and

WHEREAS a B. C. resident can and has been denied benefits because travelling time while moving to another participating province over and above three months limit to establish residence is not allowed and such coverage is provided by every other province plan,

THEREFORE BE IT RESOLVED that the B. C. Hospitals' Association request the Government of B. C. to change the regulations under the Hospital Insurance Act so as to grant out-of-province benefits at least equal to those provided by other provinces participating in the Federal-Provincial Hospital Insurance plan. Carried.

G46/51

a. C45/R19. Requesting formation of a Division of Hospital Improvement Districts. *8, d, unchanged*. Referred by the Assembly to the Executive.

b. C45/R20. Approving an Association crest. *9, a, unchanged*. Carried.

c. C45/R21. Suggesting changes in the Association's Governing Body. *9, b, unchanged*. Referred by the Assembly to the Board.

d. C45/R22. Limiting Association membership to non-profit hospitals. *9, c, unchanged*. Referred, with C45/R23, by the Assembly to the Executive.

e. C45/R23. Requesting dissolution of Private Hospital Executives' Division and assistance in formation of a Private Hospital Association. *9, d, unchanged*. Referred, with C45/R22, by the Assembly to the Executive.

f. C45/R24. Requesting that the Metropolitan Hospital Planning Council become the Provincial Hospital Planning Council. *10, a, unchanged except for insertion of* Hospital *at end of third line*. Carried.

g. C45/R25. Requesting members to keep in "constant communication" with the Association and invite its help in trips to Victoria. *10, b, amended in committee by deletion of last 8 words and substitution therefor of the words* some person designated by the Executive to accompany such a delegation, *and further amended on the floor by insertion of the word* may *before the word* request *in the second last line*. Carried.

h. C45/R26. Requesting formation of an Association advisory service. *10, c, unchanged*. Carried.

i. C45/R27. Suggesting supplementary revenues for Association be sought. *6, d, amended by insertion of words* and report back on *after word* investigate. Carried.

j. C45/R28. Requesting that Association dues be increased to $7.50 all inclusive. *11, a, unchanged*. Referred by Assembly to Board.

k. C45/R29. Authorizing maximum Active Member 1963-64 dues at $5.50 a bed set up, including collection for C.H.A. *11, b, unchanged*. Carried.

l. C45/R30. Authorizing personal subscribing member dues at $5.00. *11, c, unchanged*. Carried.

m. C45/R31. Requesting study of possibility of annual meetings earlier than October. *11, d, unchanged*. Carried.

n. C45/R32. Requesting that Association mail for Chairmen of Boards be sent only to Administrators. *Not previously published and not printed here because it was defeated*. Defeated.

o. C45/R33. Requesting representations to government on financial difficulties of hospitals. *Not previously published, and not printed here because* no action *was voted on it in view of C45/R36 below*. "No action" carried.

p. C45/R34. Requesting a statute to implement hospital districts all over province. *Not previously published, and not printed here because defeated*. Defeated.

C45/R35. New Motion. a.

BE IT RESOLVED THAT the Physiotherapists' Division be expanded by inclusion of Occupational Therapists and its title be changed to the Physiotherapy Occupational Therapy Division. Carried.

C45/R36. New motion, requesting government to meet Executive to discuss financial problems, reading: b.

WHEREAS government policy on the operation of hospitals in this province was enunciated in a statement in the legislature in 1954 containing these words "This government re-affirms its stand by replying that it is not the intention of the government to encroach upon the autonomy of hospital boards",
WHEREAS the Hospital Act appears to be designed to give effect to the policy above enunciated, in Section 4 (1) therein requiring that every public hospital shall:
1. "have full control of the revenue and expenditure of the hospital vested in its board of management" and
2. "have a properly constituted board of management and such By-Laws, rules or regulations as may be deemed necessary by the Minister for the proper carrying-out of the administration and management of the hospital's affairs and the provision of a high standard of care and treatment for patients".
WHEREAS the hospitals of this Association endorse and support the above principle and have consistently tried to conduct themselves in accordance with the policy enunciated or implied in the words quoted;
WHEREAS over the years many difficulties and contradictions in the practical application of this policy have appeared, both for government and for hospitals, and
WHEREAS in this present year the difficulties referred to have become aggravated and certain developments outside the control of the Hospital Insurance Service appear to threaten the ability of the hospitals to carry out the administration and management of their affairs and the provision of a high standard of care and treatment for patients;
THEREFORE BE IT RESOLVED THAT this Association here and now requests the Premier and the Minister of Health Services and Hospital Insurance to grant an interview with the Executive for the purpose of working out a mutually agreeable solution to the problem now facing both hospitals and government:
AND BE IT FURTHER RESOLVED that the Executive be authorized and directed to take any and all additional steps that may assist hospitals to overcome their present difficulties. Carried.

C45/R37. New motion on Tariffs, reading: c.

WHEREAS increasing hospital costs are of grave concern to officials in government, to hospital officials, and to the public, and,
WHEREAS the imposition of tariffs is known to have dramatic effects in raising costs,
THEREFORE BE IT HEREBY RESOLVED that the B.C. Hospitals' Association recommend to the Canadian Hospital Association that a study committee be established to pursue the feasibility of eliminating all tariff restrictions on all goods and services purchased by Canadian hospitals, and
BE IT RESOLVED that the Canadian Hospital Association be requested to make representations to the federal government regarding exemption of hospitals from such tariffs, if such exemption proves feasible in terms of total national goals for Canada. Carried.

C45/52

a. C45/R38. New motion on Conference Programming, reading:

BE IT RESOLVED THAT future Conventions of this Association shall immediately after the opening addresses proceed with the business session, and further, such business session shall continue until completed, and then such other programmes as the Executive may arrange be proceeded with. Tabled.

b. C45/R39. New motion, complimentary, reading:

BE IT RESOLVED THAT this meeting express its appreciation of the contributions to the success of this Conference made by many organizations, agencies, and persons, and do now hereby particularly express its gratitude to the following:

The Honourable Eric Martin, Minister of Health Services and Hospital Insurance;
Mr. D. M. Cox, and the staff of B. C. H. I. S.,
All speakers who appeared on the program;
The Mayor and Council of the City of Penticton;
The Penticton School Board;
The Local and Provincial Press;
The Penticton Local Arrangements Committee;
Dr. A. A. Larson and Staff of Emergency Health Services;
The Exhibitors and Challier Display Associates Limited;
The Martin Paper Company and Crown Zellerbach of Canada for material for registrants' folders;
Mr. I. F. DeWest and the Sun Life Assurance Co. of Canada for notebooks supplied registrants;
B. C. Tree Fruits Ltd., Sun-Rype Products Ltd., and Summerland Sweets Ltd., for favours provided to registrants;
International Business Machines of Vancouver for free use of a Selectric typewriter during the Conference;
Mr. Ian Morrison of Wright's Travel Service Ltd., and the Penticton Chamber of Commerce and Junior Chamber of Commerce for arranging reservations and other facilities for registrants;
Buttar and Chiene for gratiutously auditing the Association's accounts; and
St. Ann's Hall, Penticton, and all who contributed to the banquet held therein. Carried.

c. Mr. James L. Manz, administrator of Fraser Canyon Hospital at Hope, was taken to Penticton Hospital during the last day of the Conference, acutely ill of the diabetes which had long afflicted him, and died there on Saturday, October 20th. Although still a young man, he had gained intensive experience in B. C. hospitals before being engaged for the planning of the Fraser Canyon Hospital, and had administered it with distinction continuously since its opening four years ago.

## 45th Conference Themes

a. Those who were not present may get a true taste of the mood and motion of this year's Conference by studying the resolutions printed in preceding pages. Previous events inescapably determined the theme of the 45th annual meeting of B. C. hospitals without any official naming of it by the Program Committee. Intruding into set discussions of academic matters, directly or obliquely referred to in many reports and most addresses, vigorously described in the deliberation of resolutions, heard and overheard everywhere in hotel rooms and Conference corridors, were the financial problem of B. C. public hospitals in this year of 1962. There appeared to be almost complete unanimity on the existence and nature of the problem. Such differences as appeared among the assembled delegates concerned only the appropriateness of the various solutions proposed.

b. One general solution gained such prominence as to become almost a second theme. In academic discussions again, in reports and addresses again, in lobbies and elevators even, and above all in the resolutions and deliberations upon them, the need of a stronger, more close-knit and more stream-lined provincial association was often voiced, and often supported. In the event, apparently for the first time in its history, the Association's 45th Conference adopted more resolutions about its own structure, organization, finances, and general business than about all other subjects put together - including B.C.H.I.S.

c. Preparation of the Proceedings of the Conference has begun, but will inevitably take many weeks or months to complete. In lieu and foretaste thereof, here following are significant excerpts from the address given by the Honourable Eric Martin and from Mr. H. R. Slade's presidential report, and, - on direction - main text of a report by Mr. P. B. Blewett, chairman of the Hospital Finances Committee. All concern the primary theme developed at the Conference - the current financial plight of B. C. hospitals.

## The Minister's Address

### Excerpts

d. "I put on the same old record, clothed in slightly different language,.....not as criticism.....but with the desire to assist and protect."

e. "There has been a large turn-over of ...hospital boards...there appears to be many trustees who do not possess the necessary history and background of the principle of hospital management as well as of hospital insurance ... that the cost of running a hospital is just as important as maintaining a high level of patient care."

f. "....that anyone would play politics with the health of the people is almost unthinkable. Most hospital boards are doing an extremely good job...however, occasionally we do meet with a Board which appears to have lost all sense of responsibility..."

G46/55

a. "Why should government funds be provided in greater proportion to those Boards who have given way to certain pressures and allowed costs to increase over the levels maintained by the majority of hospital Boards?"

b. "...equally important to your maintenance of good hospital standards is your responsibility to ensure that your hospital services - here it is again - are kept within the ability of the public to finance. This is also a responsibility of the provincial government, but it is a responsibility which is shared equally with you."

c. "Contrary to what some have claimed, hospitals are better off this year than they ever have been before. By that I mean they are getting far more money and have higher levels of staffing and service than ever before. And yet some keep saying that they haven't enough."

d. "In the strict sense of the word it is not a budget which you submit.. they are ... estimates. What it boils down to is this, that you make an application for funds."

e. "Every year your revenues have never been in accordance with your estimates because you apply for as much as you think you can get. That's human nature."

f. "...you'll say 'but we don't know how Hospital Insurance arrives at these figures.' Well...do you want us in your business any more than we are now? My guess is no, you don't."

g. "Every hospital's approved budget is higher this year than it was last year."

h. "In this year's estimates of expenditures, payments to hospitals through the Service are estimated to be $57,240,000.00, while grants-in-aid of construction are estimated to be $5.6 million, for a total of 62,840,000 dollars."

i. "So, Mr. President, coupled with an apology for taking up too much time, I have great pleasure in presenting to you these two murals of our hospitals, to be hung in your Association office...or wherever you decide to hang them, with the hope that you will have some kind thought for us."

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## President's Report

### Excerpts

j. "I listened closely to the Honourable Minister this morning and appreciated his being with us and forthright in his statement regarding the present and future financial operation of our hospitals. I do not intend at this time to submit detailed statistics that could possibly refute many statements made by the Honourable Minister. Sometimes the whole story is not told."

k. "...I submit that a budget and an estimate, as far as we are concerned, are the same thing...On behalf of this Association I wish to emphasize that the hospitals' own budgets, in the majority of hospitals, were cut, forcing them to have serious deficits this year, into borrowing money, with the interest cost disallowed...."

"....there will always be a difference of opinion between hospitals and governments as to what is good basic care. I submit that the judgement of an acceptable standard of care must be made by professionals in the hospital field, which include the hospital Boards, administration, nursing, medicine, and allied fields...In all fairness it is safe to say that the complexities of hospital administration make it impossible for the Hospital Insurance Rate Board, as presently set up, to have the time or staff to make a true assessment of individual hospitals..." a.

"...regardless of the collective hospital budgets and regardless of the Hospital Insurance Service's financial requirements, the provincial government provides funds that this year are insufficient to meet basic hospital costs." b.

"I do not believe this Association wishes to enter into any discussions or argument regarding Sales Tax or other sources of revenue from which the provincial government meets its commitments in paying hospitals for the costs of operation. All the member hospitals are interested in, and vitally so, is to receive from government sufficient funds to meet the true costs..." c.

"The Honourable Mr. Bennett, Premier and Minister of Finance, made a recent statement to the press that hospitals would have no trouble if they did as the provincial government does, and lived within their budgets. We must agree with him: if hospitals were allowed to use their own budgets - not the provincial government's - the hospitals would have no trouble..." d.

"...Mr. Martin mentioned, and was quite seriously worried about, the change in hospital Boards - he spoke of the high turnover - and suggested that maybe new Board members, or some of them in certain places, did not measure up to the calibre that they might do. This is quite a serious situation, and I say that if we don't regain some autonomy, then Board members are going to lose more interest and we're going to be in a vicious circle..." e.

"We, the hospitals of B. C., must sit down with government and agree on a formula whereby the government agrees to pay the full basic cost of operating hospitals and allow the hospital Board the right to other avenues of revenue." f.

"It has been truly said by the Minister, and by this Association, that the success of B. C. hospitals depends on teamwork between the government and hospitals. We have asked the Premier to meet with us and discuss our major problems. I sincerely hope that we will hear from him in the very near future." g.

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## Hospital Finance Committee Report
## Verbatim last six paragraphs

In 1961, 69 hospitals representing 5,756 beds and having operating expenses of $37,489,081.00, submitted the requested financial reports to the B.C.H.A. Of the 69, 49 or 71%, had rate base deficits totalling $949,991.00, and 20, or 29%, had rate base surpluses amounting to $148,963.00. h.

a. The $949,991.00 in deficits represented 3.3% of the total operating costs and 73¢ per patient day for the 49 hospitals reporting deficits.

b. The $148,963.00 in surpluses represented 1.7% of the total operating costs and 33¢ per patient day for the 20 hospitals reporting surpluses.

c. How did 1961 compare with 1960? In the first place the percentage of hospitals reporting deficits increased by 10%. Secondly, the size of deficits expressed on a patient day basis, increased by 27¢ or 36%.

d. The figures I have mentioned seem to present a different picture than did the figures presented to us by the Honourable Mr. E. Martin. Mr. Martin indicated that only a few hospitals in the province were having financial problems. The figures which your finance committee has assembled indicates that a large majority of our hospitals are in financial difficulty. In 1960, 61% of our reporting hospitals had operating deficits. In 1961 this figure increased to 71%.

e. Mr. Chairman, Reverend Fathers, Reverend Sisters, Ladies and Gentlemen, your finance committee asks you to consider two questions. Can 71% of our reporting hospitals be wrong in their assessment of the standards of patient care which they should be providing their community? Are 71% of the reporting hospitals being financially mismanaged?

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"Hospitals get extra $800,000."

f. So headlined the press at the end of last month, and proceeded to elaborate with reports showing accurate knowledge of the complexities of hospital financing under B.C.H.I.S.

g. "The move will not affect the total to be paid to hospitals" stated one such report. "But it increases to $6.7 million the total that B. C. Hospital Insurance Service can make in advance payments."

h. On the face of it this reported increase in the advance fund looks like a direct and favourable answer to resolution C45/R14 and representations repeatedly made by the Executive during the year - despite the Honourable Eric Martin's reported denial of any connection.

i. As yet the Association has no official word on this subject, and to date no hospital has reported having previously withheld advances now suddenly made up. In any case, although the sum mentioned appears adequate to meet the strictly limited purposes which the advance fund has lately been failing to meet, that alone obviously will not solve all the financial problems discussed by members at their 45th Conference.

j. The Executive, still searching for an answer to these problems, is still pressing for a meeting with the Premier and the Minister of Hospital Insurance together, and at this date still lacks acceptance of it.


BRITISH COLUMBIA HOSPITALS' ASSOCIATION
.... of hospitals, by hospitals
FOR THE PATIENT

# The Back Page

a. Convention - Institute - Conference

## Statistical Comparisons

| Year | 1958 | 1959 | 1960 | 1961 | 1962 |
|---|---|---|---|---|---|
| Name | 41st Conv. | 42nd Conv. | 15th Inst. | 44th Conv. | 45th Conf. |
| Votes eligible | 76 | 117 | 126 | 133 | 145 |
| Votes present | 68 | 112 | 105 | 115 | 126 |
| " " % | 89.5% | 96% | 83.5% | 86.5% | 87.5% |
| Other registrants | | | | | |
| Public hospitals | 145 | 158 | N/A | 179 | 103 |
| Private hospitals | 45 | 40 | N/A | 34 | 5 |
| Visitors | 68 | 106 | N/A | 94 | 72 |
| Auxiliaries | 72 | 143 | N/A | 176 | 133 |
| Total Registration | 398 | 559 | N/A | 598 | 439 |
| Exhibits | | | | | |
| Booths | 44 | 48 | N/A | 53 | 31 |
| Firms | 35 | 39 | N/A | 42 | 26 |
| Attendants | 130 | 150 | N/A | 160 | 64 |

The above table - hurriedly prepared and not guaranteed for minute accuracy - is intended to answer that persistent question "How did things work out at Penticton?" If further comment is still demanded, here's a few notes:

1. Our officers are of the opinion that a larger percentage of trustees - perhaps even a larger absolute number - attended this annual meeting than ever before.
2. No fewer than 450 people sat down to the banquet - probably more, because Registration staff was busy for some while hand-printing needed tickets in addition to the 450 provided. Some fine calculations entered into this effort: the new tickets exactly equalled the number of old tickets astray in back-pockets and snagged on the barbed wire around apple orchards, all seats were filled, and everybody ate well.
3. Statistically speaking, our Conference was a disappointment to the Penticton constabulary: the Mayor circumvented them by providing us all with free parking stickers. (The Mayor and Council, in true Okanagan hospitality, also made a handsome grant toward our banquet costs.)

b. How many petals in a dogwood?

The crest on the back of this page, officially adopted by Resolution C45/R20, shows four petals on the flower in the right lower quadrant. That identifies it as a dogwood, just as the six petals on our Auxiliaries' Division emblem also identify that as a dogwood. It seems that we're both right, but heraldic and botanical authorities confirm that we're more sternly correct than our ladies. We have it from the Encyclopaedia Canadiana that the stereotyped emblem shows four, and from a high official of the Vancouver Parks Board that on the actual tree four are common, but neither five nor six are rare, under favourable conditions.

What did the Parks Board man mean by "favourable conditions"? Well, never underestimate the power of a Women's Auxiliary. We are told that they also had a highly useful and harmonious meeting in Penticton.

G46/60

EXHIBIT 23

# A PROPOSAL

## On the Financing of Hospital Insurance Costs in B. C.

### INTRODUCTION

1. Government sponsored health insurance programs have been in operation in other countries for many years. A majority of them incorporate certain policies which are not yet accepted in this country but which have nevertheless withstood the test of time and have proved both politically and administratively practicable in other democracies. Among these is the principle of co-insurance as a means of assisting the state to meet the costs of its commitments and of preventing abuse of the services offered its citizens.

2. This principle is in some degree already familiar to the citizens of this province. A co-insurance - or deterrent - charge of $1.00 per patient day is universally collected from patients by public hospitals at the present time, with little trouble on one side or resistance on the other. For reasons which will appear, we prefer the term "utilization fee", and the essence of this proposal is that a variable utilization fee be adopted as a means of assisting the provincial government in the financing of the B. C. Hospital Insurance Service. At the same time it would make available to the hospitals a method by which they could provide and pay for services additional to those authorized under the hospital insurance program.

3. We recommend that this fee be:
(1) Variable (from hospital to hospital, as financial and performance conditions, in the opinion of their individual Boards, may require);
(2) Set by hospitals (again as financial and performance conditions, in the opinion of their individual Boards, may require);
(3) Collected by hospitals (through mechanics already established in them);
(4) Used by hospitals (again as financial and performance conditions, in the opinion of their Boards, may require); and
(5) Supplemental (in the eyes of government, hospitals, and citizens alike) to payments made by the government to hospitals for the basic hospital services they render to the people of this province.

4. We believe that such a variable utilization fee would
1. *Assist the government to meet the basic costs of hospital care* in this province, by relieving it of pressure to meet the less predictable, less controllable, and more controversial costs of refinements above basic hospital care.
2. *Deter hospitals from providing extravagant or unnecessary services*, by throwing squarely on them full responsibility for all costs outside the basic services authorized and paid for by the government.
3. *Deter the public from extravagant or unnecessary use of hospital services*, by directly and realistically reminding them of the costs of such services.

The remainder of this proposal will develop these three benefits under separate headings. In all three, both theoretical and practical factors appear to require consideration. Frequently the theoretical and practical merge, and it is not pretended that the division made in our subsequent pages is fully satisfactory, or that all aspects of this important subject are fully covered.

## II The Utilization Fee as a Means of Assisting the Government to Meet the Basic Costs of State Hospital Insurance.

6. (a) Theoretical

In a purely socialist state a utilization fee would appear to be ideologically taboo. In a state fully committed to the free enterprize principle, government hospital insurance would be equally taboo. In a mixed state, where public and private enterprize are intertwined, there appears to be no theoretical reason why the utilization principle should not be brought in to help with the costs incurred by the state insurance principle. The combination of the two is a happy application of that middle way on which Canadian life and the Canadian economy are founded.

7. It is now accepted as right and proper in this country that government should protect its citizens against individual financial disaster or severe hardship caused by the accident of disease - at least as far as hospital services for acute illness are concerned. Yet the very fact that all government hospital insurance plans exercise greater or lesser measures of control over hospital admittances and procedures is evidence that they do not interpret this to mean that they should guarantee every ailing citizen against the costs of all the services that he, or his doctor, or his hospital, may feel that he should have. The fact that the citizens generally - including hospital people - accept the argument that government cannot give hospitals a blank cheque is evidence that the public largely agrees with government on this matter. In fine, what is accepted by all parties as right and proper is not that government should insure the citizen against all hospital costs, but only against all basic hospital costs.

8. No satisfactory definition of "basic," in this connection, appears to exist. For the purposes of this proposal, a precise agreed definition would theoretically appear to be necessary, but certain considerations suggest that any such definition is impossible, and perhaps undesirable. Because these considerations are severely practical, they will be treated under the appropriate heading for such factors, in paragraphs 13-18 following.

9. Whatever basic hospital costs may be, they will not remain static in this province during any foreseeable period of time. They will grow, and any government committed to meet them should accept the necessity of providing continually increasing funds to meet their increasing costs. Three of the factors that will cause them to grow appear subject to purely theoretic considerations, statistical correlations, and more or less accurate short term prediction. We treat these immediately, in paragraphs 10-12 following.

10. Population increase. As the population grows, so will the cost of serving its hospital needs, in more or less direct proportion. Because the tax-base will increase at the same time in more or less the same proportion, no theoretical difficulty appears likely to be caused by this factor. This, unlike all others to be considered, is not a per capita increase in costs.

11. Increased ratio of insured beds per capita. There may from time to time be very good reasons why the number of beds of any type per thousand population should be increased over-all or in some particular locality. There may be equally good reasons, both theoretic and practical, why government may wish to extend the protection it affords the citizens into types of hospital care not previously covered. This has the same effect as increasing the proportion of insured beds per capita and should be accepted wherever and whenever it occurs, as a cause of more or less proportionate increase in basic hospital costs.

12. Increases in the general cost of living and standard of living. Basic hospital costs will necessarily increase with other cost increases in the provincial economy. Because the largest cost factor in hospitals is labour, they will probably increase more rapidly: few of the labour-saving measures available to other modern industries can be successfully employed in hospitals. For this reason, basic hospital costs will increase in close proportion to increases in the cost of labour, and may sometimes increase more rapidly than the statistically determined costs of living or the corresponding increase in tax revenues. In any assessment of basic hospital costs, hospital workers as a group cannot be denied wage increases and other employee benefits comparable to those of comparable workers in the province at large. Under any hospital insurance program, hospitals must be fully compensated for the cost, after honest bargaining, of providing them.

(b) Practical

13. A practical, but fundamental, factor in the determination of basic hospital costs is money - money and its availability, available money and the demands made upon it for other purposes. This is true equally of the people of the province as a whole and of the government which represents them and acts on their behalf: neither can spend as much on hospitals as it would like; both must recognize competing demands on the tax revenues which one provides the other. In the long run it may be the people who decide how much they are willing to pay for hospital services, but year by year it is the government upon which this difficult decision rests. As the political and economic climate caries from time to time, "basic hospital costs" must contain a factor of like variability; at any given time they must lie at some practical point between the politically and the economically feasible. It cannot be otherwise: for the proper discharge of its responsibilities to the people whom it represents government must retain flexibility in the expenditure of the revenues it receives from whatever source. B. C. hospitals accept this fact.

14. The above considerations apply with particular force to the acceptance or rejection of advancing costs arising from advances in the healing sciences. Admittedly government must remain flexible in its view of them as basic hospital costs, but it cannot entirely ignore them. Basic hospital costs are higher today than they were a year ago for the simple reason that basic hospital services are better than they were a year ago. They are better in a sense of the utmost practicality to those most intimately concerned: in some cases they can preserve lives that could not be preserved a year ago; in others they can restore to full health those who could not have been so restored a year ago, or restore them more quickly, or restore them with less pain. The public, continually treated to the miracles of modern medicine over the air-waves and in popular magazines, is not i norant of these advances, and at times vociferously demands them,here and now. The taxpayer may be on the side of the taxpayer most of the time, but the moment he or someone dear to him falls ill his attitude rapidly changes, and he then demands the best medical and hospital care possible. The pressure thus generated is immediately felt at the local level. Where hospital care is involved, it is immediately felt in the local hospital or in whatever hospital the patient may be sent to. Since the hospital is now supported by government, government eventually gets the blame - along with the Board, the Administrator, the head nurse, the cook, and the ward-maid - if the hospital is unable to supply the hitherto uncomplaining taxpayer with the services the Reader's Digest and television's Ben Casey have taught him to expect. Under modern conditions, with no immediate worry about the cost of providing it, the ordinary citizen now expects his hospital to give him "the best possible care" - and thinks he knows what it is.

15. "The best possible care" in theory is, in practice, impossible. Developments occur so fast, and need is sometimes so intense, that the education and supply of personnel, even under near-ideal circumstances, must always lag behind the ideal. More important in this connection, "the best possible care" now actually available could be fantastically expensive - in drugs, in equipment and the employ of its technicians, and in what Bill 320 describes, but does not define, as "necessary nursing service."Modern healing sciences have concentrated their studies on healing, not on automation. Few of the savings available to modern industry are available to modern hospitals, and the effect of 20th century science is rather to increase costs than to decrease them. Uncontrolled, they could virtually bankrupt any state that undertook to give its citizens the literally "best possible care."

16. Anyone who doubt these statements is invited to examine a table reprinted in the August 1, 1962, Guide Issue of the Journal of the American Hospital Association, here printed.

Percentage increase in hospital costs by selected indexes for short-term general and other special hospitals, 1946-1961.

| Indexes | 1946 | 1961 | Increase |
|---|---|---|---|
| Total expense per patient day | $9.39 | $34.98 | 273% |
| Total expense per patient stay | $85.57 | $267.37 | 213% |
| Payroll expense as a per cent of total expense | 53% | 62% | 16% |
| Total payroll expense (in millions) | $619. | $3,848. | 521% |
| Number of employees (full time equivalent) | 504,961 | 1,149,086 | 128% |
| Average payroll expense per employee | $1,226. | $3,349 | 173% |
| Number of employees (full time equivalent) per 100 patients | 148 | 235 | 59% |

Surely any provincial treasury cannot view with equanimity the picture presented in this table. It is clear that the increased labour costs here alarmingly revealed were only partly caused by the factor due to improved living standards considered in our paragraph 12. The main push undoubtedly came from the introduction of new life saving equipment and services.

17. There is no indication that this push is anywhere near its end. Indeed, other current and equally authoritative surveys made in the United States indicate that hospital costs increased there 12% last year, and may be increasing even more rapidly this year. To a lesser degree, but with the same inevitability, the same thing is happening all across Canada.

18. Such is the effect on hospital costs of modern healing techniques, and of such is the problem created which faces all hospital insurance plans on this continent today - whether private, as, under the Blue Cross, in the United States, or whether governmental, as in this country. It has been suggested above that under these circumstances basic hospital costs acceptable in any government insurance plan are necessarily a compromise - a practical position somewhere between the good and the best, modified from time to time as revenues flourish or falter and as other public needs exert stronger or weaker demands upon them. It is here suggestdd that the trend of this compromise, except in the event of major national or provincial emergency, must be constantly upward. Among the basic hospital costs which such a plan must provide for it appears impossible to ignore an increment factor due to the public's demand for the "best possible care" in the hospitals which it vicariously owns and supports.

19. There is a danger here. There is a danger not only at once visible to the Treasury of any government committed to a hospital insurance program, but equally to that program itself and to the hospitals and people which benefit from it. For the safety of all, to assure the continuance of those basic hospital services which the program is intended to support, it appears a wise precaution to set some buffer between government and the public's demand for the "best possible hospital care." Otherwise government may be so hard-pressed, by hospitals directly, and by the people indirectly, through their hospitals and the Press, and eventually through the ballot box, to provide the refinements of hospital service, that it may run into difficulty in providing for the basic essentials of hospital service. While it has been here suggested that government must continually give some recognition to the public's demand for the "best possible care," it is he here also suggested that, for the best interests of the hospitals themselves, and the people equally, the government must be relieved of some of the pressure caused by this demand.

20. For this purpose no other means seems so effective as a variable utilization fee. If the hospitals insist upon giving more than basic hospital care, let them find the extra funds required for so doing! If the people insist upon receiving the "best possible care" let them be made to realize the costs of all approaches to this impossible ideal!

## III The Utilization Fee as a Means of Deterring Hospitals from Unnecessary Extravagant Services.

### (a) Theory

21. To say that a utilization fee would deter hospitals from providing unnecessary or extravagant services is to suggest that they may now be providing unnecessary or extravagant services. If this is true, it is true only because in this connection those words cannot be exactly defined. The reality faced in giving bedside care is utterly different from the reality faced in accounting for it in a ledger. The difference in outlook so produced is the root cause of most of those differences that occur between hospitals and government under the present system.

22. It is remarkable that under this system those differences are not greater. It is remarkable that in their intimate acquaintance with death and disease and their knowledge of how to prevent or alleviate these harsh realities hospitals do not allow their actual expenditures to exceed their approved budgets by more than they do. It is equally remarkable that the hard-pressed civil servants of the government retain a vision of the harsh realities of hospital care and remain flexible in their assessment of individual hospital needs.

23. The truth is that the present system contains policies which are basically in conflict. The controls which B.C.H.I.S. is empowered to apply are essentially negative: its worst threat is that it will not pay hospitals for certain expenses met by them; its severest punishment is not to pay them. Further, its controls are remote: it cannot immediately and on the spot prevent any actual expenditure that the hospital can somehow find money for; it can only refuse from afar to reimburse for such expenditures. Further, its controls are tardy: its withholding of funds necessarily comes after the event, not at the time the expense is incurred. Further, its controls are uncertain: the flexibility which government rightly and realistically allows it encourages hospitals to hope that the threatened controls will not be rigidly applied, that some year-end adjustment will be made in their favour, that money more than promised will eventually be provided to replenish their emptied coffers.

24. The present system raises problems for yet another and more fundamental reason. However negative, remote, tardy, and uncertain the controls exercised by B.C.H.I.S. may be, they remain controls and are in conflict with that passage of the Hospital Act that requires that every hospital subject to this portion of the Act shall "have full control of the revenue and expenditure of the hospital vested in its board of management." It is not here denied that some degree of control by government of hospital revenues and expenditures is necessary, but it is here pointed out that under the present system hospital boards of management have in fact little control in the long run of their expenditures, and no control, in the usual sense of the word, of their revenues. In theory, on strict interpretation of the Hospital Insurance Act, full control of both is exercised in Victoria; if in practice it is not fully exercised there, this is because of the imperfections of the system noted above. The result of this conflict between theory and practice - indeed between the law and its application - is that both the B.C. Hospital Insurance Service and hospital boards are constantly put into a false position. Both are assigned powers which they cannot fully exercise, and given responsibilities which they cannot fully discharge.

25. These conflicting policies were not created by the present government, but rather inherited by it. They were written into the original Hospital Insurance Act. At first overshadowed by fiscal problems, they have become gradually apparent to those studying the operation of the voluntary boards. Recently they have emerged as the root cause of the financial crisis in hospitals this year.

26. The effect of this conflict on hospital boards has been brought to the attention of the B. C. government before this. The Brief presented to the Cabinet by the Executive of the B. C. Hospitals' Association on June 4, 1959, spoke of "a sense of frustration, of ineffectiveness .....voiced at many hospital meetings recently." It warned that if the questions causing such frustration were not satisfactorily resolved it might soon be difficult to find suitable personnel to sit on hospital boards. The danger then foreseen is now still more apparent. Last spring's round of annual hospital society meetings were, with few exceptions, poorly attended. The public, growingly aware that involvement in hospital management means involvement in wrangles with Victoria, in charges and counter-charges of "maladministration," sometimes even in public verbal floggings, wants no part in such involvement. The public may be ignorant of the correct details of modern advances in healing, but it quickly recognizes the falsity of a situation where local citizens are given the trappings of office but denied the authority, without jeopardy to their business interests, their home life, and their reputations, to exercise them. Happily there are yet devoted men and women in all the communities in which B. C. hospitals are located who are willing to run this risk, but their numbers are being reduced by the bitter lessons experience as hospital trustees inflicts upon them. Unless a change is made in the conditions under which hospital boards operate, the whole system is in danger of breaking down for want of effective participation at the local level.

27. It is one of the chief values of the present proposal that it would remove this danger. It would kindle new public interest in the operation of hospitals. Where the responsibilities assigned to hospital boards are now vague, they would then become precise; where the work involved is now frustrating it would then become challenging; where public censure - often undeserved - is now too often the sole reward of such work, public acclaim would then result for any job well done. Under these conditions it would soon again be easy to recruit men and women willing to accept responsibility on hospital boards, and competent to discharge it.

28. The hospitals of this province are firm supporters of the principle of local management, and have cause to believe that the provincial government is equally convinced of the value of that principle. They would happily subscribe to the policy of partnership between the local and provincial authorities eloquently expressed by the Minister of Health and Welfare in his 1954 speech to the Legislature.

> *"This government believes that it is of paramount importance to encourage administration of hospital affairs, to say nothing of other such endeavours, as much as possible on the municipal or local level. This government re-affirms its stand by replying that it is not the intention of the government to encroach upon the autonomy of hospital boards."*

29. There appears no more effective means of promoting the partnership which these words imply than a variable utilization fee under control of the local authorities.

(b) Practical

30. It has been stated earlier that one essential condition for the success of this proposal is that government - through the B.C.H.I.S. - continue to meet basic provincial hospital costs. It is suggested that the per diem rates approved at the time the proposal comes into effect would provide a satisfactory measure of such costs initially. Applied then for the year next coming, some adjustments would be necessary. Increases and decreases in population and bed capacities would, as now, have to be considered in estimating patient days. Equally, and of more moment, cost increases should probably be allowed for higher prices of food, drugs, and other items, especially labour.

31. The procedures involved in making these estimates would not need to vary from those now in use. Exactly as now, individual hospitals would prepare their own estimates before year-end, and submit them to B.C.H.I.S. Exactly as now, B.C.H.I.S. would review them and then use them as the basis for its submissions to Treasury. Exactly as now, after B.C.H.I.S. learned the precise amount of money voted, it would accept or modify the hospitals' individual estimates, and return them to the hospitals as their approved budgets for the year.

32. It is at this point that a significant difference would occur. Neither in theory nor necessarily in fact would the per diem rate approved by B.C.H.I.S. be the individual hospital board's actual per diem for that year. Instead, some hospitals might add a utilization fee sufficient to meet the difference between their own estimates and B.C.H.I.S. approvals, perhaps with some small addition aimed at recouping past losses or building up capital reserves. In any event, the decision would be theirs, and, if unpopular, on their own heads would largely fall whatever local indignation there might be. Wide differences between submitted estimatese and approved estimates would undoubtedly be brought to local public attention, but they could not long be maintained as the main issue of subsequent local debate; the onus would soon be placed on local managemnment to justify itself to the local public.

33. There appears little reason to fear that the utilization fees then adopted would be exorbitant, or add greatly to the overall cost to the people of hospital services in B.C. Positive, near, swift, and certain controls would lie in the hands of the people most concerned if ever they appeared out of line with those of other areas. Among the people directly concerned would be the hospital's medical staff, the very people from whom the pressure for increased services at increased costs now often originates; if increased costs meant increased charges directly applied to their patients, they would at once be subject to direct pressure to assist in curtailing them. In this way, and many others, the natural laws of supply and demand, of action and reaction, would once again effectively come into play to enforce economy instead of, as now, to ignore it.

34. Among many factors promoting economy on the part of hospital boards would be the restoration of incentives to achieve it. Whatever money they could save they could immediately use, either to improve present services, or, to their local credit, to reduce their utilization fees. Capital expenditures that would reap rich returns in lowered operating expenses could be almost immediately justified and would therefore be almost immediately adopted. (All across the province, in big hospitals and small, plans for capital expenditures that would reduce current operating costs, lie gathering dust on shelves because the boards concerned believe, rightly or wrongly, that their hospitals would not be allowed to retain the savings achieved, and so refuse, rightly or wrongly, to proceed with them.) In this way the restoration of incentive, of positive for negative instruments of control, of near, swift, and certain forces correcting error, would not only make the work of hospital boards again a challenging and rewarding endeavour; it would also incite them to continual efforts to reduce costs, at the same time as utilization fees would provide them a means to achieve that end.

35. It is too much to hope, of course, that all hospital financial problems would thus be solved and no trouble spots would occur. Government would have an indisputable interest in such trouble spots, particularly in any locality where it appeared that the citizens were being grossly over-charged for the hospital services available to them. . It is suggested that for the best handling of such cases, with least danger of government becoming involved in charges and counter-charges, a mechanism should be provided for a board of review comprised of expert and impartial consultants.

36. Nothing has yet been said in this section of the possible effect of modern advances in the healing sciences on either the provincially approved budgets or the locally established utilization fees. As previously noted, this proposal would depend for its success on some compromise recognition by government of the costs of such advances. The full force of any single such improvement would now, however, first be felt at the local level. If the local board wanted something new it would be up to it to try it out, up to it to find the money for any increase it might add to costs, and up to it to explain and resolve any financial difficulties that might follow. By and large government need not concern itself - except as it is responsible for hospital inspection - in such new developments until they had been sufficiently tested by local people in local conditions. In these developments it could discharge its responsibilities to the people most effectively by province-wide measures to take advantage of them whenever individual hospitals seemed to be moving too slowly, and by refusing to move wih them whenever they seemed to be moving too fast. With the co-operation in this matter of the provincial hospitals' association and the provincial medical association, its position would be unassailable.

37. Objection may be raised that this proposal would run into difficulties whenever a hospital's approved patient days varied widely from its experienced patient days. If there is a problem here, it is a small one. At this stage it appears that some of the complications of the present Variable and Stand-by Rates and their attendant bookkeeping could be forgotten. The flexibility of local management with actual control of revenues and expenditures should be able to adjust with little difficulty to the varying conditions which now require such

mechanisms. B.C.H.I.S. would possibly budget more accurately than now, and it seems unlikely that supplementary budgets would ever be required from the provincial government. This is only one of numerous benefits that would inure to government from adoption of the utilization fee.

## IV The Utilization fee as a Means of Deterring the Public from Unnecessary or Extravagant Use of Hospital Services.

38. (a) Theoretical

There appears no theoretical reason why the users of hospital services should not pay a realistic proportion of their costs under a state hospital insurance plan, as is the case in the majority of government sponsored plans throughout the world. It is a common principle of insurance generally that the beneficiary pay some costs additional to his premium - a principle made familiar to many citizens by the $100 deductible provision now common in automobile insurance contracts. In government hospital insurance in B. C., furthermore, the principle has already been established in the co-insurance charge. There is no evidence that this charge is ever seriously objected to on theoretical grounds. Some hospitals are in effect now achieving some of the benefits of a pseudo variable utilization fee through the judicious application of room differentials. Despite the fact that others do not, or cannot, supplement their revenues in this manner, the public generally accepts differential charges without demur. If they do object to them, it is certainly not in theoretical grounds.

(b) Practical

39. To suggest that any measure could deter the public from unnecessary or extravagant use of hospital facilities is to imply that the public is now making such use of them. This proposition would be hard specifically to refute or to confirm. It seems probable, however, that in some degree it is true. Certainly no control over admissions and discharges set up by government, and no application of those controls by local administrators, can be 100% effective. If it is to the advantage of certain citizens to make unnecessary or extravagant use of hospital services, some of them, somehow, will always find a way to do so.

40. Unquestionably there is true financial advantage for some citizens in the province in entering hospitals more often, and staying longer, than their health requires. The dollar a day cost to them of so doing is in almost all cases less than the raw food costs alone that they would have to meet if living at home. If the cost is not less, the food is unquestionably better, and probably better prepared. The present co-insurance charge is, in fact, whatever else it may be, no deterrent whatever.

41. It appears impossible to select a specific figure at which a utilization fee might become a deterrent. Individual standards, habits, and income vary too greatly to establish any point below which it is cheaper to live in hospital than to live at home, and above which the reverse is true. To take a suggested figure, $1.50 a day would hardly

be a significant deterrent to the majority of people in the province. (Incidentally, the returns of a utilization charge in that amount, averaged in all hospitals across the province, would have brought a return in 1960 - the last year for which statistics are available - of some $3,750,000.) About all that it is safe to say is that the higher the utilization fee becomes the greater a deterrent it will be.

42. Few safeguards appear necessary to ensure that the deterrent aspect of utilization fees does not become too effectual. Neither hospitals nor government would want them to prove a deterrent on the use of hospital services by citizens genuinely in need of hospital care. One reason why few specific safeguards appear necessary lies in the condition already described as essential to this proposal, namely, that the provincial government continue to pay for basic hospital costs. Another reason lies in those local checks and balances which have been considered as likely to prevent any hospital from setting utilization fees much out of line with others. But the greatest safeguard of all lies in the traditions of hospitals themselves; they have always recognized their special responsibility to the indigent and the hard-pressed.

43. If provincially applied safeguards appear desirable, it is suggested that they should be designed chiefly to ease burdens unwittingly thrown on large family units, or on individual patients receiving prolonged treatment in more than one hospital during the course of a year. It is suggested that it would be a useful regular, and inexpensive policy for the provincial government to offer to refund to any citizen at the end of a year whatever utilization fees he had paid during the year in excess of say $50 or $100 on behalf of himself or his dependents as reported on his Income Tax returns. By contrast, under the present plan the $1.00 per day co-insurance charge in any one year can easily reach a total in excess of these sums.

44. At this point we have reached administrative detail. Many other such items of detail have been considered. It is enough to say of them now that none appear to cause any practical difficulty. It would be administratively simple to set up a system which would work hardship on no individual and sufficiently deter individual misuse of hospital facilities to save a significant amount of money in the operation of hospitals. A simple amendment to Hospital Insurance Regulations 8-1 and 8-2 would be all that is required to bring the utilization fee principle into immediate effect.

## V Conclusion

45. Hospitals and government, true partners in a noble enterprise, together face a common embarrassment. Hospitals say they must have, or should have, more money to provide the standard of hospital care which the government has promised the people. Government says it cannot, or will not, or should not, provide the funds which the hospitals state are necessary to provide this standard.

46. Both positions are subject to argument, but argument on either is futile. It can only stir ill-feeling, without resolving the difficulty. If both positions are accepted, only one general solution appears possible: hospitals must somehow be found some source of supplemental revenue.

47. Particularizing, there appears to be only one source to which hospitals can turn. That is the local community - the separate local communities in which the individual hospitals perform their works of mercy. Small additions to the hospitals' revenues from their local communities would solve the financial problems now faced by government and hospitals together.

48. This reasoning leads immediately to thought of a local community tax in support of hospitals. Analogy is easily made with present local community taxes imposed to provide capital funds for hospital construction. This analogy suggests that the hospital improvement districts now existing, and others to be formed for the specific purpose in mind, should have their functions extended to provide supplemental local revenue for local hospital operation.

49. Much can be said for and against hospital districts so conceived. For brevity, this concept is here dismissed in one paragraph. Hospital districts would effectually return a portion of the control of and responsibility for the management of hospitals to the local level, where hospitals for many reasons - including economy - feel that it should belong; in so doing, however, they would introduce into the control and management of each hospital yet a third party - district trustees and municipal councillors. Division of authority multiplies confusion, inhibits action, promotes argument; foreseeing endless local political squabbles inherent in the system, hospitals are uneasy at the thought of hospital districts being brought in to aid with their operating expenses. Their proper business is caring for patients, not engaging in political in-fighting. Allied to this objection, though less fundamental, are the administrative complications involved in the "districts" proposal: one needs only to consider the different district organizational requirements of, say, Fort Nelson and say, Vancouver, to visualize the complexities involved. Either of these objections seems sufficient alone to rule out the "district" concept, if any other workable proposal can be formulated.

50. Such an alternative has been here presented, and is here recommended. The B. C. government is now asked to give serious consideration to empowering hospitals to set, collect, and use a variable utilization fee for the purpose of assisting the government in the financing of the B. C. Hospital Insurance Service and of allowing the hospitals to supplement the revenue they receive from provincial sources.

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A B R I E F

to the

Royal Commission on Health Services

from the

Metropolitan Hospital Planning Council

of the

Lower Mainland

of

British Columbia

XxX-X-X-XxXaX-X

For presentation in Vancouver, B.C.
on or about
February 21, 1962

## Introduction and Summary

1.) The Council here represented speaks for many interests of unselfish concern for Patient Care. (a) It was originally sponsored, and it remains strongly supported, by the B.C.Hospitals' Association. Almost immediately after its birth specific tasks were suggested by the provincial government of B.C., (b) and in furtherance of those tasks, and of others suggested to it later, (c) it has had continual extensive co-operation from the B.C.Hospital Insurance Service. Among its members are official representatives of the elected local governments of all the municipalities centred around the city of Vancouver. It has the active support of the Faculty of Medicine of the University of British Columbia and of the B.C. Division of the Canadian Medical Association, (d) and from these bodies it has had the benefit of expert professional direction of the several research projects which it has undertaken. Finally, in the prosecution of these research tasks it has been financially assisted by the National Government through National Health Grants to a sum now in excess of $45,000 with a further sum of at least $10,000 for next year.

2.) It is the main thesis of this brief that this Council be further supported, and that like councils be encouraged to form, and be supported financially and morally by the several governments of Canada, wherever the need for integrated planning of hospitals and health services may arise. The Commission to which this Brief is addressed is particularly charged to enquire into and report on, among other subjects, "the present physical facilities and the future requirements for the provision of adequate health services." It is precisely for such a purpose in this area that this Council was formed, and its officers now appearing here believe that its experiences and achievements in this field may be of much value to the Royal Commission. This Council may serve as an experimental model for the formation of others as need arises. To the best of our knowledge no other on this continent appears to have reached the state of useful development achieved here.

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(a) Exhibit A, attached, lists the organizations generally assigned membership in the Council, and the names of its officers and special committee members.

(b) Exhibit B, attached, is copy of a letter from the Honourable Eric Martin, Minister of Health Services and Hospital Insurance, of date December 28, 1959.

(c) Exhibit C, attached, is copy of a letter from the Honourable Eric Martin, of date November 14, 1961.

(d) Exhibit D, attached, is copy of a letter from the Canadian Medical Association, B.C.Division, of date March 30, 1961.

Introduction and Summary -

no other has so satisfactory a base of theoretical studies made and practical results obtained; no other has elicited similar support from government at all levels, from the voluntary hospitals and other health authorities concerned, and from the whole of the provincial medical profession. It is a most happy combination of interested and authoritative forces working together in search of solutions to one of the most pressing problems that face health services in Canada today.

3.) That problem may be simply stated. Expanding population, advancing medical science, increasing longevity, rising standards of living, a widening social conscience, all multiply the demand for new health services of every kind, and, in this context particularly, for those services represented by hospital beds. Those beds will be built, sometimes lagging behind demand, sometimes in immediate excess of demand, but always in some measure proportionate and in response to increasing demand, and to the variable, and often illogical, expressions of that demand. The problem is to assure that invalid expressions of demand do not outweigh the pertinent considerations of efficiency and economy, to the end that these beds that will be built shall be built in the right places, at the right time, and of the right kind.

4.) There are many "political" pressures that can easily lead to inefficient and uneconomic development of hospital systems. All across Canada the national and provincial governments together have assumed responsibility for all but a minute fraction of the costs of serving hospital beds once they are built. In B.C. the provincial government has assumed half the responsibility for all initial capital costs, and the national government takes a proportion of the remainder. It follows that any community able to persuade the proper authority to permit a hospital to be built within it can be assured, at small cost to itself, of an immediate inpouring of construction money and a subsequent unending inflow of operational cash. Every ten thousand dollars it spends produces almost thirty thousand from outside sources, and guarantees an annual pay roll of approximately double its original expense (e). Hospitals have become big business in the modern age; from the point of view of elected councils they are also good business.

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(e) Exhibit E, attached, shows rough estimates of the capital cost, the amount of capital cost raised by the community, and the actual annual pay-roll and annual expenditure on supplies, for a small hospital recently built in a typical small B.C. community.

Introduction and Summary -

5.) Financial benefits are not the only motives behind local pressures for construction or expansion of local hospitals. Community prestige is another. Community convenience is yet another, not lightly to be dismissed: there is often genuine therapeutic value to a patient in being able to obtain the required treatment in his home town, where doctor and nurse are often already known to him, and where his relatives and friends may visit him without his having unease for the trouble he has caused them: economy may also be best served sometimes by such convenience, the travel costs of patients and relatives being one of the hidden costs of the nation's total health bill whenever local facilities are inadequate. Community organizations, inspired often by the most altruistic motives, are a third cause of local pressures demanding local beds at the expense of efficiency and economy. They draw the support of the most prominent, the most active, the most unselfish, and the most vocal citizens of the community. The pressures they create are all the harder to resist because of the patent goodwill behind them.

6.) Such are some of the pressures from the local community level. At the level of provincial governments other pressures also necessarily exist. New hospitals can buy votes as effectively as new roads or new harbours or new bridges. Rejection of new hospital proposals can easily be interpreted as miserliness, or as the rejection, for political reasons, of the popular will.

7.) The pressures so far considered tend to increase the provision of beds without regard to the overall need or the most efficient and most economical use of them. Other counter-pressures exist, tending to produce shortages of beds overall or in some particular locality. City Council may see a new or larger hospital as a good investment for the community as a whole, but cannot sell the idea to the community's ratepayers. Provincial government authorities may find themselves in a similar situation in determining the expenditures for services in various fields. Ultimately they must have control of where beds are built, and when, and of what type, and they fail to exercise the responsibilities of government if they lose that control or yield to unreasonable local pressures or internal political pressures. The temptation to do so at times is nevertheless immense, and it is highly creditable to the various governments of British Columbia that hospital services are as well adjusted to health needs as they are in this province today.

Introduction and Summary -

8.) It is the purpose of the Metropolitan Hospital Planning Council to assist government, by eliminating pressures irrelevant to overall efficiency and overall economy, from whatever source, as factors in the planning of hospital construction, and substituting therefor scientific analysis of actual need, based on professional research into present operations, potential population growths, medical advances, demographic statistics, and all other factors that may throw light on how to provide the best patient care at least cost. The following pages will show how and with what success this Council is working towards these objectives. Before turning to them, however, it seems proper to outline principles upon the general acceptance of which the successful operations of such Councils must depend. These are given hereunder, as:

9.) Recommendations.

I. That such Councils be operated as non-profit societies, either in their own right, or as semi-autonomous branches of some other professional non-profit organization, such as a provincial hospital or medical association.

II. That local governments and presently existing local hospitals in some manner be given a voice in the decisions and recommendations of such Councils, so that local interests may have a part in decisions affecting them. This also applies to obtaining the official opinion of the provincial hospital association, the provincial division of the Canadian Medical Association, and the Faculty of Medicine at appropriate universities.

III. That such Councils, in whatever area they may begin their studies, must plan expansion, directly, or by participation in or with other Councils, to the whole of the provinces in which they exist; and must further develop close liaison with other like bodies in other provinces.

Introduction and Summary -

Recommendations -

IV. That such Councils do not limit their studies to hospital beds and services only, or to any particular type of hospital beds and services, but also take into consideration the effect on the need of such hospital beds and services of other developments in the hospital field, such as home care and increased diagnostic or outpatient services, and rehabilitation programs, and for this purpose establish effective liaison with all other organizations concerned in such matters.

V. That governments responsible for hospitals support such Councils financially, defraying all their reasonable expenses up to the proportion of such responsibility. (f)

VI. That governments also support such Councils

(1) By close liaison between provincial health and hospital insurance departments and Councils.

(2) By general acceptance, except for stated good cause, of the recommendations of the Councils, and by the responsible government first referring each application for hospital construction and expansion to the appropriate Council.

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(f) Exhibit F,attached, is copy of a recent budget prepared by the Metropolitan Hospital Planning Council, with explanatory comments and suggestions for other revenue sources than those considered in this budget.

## Review of Purposes and Achievements.

10.) Little more than 100 years ago there was not a great deal that could be done for sick people. Diagnosis of disease was in its infancy and preventive medicine was just beginning. There was great need for medical and hospital care, but there was little demand for the medical and hospital services then available. Hospitals were known as pest-houses, and were frequented only by the indigent, shunned by all who could afford to remain out of them.

11.) As new treatments and diagnostic procedures were developed, hospitals developed with them, and won a new public image. First sponsored by well intentioned wealthy persons or groups, they soon became community centres, and are today an integral part of our community being. Their services are no longer restricted to the indigent but are sought by all sections of the community. They have become the medical profession's workshop, and the focal points of all treatment of the community's ill.

12.) From their philanthropic origin modern hospitals have naturally developed all the organizational features that one would expect them to have in a free-enterprise democratic society. Among these features is control by autonomous Boards of Trustees, accustomed to enjoy freedom in planning the future of the institutions over which they have been given control, and reluctant to yield that freedom to outside authorities or upon consideration not directly affecting their charges.

13.) Until the advent of provincial hospital insurance, hospitals have been in some measure in competition with one another - for capital finance, for operating subsidies, for medical services, for prestige, and even for patients. Their Boards were responsible only to their own communities, and in order to fulfill that responsibility jealously guarded their autonomy. They planned

13.)
expansion or retraction of facilities, extension or retrenchment of their services, entirely according to their estimates of their community's need and its ability to finance provision against that need.

14.) The comparatively recent development of 3rd party prepayment plans has completely changed that picture. That is particularly so in Canada, where all but a small fraction of any public hospital's income derives from a government approved hospital insurance program (ff). Public hospitals, willingly or unwillingly - in most cases willingly - have traded a large part of their individual autonomy for almost complete financial security. They now have an assured and closely predictable source of income, but they have of necessity lost a great part of their control over expenditures, both on capital projects and for operating purposes.

15.) In various degrees the same pattern of autonomy diminishing as financial security increases is being repeated elsewhere on this continent. In the United States, government at various levels contributes more and more of required hospital capital costs, and larger and larger percentages of the population come under Blue Cross or other third party paying agencies. The effect in both cases is to spread costs over the whole population instead of recovering them only from those individuals who receive benefits. Rising hospital construction and operating costs have therefore become a public concern and have drawn public criticism. One result of such concern has been a growing acceptance of the need of planning based not

(ff) The phrase "hospital insurance" primarily applies to the citizen: the various government plans insure him in whole or in part against the costs of becoming a hospital patient. Secondarily, it also applies to the hospital:the same plans insure it to a major degree against losses incurred by admitting patients.

on individual community needs alone but on the overall needs of larger natural or political groups.

16.) So two forces have come into conflict in the planning of hospitals today - local need, local pride, local prestige, and local knowledge on the one hand, and the overall advantage of the larger community in terms of the best possible service at least possible cost on the other. This conflict is at present more acute in Canada than it is in the United States. Senior governments here have taken so large a share of the costs of hospital construction and operation that they have made it possible for local communities to push building plans with small regard for costs to local rate-payers, and have at the same time made it incumbent upon themselves, in the interests of tax-payers at large, to assure that money so spent is wisely spent.

17.) The public manifestations of this inherent conflict can at times be most unhappy. Local knowledge, local prestige, and local popularity appear to be pitted against central authority and bureaucracy. Personalities and side-issues may take sway, and in the ebb and flow of argument the immediate issue - whether such and such a community needs so many beds, of what type, and when - is frequently quite submerged.

Fortunately such occasions are rare, because both parties are sincere and basically seek the same objective of better patient care at minimum cost. Both sides also have a proper part to play in the decisions that are finally made. The senior governments are right to set their gaze on the whole picture and judge accordingly. The community representatives are equally right in presenting and pressing local needs and desires. They bring an intimate knowledge of actual local need which no studies made from a distance should every try to supplant. They also offer the best of that devoted, unpaid, and often unthanked voluntary service

which sets hospitals aside from all purely scientific endeavours and inspires them to be more than coldly efficient instruments designed for the machine-like cure of merely physical ills. The knowledge, the interests, and the devotion of the voluntary representatives of local communities is neither to be belittled nor to be ignored in any overall planning. To do so would be a denial of democracy and a waste of talent.

18.) The inherent conflict of interests just described is not the only factor to be considered in the integrated planning of hospital facilities today. The rapid advances of medical science, and the resultant complexities of therapeutic treatments, and the tremendous costs associated with some of them, have made it impractical to think in terms of so many beds per thousand distributed over the area of concern in direct proportion in each community to the number of that community's inhabitants. For a single example, it would be ridiculous, and wantonly extravagant, to provide facilities for open-heart surgery in every community . Usually, it is neither practicable nor economical to support all specialized services in all hospitals, although a very high standard can be achieved by the process of referral of work and patients. Surveys conducted in rural areas, while attemping to determine the same needs for these people as those in metropolitan areas, must take into account the ability of the area to support the services, and usually recommend some sort of compromise. A higher degree of integration is possible in metropolitan areas, where there are several hospitals within a short distance, as compared to the rural area where there are long distances between each institution.

19.) The foregoing was the environment which existed prior to the commencement of a survey of the metropolitan area of the Lower Mainland of British Columbia in early 1959. At that time requests had been received by the B.C.Hospital Insurance Service from various hospital groups in the area for expansion of beds and hospital services.

20.) An examination of these requests revealed that hospitals were acting independently and, in some instances, appeared to be duplicating facilities requested by other individual hospitals. It was discovered that there was no co-ordination in the planning of facilities in the area, and that present plans would result in some duplication of expensive facilities. It was, therefore, decided to undertake a survey of the hospital needs in the Lower Mainland area as rapidly as possible.

21.) Preliminary work served to confirm that the planning of hospital facilities for the metropolitan area of the Lower Mainland was proceeding on an individual hospital basis and would result in services being constructed which duplicated each other. It was obvious that, unless steps were taken to develop some sort of integrated plan, an expensive and not necessarily efficient hospital program could result in the Lower Mainland area.

22.) It was also apparent that in some Vancouver hospitals there was a marked pressure for hospital beds, but in others there was not the same pressure for beds, although at times there was a shortage. It was therefore decided that detailed statistics should be prepared which could analyze patient loads of the hospitals in the area. These detailed statistical runs were subsequently developed by the Research Division of the B.C.Hospital Insurance Service. (g)

23.) When the first statistical tabulations were completed, the picture presented clearly indicated the cross-referral of patient load within the metropolitan area itself. Residents of one municipality were being referred into other

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(g) See Exhibit G - a single volume entitled "Interim Statistical Tables Pertaining to Hospital Facilities in the Lower Mainland". One copy only of this highly technical report is available for presentation with this brief.

municipalities and, in addition, patients were being sent into the area from all over the Province. It also appeared that doctors with staff privileges in several hospitals were referring their patients between hospitals.

24.) Because of this situation, it was decided to try and bring together the groups in the Lower Mainland that were interested in the hospital field. A meeting was sponsored by the B.C.Hospitals' Association during its 42nd Annual Convention, held in Vancouver in October,1959. The Metropolitan Hospital Committee (now known as the Metropolitan Hospital Planning Council) was established as a result of this initial meeting. In response to a request to the Minister of Health Services and Hospital Insurance for terms of reference, the Minister suggested that advice on the following areas of study would be of assistance to the B.C.Hospital Insurance Service and the Government. (Exhibit B)

(1) The type of beds to be built and the diagnostic and treatment services to be provided in the area;

(2) The location at which beds should be built; and

(3) The method of financing the community's share of hospital construction.

25.) The Metropolitan Hospital Committee (The Council) established a professional sub-committee composed of representatives from the B.C.Division of the Canadian Medical Association, the Faculty of Medicine of the University of British Columbia, the Vancouver Medical Association, the Metropolitan Health Committee, the B.C.Hospitals' Association, representatives of major metropolitan hospitals, the Health Branch, and the B.C.Hospital Insurance Service of the Department of Health Services and Hospital Insurance.

26.) The first survey to be undertaken was a study of cases referred into the metropolitan area. This decision was a direct result of an analysis of the statistical data mentioned earlier, compiled by the B.C,Hospital Insurance Service, which indicated that a much smaller percentage of cases were being referred than had been thought to be so in the past.

27.) Another area that required attention was that of bed utilization. It had been suggested that there was a shortage of acute beds in the area, although there appeared to be a reasonable number of acute hospital beds in relation to the population. Perhaps the greatest factor involved in the evaluation of acute bed needs, is the effect which the Rehabilitation, Chronic Treatment and Convalescent Care Program will have on bed demands. Estimates have indicated that 10% to 30% of the cases in some of the acute hospitals could be cared for in proper chronic hospitals or nursing homes. If, with the implementation of the Rehabilitation, Chronic Treatment and Convalescent Care Program, these cases are transferred out of the acute hospitals into chronic hospitals, this will release a comparable number of beds for acute care. However, some of the acute general hospital beds may be utilized to look after some of these cases, by converting acute beds to chronic care wings or wards.

28.) Further, there is a bed problem in the metropolitan area of the Lower Mainland, which is the result of the geographic distribution of facilities and other factors, rather than a shortage in the total number of acute beds in the area. Concentrations of population in certain areas will increase the demand for hospital beds, but increased demand is also due to the fact that some of these hospitals have excellent facilities available for special treatment, have a great many doctors on their medical staffs, and receive the largest proportion of the difficult referral cases. It seems that as hospitals grow in size and add new services to their facilities they attract more doctors and more patients; the problem of bed pressures pyramids almost in direct relationship to their growth. Let a hospital become a prominent medical centre, and problems at once arise in finding accommodation for patients attracted by the renown of its facilities.

29.) A quite opposite situation was to be found in other areas of the metropolitan Lower Mainland. At one time when it was publicly stated that there were long lists of waiting patients at certain hospitals, in other sections of the Lower Mainland, hospitals were looking for patients. One hospital opened a new wing in response to requests for beds, but found that it later had to close down a part of this wing, not because of a shortage of staff, but because of lack of patients. Here was an anomalous situation: a shortage of beds in one part of the metropolitan area of the Lower Mainland and a dearth of patients in another a few miles away.

30.) Conflicting bed requirements make a difficult problem to solve. It involves not only the geographic location of the hospital but also methods of staff appointments, the services that are available in the various institutions, the desires of the patient, and a myriad of other factors that affect the doctor's and patient's decision to request admission to a certain hospital.

31.) Because of the influence which the type of medical care provided both within and without the hospital has upon the hospital program (and especially in the matter of referrals), it is felt the time has arrived for a closer integration of medical and hospital planning, in order to establish patterns of practice in both areas,which will complement, rather than supplement, each other. The necessity for this type of integrated planning, to provide total area programs, is becoming quite apparent, both generally and in certain of the specialty fields such as paediatrics, emergency services, chronic care, etc.

34.) If, through the professional studies of the Metropolitan Hospital Planning Council, it is possible to trace out the medical care patterns for the area, and in some instances go beyond the Lower Mainland when necessary, and apply these results to hospital planning, a better integrated hospital program should be possible. In any such planning, care must be taken that the program is not so inflexible that it cannot meet changing demands on individual hospitals, thereby stifling local initiative.

35.) The first study conducted by the Council (which was an analysis of referral patterns into the metropolitan area) has been completed. Rather than summarize all of the recommendations, perhaps it would be sufficient to comment on one or two of the more important ones as they relate to the area. (Exhibit H

36.) The report recommended the construction of some 850 beds in the periphery of the area by 1965, in order to maintain the 5.7 beds per 1,000 population ratio which exists at the present time.

37.) It also recommended the construction of a University hospital which would act as a referral centre for the Province, and these beds were included in the 850-bed figure. The provincial Government has acted upon the recommendations and has already approved the construction of the referral hospital at the

37.) University and a new hospital for Richmond, one of the municipalities in the periphery area. Other projects are currently under review.

38.) Several hospitals in the metropolitan area have submitted briefs to the provincial Government, requesting approval of expansion programs. The Government has, in turn, suggested to these groups that they present their plans to the Metropolitan Hospital Planning Council, so that it can be aware of the proposals of the hospitals and take them into consideration in its studies. These proposals present problems in expanding the total number of acute beds in the area and affect the patterns of future development of certain specialties. To have professional advice available through the Metropolitan Hospital Planning Council in determining these future patterns, and to be able to receive its recommendations, is of great assistance to the B.C.Hospital Insurance Service and the Government. The importance of co-ordinated planning is shown by the fact that if all the requests for expansion presently received from hospitals in the metropolitan area of the Lower Mainland were implemented ,this would provide for sufficient acute hospital beds to serve the total population of the province.

39.) When the basic data of these hospital briefs are analyzed, there are several instances where the same population groups are being used by two hospitals to justify their request for expansion. In one instance, the population of an area is used by three, and possibly four, hospitals to support their requests for additional beds. Some of the briefs draw a comparison of the number of hospital beds per thousand in their respective districts or municipalities to the average for the metropolitan area, or the Province as a whole, stating that, because their ratio is perhaps below the average, their citizens are not being adequately hospitalized.

40.) However, an analysis of the hospitalization experience of the municipalities that make up the area under study shows that such a statement is contrary to fact. For the years 1959 and 1960, one district presently requesting additional beds, on the basis that its ratio of beds per thousand is almost one-half that of the Province, or the metropolitan area, has, in fact, an incidence rate of cases admitted per thousand population that is higher than the Province as a whole, the total metropolitan area under study and, in fact,

40.) higher than any other municipality included in the survey. A review of the days of care provided the areas under study follows almost an identical pattern to the case analysis.

41.) This situation is understandable, for a population that is growing on the outskirts of a metropolitan area is bound to be serviced by the latter until the peripheral district is large enough to commence providing its own facilities. Once this has been started, there is usually a gradual change in the pattern of hospitalization and patient flow, until ultimately the municipality which formerly relied on the metropolitan area for hospitalization may, in fact, be providing care for some residents of the adjacent metropolitan area.

42.) A closer examination of the hospitals under study revealed that perhaps an answer to their problem of high occupancy and bed shortages would be found in a study of the way in which the beds of the hospital were being utilized. It was felt that in some instances some of the cases might be cared for in accommodation other than the acute general hospital and, therefore, should not be occupying acute beds. As this involves professional decision, it was obvious that this matter should be referred to the appropriate medical body in the Province. Discussions were held with the representatives of the B.C.Division of the Canadian Medical Association, to see if a professional survey could be carried out, especially in view of a resolution recently passed by the Executive of that body, which reads as follows:

> "We recommend that a survey be carried out under the aegis of the Canadian Medical Association, B.C.Division, the purpose of this survey being to determine factors affecting utilization of hospital beds. This survey to be done with the co-operation of the medical staffs of the hospitals surveyed. The Metropolitan Hospital Planning Council could be approached to obtain funds and assist in the research."

Review of Purpose and Achievments -

42.) This recommendation is recorded as evidence of the strong interest and full co-operation of the provincial medical profession in the work of the Metropolitan Hospital Planning Council. (Exhibit D). Its acceptance by the provincial government (Exhibit C) is equal evidence of a most desirable relationship which as far as we know has no similar fruition elsewhere on this continent. In this province the government not only has won, but also welcomes, the full co-operation of the medical profession in study of the health needs of the people.

43.) The first study of the kind envisaged by the medical association was begun in the spring of 1961, and is now nearing completion. It involves two hospitals adjacent to each - Surrey Memorial Hospital and White Rock District Hospital and their surrounding populations, - in the southwest corner of the Council's field of study. Both had applied for permission to expand. Both, it was suspected, based some of their expansion estimates on the same, overlapping, populations. A report on this study, delayed in order to permit correlation with 1961 census returns for the area, is, at this writing, nearing completion.

44.) Another project recently completed by one of the Council's research teams is a study of emergency facilities in the area. (Exhibit I). It is already in use as a guide to the improvement and better use of present emergency facilities, and may well serve as the basic plan for further development of emergency facilities in the area for many years to come. It has now been approved by the Council and presented to the provincial government for consideration.

45.) Another project nearing completion is a paediatric survey, commenced on April 1st of last year. Pending completion of this study, the Council recommended the suspension of all paediatric construction in this area. The government has accepted this recommendation, with the result that several institutions actively planning such expansions have been brought to a full stop in their planning. Greatly to their credit, their Boards have accepted this delay in their plans, reluctantly, but with good grace, and with none of the public

45.) furore that might have arisen if such a decision had been made by the provincial government alone. The reaction of these Boards provides gratifying proof of the willingness of local community representatives to accept painful decisions when they have some voice in the body that makes them.

46.) In addition to the four above-mentioned studies completed or nearing completion, the Council has agreed to proceed with one of the projects proposed in the Minister's letter of November 14,1961. (Exhibit C ). It is expected that this demographic survey will produce material of great value in any future studies of bed needs throughout the whole province. In this study for the first time the Council sets terms of reference specifically requiring study beyond its own originally chosen area. This development, recommended as point III of page 3 of this brief, appears inevitable: illness recognizes no man-made boundaries, and the periphery on any study continually enlarges.

47.) To date the Council has been unable to make any progress on the third item on which the Minister sought advice in his first letter to the Council. The development of basic data showing the present capital involvement of the 14 municipalities of the area in the 12 public hospitals of the area is a research project different from those which the Council is at present geared to undertake, but would not be difficult. It does not appear amenable, however, to the support of National Health Grants, and the Council so far has been unable to find the money required to proceed with it.

48.) The only source of revenue the Council has yet been able to draw on comes from the federal government through National Health Grants. Such grants are made specific to approved research projects and cannot be used for other purposes. The Council last spring proposed a voluntary assessment of participating municipalities at one cent per capita, with a matching amount from the provincial government (see Exhibit F), and has in fact received moneys on that basis from a number of the municipalities. It does not feel that it has any right to use such moneys, however, until it is assured of equivalent pro rata contributions from all, or all but a very few, of the municipalities which stand to benefit from its work: it is therefore holding all funds received from this

source in trust for the time being. In the meantime, its secretarial work is being done, and its secretarial supplies provided (as, for example, in this present brief), by courtesy and at the expense of either the Faculty of Medicine at the University of B.C. or the B.C.Hospitals' Association. The proposal that it draw general working funds equally from local governments and the provincial government seems reasonable and equitable so long as the Council's work is restricted to the present area, but might prove impractical when, and if, its work spreads out to cover the numerous other local governments in the province. In any case, as of this writing, the provincial government has not committed itself to the financial support requested of it. Without dwelling on this difficulty we wish to point out that if the provincial government makes a contribution through a small yearly assessment on hospitals proportionate to their bed capacities, this will be a properly sharable cost and therefore partly borne by the federal government.

49.) It is difficult to predict future financial requirements. However the highest estimate of continuing need yet tentatively suggested is around $20,000 - for one full time director, office and staff -. This may not include the cost of some of the larger special projects. To effect savings for the whole provincial economy in excess of that figure, the Council needs only to prevent the unnecessary provision of two hospital beds per year.

50.) Despite its present financial difficulties the record of the Metropolitan Hospital Planning Council to date has been impressive. It has been successful in bringing together medical, hospital, and municipal groups to examine the problem of integrated planning. Above all, it has brought professional medical knowledge into the planning of hospital facilities, and has helped to build the excellent relationship which exists between the groups concerned.

Review of Purposes and Achievments -

51.) The successful integration of patterns of medical care with the planning of hospital facilities by a voluntary body at the community level makes it unique.

52.) While the Federal Government has made it quite clear that the responsibility for hospital matters lies with the Provincial Governments, and the Provinces, in turn, have delegated certain responsibilities to the hospitals, (j) the question of local autonomy and central control is still unresolved in many respects. The existence of policies which, on the one hand, profess to preserve the autonomy of hospitals at the community level, and yet take away some of the effectiveness of community decision on the other, presents a challenge to those responsible for the future development of our provincial hospital plans.

53.) This basic problem of autonomy and control is being studied across Canada. In the field of area planning, a practical resolution of it appears in the making in B.C. The Provincial Government there has sought the advice and counsel of the professional groups and local authorities interested in these matters, and provided them with an opportunity of taking part in the development of hospital facilities in their area through the Metropolitan Hospital Planning Council. Perhaps this method will prove to be one way of solving one part of this problem so that we may retain the advantages of the autonomous hospital at the community level, and yet support its operation with government funds. In any event, the progress made up to the present time is most encouraging, and suggests that this newly developed concept of local and provincial integration and co-operation in hospital planning will provide some of the answers to the vexing problem of hospital development in the future. The achievments made by this Council, and the interest they have excited in other parts of Canada, and other parts of the world, suggest that its purposes and experiences may be worthy of study by the Commission. To that end this brief and its attached exhibits are now respectfully submitted.

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(j) Exhibit J, attached, outlines the relations between the several governments and hospitals as they develop in practice and as determined by responsible statements of policy.

METROPOLITAN HOSPITAL PLANNING COUNCIL

Exhibit A.

1. General Membership.

Failing formal Constitution and By-Laws, the following organizations have been generally accorded right to voice and vote at general meetings of the Council, in addition

Cities

New Westminster
Port Coquitlam
Vancouver
North Vancouver
Port Moody
White Rock

Municipalities and Districts

Burnaby
Delta
North Vancouver
Surrey
Coquitlam
Fraser Mills
Richmond
West Vancouver

Hospitals

Burnaby General
Grace (Vancouver)
Mount St. Joseph's (Vancouver)
St. Mary's (New Westminster)
St. Vincent's (Vancouver)
Vancouver General
Children's (Vancouver)
Lions Gate (North Vancouver)
Royal Columbian (New Westminster)
St. Paul's (Vancouver)
Surrey Memorial
White Rock District

Other Organizations (usually non-voting)

Canadian Medical Association, B. C. Division,
B. C. Hospitals' Association,
B. C. Hospital Insurance Service,
Faculty of Medicine, U. B. C.,
Department of Health Services, Provincial,
Metropolitan Health Committee,
Vancouver Medical Association,
Metropolitan Joint Committee,
and other like bodies.

2. The Executive (1961-62)

D. A. Thompson, President, elected
W. Orson Banfield, Vice-President, elected,
Kenneth Conibear, Executive-Secretary, elected,
Mrs. D. Hewlett, Chairman of the Board of Royal Columbian, appointed to represent New Westminster, Port Coquitlam, Port Moody, etc.,
J. A. Folinsbee, trustee, appointed to represent Lions Gate Hospital and 3 North Shore municipalities,
D. H. Jamieson, Councillor, appointed to represent Burnaby,
Mrs. Marianne Linnell, Alderman, appointed to represent Vancouver City,
Hugh D. Hudson, trustee, appointed to represent Richmond, Delta, and Ladner,
J. C. Rife, Chairman of the Board of Surrey Memorial Hospital, appointed to represent Surrey Municipality,
Roy S. Shields, trustee, appointed to represent White Rock,
L. F. Detwiller, Assistant Deputy Minister of Hospital Insurance, appointed to represent the Provincial Government.

3. The Professional Committee

D. A. Thompson, Ll.B., legal adviser to St. Paul's Hospital. Chairman
George Ruddick, F.A.C.H., Associate Director, Vancouver General Hospital
Kenneth Conibear, B.A., Executive Secretary of B.C. Hospitals' Association
L. F. Detwiller, M.A., M.H.A., M.R.S.H., Assistant Deputy Minister of Hospital Insurance
Dr. J. F. McCreary, M.D., R.C.P.&S.(C) Paediatrics, Dean of the Faculty of Medicine, University of British Columbia.
Dr. J. M. Mather, M.D., D.P.H., R.C.P. & S (C), Fellow American Public Health Association, Head of Department of Preventive Medicine, U.B.C.
Dr. B. D. Graham, B.A., M.D., Fellow American Academy Paediatrics, Professor and Head, Department of Paediatrics, U. B.C.,
Dr. C.J.G. Mackenzie, M.D., C.M., D.P.H., Director Central Vancouver Island Health Unit, Nanaimo,

Exhibit A - continued

The Professional Committee - continued

Dr. F. P. Patterson, M.D., C.M., F.R.C.S.(C) Orthopaedics,
Dr. John Balfour, M.D., R.C.P. & S(C), F.R.C.P.(c), Chairman of the Hospitals' Committee of the B. C. Division of the Canadian Medical Association,
Dr. Conrad MacKenzie, B.A., M.D., C.M., Representative of the Vancouver Medical Association,
Dr. J. L. Gayton, B.A., M.D., D.P.H., Certificate Public Health Canada, Fellow American Public Health, Vancouver City Health Officer,
Dr. L. H. Bartlett, B.A., M.D., C.M., R.C.P. & S (C), Orthopaedics,
Dr. Brock M. Fahrni, M.D., F.R.C.P.(C), Internal Medicine,
Dr. G. R. F. Elliot, M.D., C.M., D.P.H., American Certificate Public Health, Canadian Certificate Public Health, Assistant Provincial Health Officer.

EXHIBIT B

COPY

December 28, 1959

Mr. D. A. Thompson,
Chairman,
Metropolitan Hospital Committee,
Barrister & Solicitor,
311 - 535 Howe Street,
Vancouver 1, B. C.

and

Mr. Hugo Ray,
Chairman,
Metropolitan Joint Committee,
1401 - 675 W. Hastings Street,
Vancouver 2, B. C.

Dear Sirs:-

It was with great satisfaction that I learned that, following the initial meeting in Vancouver on October 21, 1959, the hospital, medical, municipal, and related groups in the Greater Vancouver area immediately made plans to assist in the development of a complete and satisfactory hospital construction program for the area. Since then the Canadian Medical Association, B. C. Division, and the Medical Faculty of the University of British Columbia have kindly consented to undertake a study of referral of patients and related matters which have such a great bearing on the bed requirements in Greater Vancouver.

At the time of the initial meeting, some mention was made of terms of reference, and subsequently I understand that it was suggested that terms of reference should be laid down. The development of the interested groups in the Greater Vancouver area is and should be a voluntary procedure and it would not, therefore, be proper for me to attempt to lay down terms of reference, but rather review those which might be developed by the local organization. I do feel, however, that I should outline the function of the Hospital Insurance Service, the information that I hope will be supplied by the local committee or committees, and the studies that I hope they will undertake.

The Hospital Insurance Service will in due course report to me on the number of active treatment and acute general hospital beds that it recommends for the Greater Vancouver area. As previously mentioned, referral of patients to Greater Vancouver is such an important factor that it was found necessary to ask the medical profession to look into this question. The information that will come from the medical study will, of course, be taken fully into account in determining the number of beds required at present and at specified future dates. Obviously the Hospital Insurance Service cannot complete its recommendations until the results of that medical study are at hand.

It is hoped that your local committee or committees will provide expert advice to the Hospital Insurance Service in regard to:-

1. The type of beds to be built and the diagnostic and treatment services to be provided in the area.

2. The locations at which beds should be built.

3. The method of financing the community's share of hospital construction.

I recall that at the October 21st meeting apprehensions were voiced that there is not too much for the local committees to do at present. It is my opinion, however, that a tremendous amount of preparatory work can be done at the local level. For example, I believe that information could be secured from every hospital and from every group which has applied for approval of hospital construction as to precisely what programs they have in mind and how many beds they desire to build.

.....2

EXHIBIT B - continued

Also I believe it would be advisable to secure a complete outline from all local hospitals as to what they now have in the way of major diagnostic and treatment services and what extensions or additions they plan. I am quite sure that such information would be of tremendous value to a local committee in providing guidance against costly and unnecessary duplication of services and scattering of facilities. I do believe that safeguards of that type would be one of the great contributions the committees could make. I believe also that the local committee could well study waiting lists of hospitals and secure accurate tabulations relating to patients unable to secure admission. From information gathered somewhat at random regarding waiting lists in hospitals in Greater Vancouver, it appears that there may well be a possibility of some patients being on more than one waiting list. I would hope that your committee would pass on to the Hospital Insurance Service the information secured from such studies. It might also be helpful if Mr. Detwiller sat in on some of your committee meetings to provide liaison with the Hospital Insurance Service and to ensure a continuity of thought in the study of recommendations that will be made by your committee.

With regard to problems of financing the portion of hospital construction costs that must be met by the communities, it seems to me that consideration of that factor need not be left until the report of the number of beds which can be approved is at hand. As a matter of fact, preliminary discussion and some sort of understanding among municipal representatives would be a tremendous advantage, as there could then be no suggestions that decisions to provide financial support were in any way influenced by questions of whether beds were recommended to be located in one municipality or another.

It is very likely that the Hospital Insurance Service will find it advisable to refer various questions to your committees for study in the hope that information useful to both your group and the Hospital Insurance Service could be obtained. However, you will understand that I could not make any specific commitment that all requests for information of a certain type would be channelled through the local committees.

There are, as you know, certain hospital construction and renovation projects underway in Greater Vancouver, including some still in the planning stage. It may be that decisions will have to be made in regard to final developments of some of those programs prior to the completion of the report and prior to completion of the final studies by the local committees. If such matters are decided, you will understand that the decisions will be made because the programs could not be held up. With the exception of any very extreme urgency that might develop, it is my earnest desire to have your committees' views along the lines outlined herein before any further approvals are given in regard to hospital construction programs in the area. In any event your committees will be immediately informed of the facts if any such supplementary approvals are given.

Yours very truly,

"signed"

Eric Martin,
MINISTER OF HEALTH SERVICES
AND HOSPITAL INSURANCE.

DMC:eb

G45/266

EXHIBIT C

MINISTER OF HEALTH SERVICES AND HOSPITAL INSURANCE

November 14, 1961

Mr. D. A. Thompson,
Chairman,
Metropolitan Hospital Planning Council,
301 Wesbrook Building,
The University of British Columbia,
Vancouver 8, B. C.

Dear Mr. Thompson:

I was pleased to learn that the surveys being conducted by the Metropolitan Hospital Planning Council are progressing satisfactorily and that the reports will be available in the not-too-distant future. It is my understanding that the emergency survey will likely be completed towards the end of this month, and I am sure that this document will be most helpful in developing this service in the Greater Vancouver area. While the paediatric and bed utilization surveys will not be ready until January or February of next year, they will also be of assistance in the planning of hospital facilities for the area. I can assure you that the work which the Council is doing in this regard is proving to be very worthwhile and is of great benefit to the B. C. Hospital Insurance Service and the Government in developing our hospital program in the Province.

As the bed utilization survey, which involved the White Rock and Surrey hospitals, was considered to be a pilot project, I am wondering if a project of this type, conducted over a larger area, might be considered by the Council next year. I believe it was intended that, if the present survey proved to be successful, the same pattern would be used to conduct a bed utilization survey of the metropolitan area of the Lower Mainland, which is served by the Council. If this could be done, it would very likely prove to be as beneficial as the present survey of the Surrey municipality, and would provide guidance in the development of hospital facilities for the Lower Mainland.

I should like to suggest that, if at all possible, this project be considered by your Council.

I have also been advised that a joint project is being considered between the Department of Preventive Medicine, University of British Columbia, and the Metropolitan Hospital Planning Council, which would review hospital utilization throughout the Province, It is my understanding that this project would review the demography of hospital utilization, which would correlate the 1961 hospital admission-discharge data to the 1961 census. Since accurate census figures are available only every five years, it would seem desirable that this type of study should be undertaken at this time, in order to provide indices concerning hospital utilization as related to population, physician, and hospital locations. The data that are developed from such a survey would not only provide trends and indices for use within British Columbia but would be of value in making comparisons with other Provinces, as well as in studies on an international level.

It would seem to me that both of these projects would be in line with those suggested in my letter to you under date of December 28, 1959, and would undoubtedly prove to be of value to the B. C. Hospital Insurance Service and the Government, as have been the studies which your Council has already undertaken in the past.

Yours very truly,

"E. MARTIN"
E. MARTIN
Minister of Health Services
and Hospital Insurance

G45/97

EXHIBIT C.

EXHIBIT D

COPY

Canadian Medical Association,
British Columbia Division,
1807 West 10th Ave.,
Vancouver 9, B. C.

30th March, 1961

Mr. D. A. Thompson,
Chairman, Sub-committee,
Metropolitan Hospital
Planning Council,
#201-1033 Davie St.,
VANCOUVER. 5. B.C.

Dear Mr. Thompson,

You will be interested to hear that the following resolution was made at a meeting of the Executive Committee of the C.M.A. - B.C. Division last Friday, and unanimously supported.

> "We recommend that a survey be carried out under the aegis of the C.M.A. - B.C. Division, the purpose of this survey being to determine factors affecting utilization of hospital beds. This survey should be done with the co-operation of the medical staffs of the hospitals surveyed. The Metropolitan Hospital Planning Council will be approached to obtain funds and to assist in this research."

We will be interested to hear through our representative of the progress of this project.

Yours very truly,

Edmond A.D. Boyd, M.B.
Executive Secretary.

EADE/ts.

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EXHIBIT D.

METROPOLITAN HOSPITAL

METROPOLITAN HOSPITAL PLANNING COUNCIL

Exhibit E.

| | |
|---|---|
| Total construction cost, 1954 | $ 450,000 |
| Paid by provincial government (approx.) | 225,000 |
| | 225,000 |
| Paid by federal government (approx.) | 88,000 |
| Raised by community | 137,000 |

Yearly return to community, 1960

| | |
|---|---|
| Payroll | 197,290 |
| Supplies, - drugs, surgical, dietary, fuel, etc. | 43,482 |
| Gross annual cash inflow | 240,772 |

METROPOLITAN HOSPITAL PLANNING COUNCIL

Exhibit F.

A tentative budget sent to the Honourable Eric Martin by the Chairman on September 11, showed the following estimates.

| | |
|---|---|
| Revenue from 14 municipalities @ 1¢ per head | $ 7,735. |
| " " 12 hospitals @ $2.00 per bed (upon approval by the Minister) | 7,658. |
| Total estimated revenue | 15,393. |

Expenditures

General Office

| | | | |
|---|---|---|---|
| A | Administration & Treasury | $ 1200 | |
| B | Supplies & Services | 600 | |
| C | Stenographer - 1/5 time | 600 | 2400 |

Special Study on Capital Costs

| | | | |
|---|---|---|---|
| D | Research Assistant | 6000 | |
| E | Stenographer -4/5 time | 2500 | |
| F | Rent, furnished office | 1200 | |
| G | Special forms, supplies, services | 1000 | |
| H | Travel | 2000 | 12700 |
| | Total Estimated Expenditure | | 15,100 |

# # # #

A 1961 meeting of the full Council also approved for study a proposal to raise sufficient revenues on a quite different basis, namely by application of a percentage charge on all Hospital construction costs as approved by the government. Details of the percentage required and the mechanics of collection have not been worked out but it appears worth noting that such an assessment would spread costs among the three sources involved in approximately the following percentages:

| | |
|---|---|
| Federal government | -25% |
| Provincil government | 50% |
| Communities | 25% |

METROPOLITAN HOSPITAL PLANNING COUNCIL

Exhibit J.

1. Sections 91 and 92 of the "British North America Act" set forth the areas of responsibility of the Federal and Provincial Governments in Canada. In the interpretation of these sections, the field of health has been designated as a provincial responsibility. The Federal Government has also provided professional and financial support in the construction of hospitals and the operation of hospital programs, but its role has been one of assistance and counsel, not of direction and control. This division of authority and responsibility between the two levels of government is basic in the operation of the Federal-Provincial Hospital Insurance Plan. It was the topic of a discussion by the Minister of National Health and Welfare in the Federal House last year, when commenting on the report of the Standing Committee on Estimates on the subject. The Committee had suggested an immediate review, on a nation-wide basis, of the availability of beds for the people, under Dominion auspices. The Minister of National Health and Welfare observed, however, that since the Provinces were now administering their own hospital insurance plans, which were dependent, both now and in the future, on adequate hospital accommodation, they should determine where there were shortages of hospital beds and initiate studies to review their own provincial situation.

2. At the same session, the field of hospital administration was discussed, with special reference to the question of open and closed hospitals. On referring to certain hospitals in particular, the Committee reported that since "these hospitals are recipients of financial aid from the Government of Canada" they might properly be subject to some type of Federal supervision. The Minister of National Health and Welfare commented on this statement in the following manner:

> "As I interpret this statement the fact that the dominion government provides hospital grants to provincial governments should imply the right to say how individual hospitals should deal with matters of this kind.
>
> "This I believe is a dangerous principle to put forward. Having in mind the constitutional and traditional development of responsibilities in the health field in Canada, the tying of this kind of federal control to financial aid would jeopardize the whole system of co-operation built up over the years between federal and provincial health authorities .."

Exhibit J - continued

3. With these statements, the Minister of National Health and Welfare has made it quite clear that, in his opinion, the role of the Federal Government should be to assist Provincial Governments through the contribution of financial, as well as technical aid, rather than to assume direct responsibility for these fields, simply because the Federal Government was providing assistance.

4. Within the Provinces themselves, the relationship between each provincial government and the local community is similar, in many respects, to that which exists between the Federal and Provincial Governments. Provincial Ministers of Health in many Provinces have adopted the philosophy that communities should retain the primary responsibility for the provision of hospital facilities in their areas and further that their governments support the concept of the community hospital with its self-governing independent autonomous Board of Trustees. These Provincial Governments may share in the construction cost of the hospital unit and will undoubtedly exercise some degree of supervision in its placement, size, etc.; nevertheless, the basic policy adhered to by them is the continuation of the autonomous community hospital at the local level. This concept was very concisely summarized by one of the Provincial Ministers of Health when dealing with this matter in a speech to the Legislature:

> "The provision of hospital facilities has always been a community responsibility. It is up to each local area to decide what its requirements are, or in other words to assess its needs, and to take appropriate action to ensure that this is translated into action. The speed with which a hospital project is developed is strictly up to the local community ..."

5. This policy of retaining the autonomous community hospital and having it function in an environment where the main payment authority is the provincial hospital plan raises the question as to how far the Provincial Government hospital plans can go in delegating to the local community authority and responsibility for hospital construction and operation. In the final analysis, the Provincial Governments must meet not only a varying cost of the construction of these hospitals, according to the different provincial formulae, but to an even greater degree their operational cost. Therefore, the central prepayment plan must exercise some degree of control over these factors, which will likely be in direct proportion to the ratio of provincial funds involved. If this is not done, it is tantamount to handing a blank cheque to the local hospitals with no responsibility for the raising of the funds. While this concept is applicable, to some degree, to the Federal Government in its relationship with the

Exhibit J - cortinued

Provinces, there are some circumstances which result in a very significant difference, and, as a result, there appears to be less likelihood of excessive construction and operating costs being incurred. In the matter of capital construction costs, since the Federal Government's share is often much smaller than that of the provincial authority, this ratio will likely protect the Federal interests. On the operational side, since approximately half of the costs of the various plans are met by the Provincial Governments themselves, this acts as a sort of built-in control, and should curtail excessive expenditures for costs of operation.

6. The majority of provinces state they support the concept of the local autonomous hospital, but even in those Provinces where this policy is being followed, there are usually provisions in their provincial hospital legislation which require that any additions, alterations, or improvements, etc. that may be contemplated by a hospital must receive the approval of some specified provincial authority before they may be carried out. The existence of these requirements would suggest that there is some question as to the degree of responsibility and authority that is truly delegated to the local areas insofar as their hospital construction programs are concerned.

7. While the provincial authority may accept the responsibility for developing a co-ordinated hospital system throughout the Province and must exercise control to achieve this, the fact that the local community must first take the initiative to have a hospital built suggests that a compromise situation exists rather than a completely one-sided one. Rather than an atmosphere of direction and control being followed on the part of the provincial authority, it is more one of review and supervision, to make certain that the most efficient hospital plan possible will emerge from the collective efforts of the local communities. There are very few, if any, instances where the provincial authority has actually taken the initiative to construct a needed hospital where the community has proven reluctant to do so.

# HOSPITAL FACILITIES AND COMMUNITY NEEDS

L. F. Detwiller, M.A., M.H.A., M.R.S.H.

"THE CHANGING ROLE OF THE HOSPITAL IN A CHANGING WORLD" was the theme of the 12th Congress of the International Hospital Federation, held in Venice last year. It was the subject of the keynote address by Dr. A. Querido. He pointed out that the world has always been changing and probably always will and, while there may be a tendency to think that any specific period in history is unique in this respect, one has but to compare it to another period to appreciate that perhaps change itself is one of the few constant factors in the process of life.

HOWEVER, IT IS A FACT that, in comparatively recent times, the rapidity of change in certain fields, especially those associated with the sciences, seems to have accelerated at an enormous rate. For example, a graphic presentation of the speed of man's travel remains comparatively constant up to the beginning of the nineteenth century, when it begins to increase rapidly until to-day, with the advent of orbital flight, the parabolic rise gets steeper and steeper, with the chart line coming closer to paralleling the ordinate.

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Presented at the Canadian Hospital Convention (Western Canada Institute and Canadian Hospital Association Assembly Meeting), Edmonton, Alberta, June 7, 1962.

DR. QUERIDO views the development of the hospital in the light of these rapidly changing events and feels that the major changes in the hospital field, when plotted against the time scale, follow a pattern that may also be expressed by a parabola, which, at present, is entering the steeper part of the curve. He pointed out that ... "The steeper the rise, the faster the rate of change, the greater the difference between two time intervals. But also, the faster the rate, the smaller the time intervals between considerable changes. In other words, taking the present as the beginning of a time interval, future changes will occur faster and will be increasingly important."

HILLEBOE * summed up the situation well in his recent editorial "New Directions in Medical Care", when he stated:

> "It is exciting to be part of a vast evolutionary process; it is tragic not to recognize it."

MEMBERS OF THE HEALTH TEAM are all part of the social evolution that is taking place in the field of health care and, while most groups recognize and are reacting to this phenomenon, there are unfortunately some members of the team who have failed to recognize this evolutionary process. It is to be hoped that they also will perceive this change and adjust themselves to the

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* Hilleboe, H. E., Editorial, New Directions in Medical Care, Public Health Reports, 77, # 2, 1962.

new time intervals and developments that are taking place in all phases of society.

HOW CAN OUR CONCEPTION OF THE ROLE OF THE HOSPITAL in the health field be tailored to-day, so that it will meet the requirements of to-morrow or, at least, be adaptable to them? What are the needs of the community, both present and future, which are constantly being converted into very real demands for additional and new services as a result of new methods of diagnosis and treatment that are being discovered constantly?

TO DETERMINE THE COMMUNITY NEEDS FOR HOSPITAL FACILITIES in the light of this rapidly changing environment, both within and without the health field, is no mean task. At best, it is an estimate to be modified by new procedures and events as planning proceeds. On the one hand, we may overestimate the importance and impact of a new discovery or trend that has recently appeared, or underestimate the long-term effect of well established procedures or developments of the past. An open and enquiring mind are needed so as to achieve a balance between what is old and what is new, and draft a course for future development.

BEFORE PROCEEDING TO EXAMINE CERTAIN AREAS IN DETAIL, there are developments which appear to be emerging as significant

trends in determining the hospital needs of the community.

THERE APPEARS TO BE A SHIFT in emphasis away from the hospital bed as the central element in the hospital. The oft used and abused ratio of beds per thousand population has remained fairly constant over the past few years and, in some areas such as England, is declining in importance in calculating health needs, with the estimated number of acute beds required to service the population decreasing. This is coming about as the result of a change in the total approach to health care, which is placing greater emphasis on preventive measures, rehabilitation, and home care programs, to say nothing of other supporting community health services. The increase in the use of laboratory, X-ray, out-patient, and other treatment facilities, and their subsequent application outside of the patient's bedroom, suggests that perhaps we should begin to try and estimate the medical and hospital needs of a community, not only in the number of beds but also in terms of the amount of laboratory, X-ray, operating-room, and other services that are required per thousand inhabitants. The fact that these services are probably best brought together in a hospital would seem to substantiate even further its development as a logical health or medical centre, co-ordinating the activities of the various members of the health team.

TO DATE, the hospital has been viewed mainly as a repair shop, with the hospital bed as its central and very important element. Admission to the bed has been the basis of eligibility for the majority of prepayment hospital schemes. However, perhaps the time has arrived to re-examine this concept, to see if the hospital's relationship to community needs is not changing as a result of new concepts in medical care.

FURTHER, are we using the hospital and the specific type of hospital bed for the purposes for which they were originally designed, or are we changing their function by treating types of patients that do not require the extensive facilities of these expensive units? If we are to answer this latter question, this will, no doubt, involve a professional evaluation of the cases in question by the appropriate medical authority, and suggests some sort of qualitative review, as well as the usual quantitative ones conducted at the present time.

WHEN ONE CONSIDERS the difference in the incidence and length of stay of patients in acute care hospitals in the United States and Canada, and the fact that the hospital programs are similar in many respects from a treatment point of view, the question naturally arises as to why this difference exists. No doubt, the method of financing care has a considerable influence on this matter, but there are probably other factors as well which would be worthwhile examining.

IN DETERMINING THE HOSPITAL NEEDS OF A COMMUNITY, perhaps the most difficult task is to arrive at basic policies and definitions which are essential in solving the problem.

GENERALLY SPEAKING, it is not too difficult to define a community. In the case of an individual hospital, the term community usually refers to the geographical location of the majority of patients served by the hospital, but, even in making this statement, a decision has been made to the effect that the community under discussion refers to a geographical entity and not a cultural group, the latter likely extending over a much larger geographical area than is usually the case for hospital service areas. On the other hand, the community under study may well be one which embraces several hospitals and the respective communities or hospital service areas, in which case there is a need to define the boundaries of each group so as to eliminate as much duplication and overlapping as possible.

HAVING DEFINED THE BOUNDARIES OF THE COMMUNITY UNDER STUDY, the next task is to determine the characteristics of the population, the salient features of its economy, and so on, by

carrying out surveys relating to

- history of background and development
- the age, and sex distribution
- population movement
- other medical care facilities in the area
- past and present hospital and medical experience, patterns of treatment, proposals for the future, and
- the economy of the area.

BEFORE EVALUATING THESE DATA, certain basic policies must be determined. Are we concerned with the total medical care field, including medical services, nursing, dentistry, etc., or are we confined to one phase, say, hospitalization? If the latter should be the case, it would be wise to first clarify where the division comes between hospital and custodial (or nursing home) care, and perhaps even boarding homes. Concurrent with the study of this problem should be a recognition of the existence of home care programs, visiting nurse programs, public health nurses, housekeeping services, and so on, so that they are not overlooked as alternatives or supports of the hospitalization problem under study.

THERE APPEARS TO BE GENERAL AGREEMENT as to what is involved at the acute care level of treatment, but, beyond this, agreement on other levels of care is difficult to achieve.

NEWLY DEVELOPED REHABILITATION CONCEPTS in the treatment, not only of long term but of acute cases, are having a tremendous impact on medical and hospital patterns. Generally speaking, the rehabilitative case is one which will benefit from activation or rehabilitative services to the extent that the patient may be returned to his home or to work. It is also stated that, even if no return is possible, if the patient benefits to the extent that the deterioration of his condition is even slowed down, though not necessarily arrested, this type of patient is also a rehabilitative case.

HOWEVER, BEYOND THIS STAGE, where the patient does not respond to further medical treatment or restorative measures, and simply requires nursing care, it is generally agreed that this is the custodial case, and may be adequately cared for in a nursing home or receive nursing services in his own home. If the case does not require nursing care but more housekeeping services only, then, in this instance, the boarding home would suffice.

THE TERM HOSPITAL is generally applied to those institutions which provide the acute and rehabilitative services. When the term goes beyond that and is applied to those institutions providing nursing and/or boarding home services, this is usually more of a carry-over of terminology from earlier days, rather than an up-to-date

classification of the level of care provided in the institution. This is more a question of sematics than level of treatment.

THE SCOPE OF CASES TREATED IN ACUTE BEDS has been broadened considerably in recent years. Not long ago, T.B. and mental cases would likely have been excluded from a community needs survey, since most of the care of this type was provided in hospitals that were operated by provincial authorities. Not so to-day. Both of these specialties are being taken over more and more by private medicine, since much can be done for these patients at the community hospital level as a result of recent medical discoveries. Thus, instead of being considered more or less outside the field of private medicine, they are now included in it. It logically follows then that facilities for the treatment of these types of patients will be included in community surveys, as are other patients, and their treatment facilities will be provided as wards or wings, located adjacent to or becoming part of the acute general hospitals of the community. This, then, represents a fairly new need for a type of hospital facility at the community hospital level that previously was referred to as a special institution, oftentimes located outside of the area under review.

KEEPING IN MIND THE EXPANDING SCOPE of the types of cases to be referred to the community hospital, and assuming agreement

that the area of need to be determined includes acute and rehabilitative cases only, perhaps it would be well to consider the basic purpose of the acute hospital bed before commencing an analysis of the survey data.

IT MUST BE DETERMINED AS TO WHETHER OR NOT the acute general hospital is going to be used solely for the treatment of the acute stage of diseases, which would mean that no other factors, such as home conditions, availability of supporting services, etc. would affect admissions or discharges, or are these factors to be taken into account in the handling of patients? If the latter hypothesis were adopted, this would, of course, affect any calculation relating to the "NEED" of the community for acute care facilities. This basic policy must be clarified if hospitals and hospital insurance plans are to answer the allegations by many that hospital facilities (mainly acute) and coverage programs have been "OVERUSED" and "ABUSED" by the public, with a resulting increase in the volume and cost of care in recent years.

THE EXTENT to which hospitals may be "OVERUSED" or benefits "ABUSED" depends on the definition of the role and function of the hospital. If, at the one extreme, the hospital is regarded as a life saving institution, to be employed only when all other alternatives have failed, then we are likely to find that, in areas

using this definition, there is a considerable amount of "OVERUSE". On the other hand, if the hospital is to be regarded as a facility to be utilized whenever its services can help to provide better care than can be obtained outside (and this is meant to be interpreted in the broadest sense of the word, including non-medical factors), then the amount of "OVERUSE" that is likely to occur under these criteria will be comparatively small. In actual practice, it is usually neither one extreme nor the other, but somewhere between the two.

IN APPLYING THIS CONCEPT to the Federal-Provincial hospital plans, it is found that most provinces have adopted the principle that the acute general hospital should be used for acute cases only. Treatment of chronic and custodial cases is encouraged in separate institutions, wings or wards, which sometimes necessitates the moving of the nursing home or custodial case away from his immediate environment, as this type of facility may not be available. On the other hand, there appear to be instances where the provincial policies allow the nursing home case to be cared for in the acute hospital bed, especially in small hospitals that are located in sparsely populated areas. While this may not be in the best of medical and hospital tradition, it acknowledges the problems of moving patients away from their home environment, and the difficulty of maintaining all types of care facilities in all areas.

ABOVE ALL, it is perhaps a recognition of what is actually happening in the general hospitals under acute prepayment programs, but is not recognized or at least acknowledged in other areas that adhere to the more rigid acute care policies. In this regard, experience has shown that where a prepayment program - and especially a government sponsored one - is restricted to any single level of care, pressures develop which attempt to have other types of cases included under the scope of the coverage program for obvious financial reasons. Consequently, where coverage is restricted to the acute phase of treatment, when this stage is passed and the next stage is entered, pressures will develop to continue to identify the case as acute so as to continue financial coverage.

IN ADDITION, representations will be made to have a case which may not be in the acute stage, considered as such so that it may be included in the financial coverage of the program. If these facts are accepted, it is not difficult to understand why pressures continue to build up for more and more acute care beds under broad prepayment programs, even although the ratio of this type of bed to the population may already be high in relation to other areas.

THERE ARE MANY OTHER REASONS (referral patterns, population, etc.) for high bed population ratios, aside from the one stated

above, but perhaps the most common one is the retention in the acute bed of cases which could be adequately cared for in other facilities but are not discharged because of the cessation of financial coverage. These cases give rise to the problem of the proper use of acute hospital beds.

THE FINANCIAL ASPECTS OF COVERAGE might be met in part by extending the coverage program to include rehabilitation cases and other levels of care. This has been done in most provinces, where rehabilitation programs have been adopted, and their effect has been significant. Patients are moved more quickly through the acute care beds as a result of rehabilitative measures, and are returned to their homes, places of work, or other facilities, in shorter periods than previously. However, a rather interesting problem has developed in some hospitals, for while the rehabilitative and other types of cases are being moved more rapidly through the acute care facilities, it is found, in some instances, that custodial cases may still tend to stay in the acute bed longer than they should, simply because there are not the proper facilities in the community to which to discharge them, and they would lose their eligibility for continued financial coverage under the program.

THIS SITUATION MAY BE DETECTED FAIRLY SIMPLY by comparing the incidence of cases and days per thousand of the population of

the area under review to other comparable areas or the whole province. These comparisons may be made for the total population or in more detail by specified age groups, etc. If such a quantitative study does suggest that an area has an abnormally high rate of hospitalization, then it seems reasonable to assume that the experience should be analyzed further, especially from a qualitative point of view as well as that of patterns of care, referrals, etc. This approach will involve professional evaluation of the type of case being treated in the acute hospital bed and should only be done by properly qualified medical personnel. It should be made clear that the purpose of such a study is not to attempt an evaluation of the actual handling of the case, since this is a field properly dealt with through a medical audit or professional review, but rather whether or not the case required the facilities of the acute general hospital and might not have been adequately treated in some other type of facility. If the qualitative professional survey shows that this latter situation actually exists, and there is a backing up of custodial cases in acute hospital beds, it would be incorrect to build more acute beds in the area. Unfortunately, this has often been the case under acute care prepayment programs, both voluntary and governmental, since the community need was not for acute care accommodation but rather for custodial or nursing home beds plus, perhaps, home care and home service programs.

WHILE MOST PLANS IN CANADA now provide coverage for the acute and rehabilitative levels of hospital care and, with bed ratios that run anywhere from 4 to possibly 8 beds per thousand population, in some instances the plans are still experiencing pressures for more acute beds from communities. To illustrate the problem, let us look at a situation comparable to that outlined above.

A COMMUNITY with a medium sized hospital requests additional acute beds from the central provincial prepayment authority. One of the reasons included in the brief is that the area has a high percentage of older people and, as a result, might be expected to have a higher incidence rate of hospitalization than the province as a whole. The existence of a large number of retired people is not questioned, and a tabulation of cases and days per thousand population of the 50 year and over group, as well as the 70 year and over group, reveals abnormally high incidence rates for both cases and days for both groups, in comparison to experience elsewhere. A comparison is made of this experience to that of comparable groups of the provincial population as a whole. Comparisons are also made of the length of stay with comparable hospitals, as well as the proportion of the population in these age groups for the area

under study and the province as a whole. The following is a summary of the tabulation, which is most interesting.

WITH REFERENCE TO THE QUESTION OF POPULATION DISTRIBUTION, the two groups (50 years of age and over and 70 years of age and over) are compared to the distribution of the provincial population in the same age groupings. (See Table I).

TABLE I

| | Per 1,000 Population | |
|---|---|---|
| | 50 Years and Over | 70 Years and Over |
| Hospital District | 27.8% of pop. | 8.2% of pop. |
| Province | 22.6% of pop. | 6.8% of pop. |
| | 5.2% difference | 1.4% difference |

IT WAS FOUND THAT, while there is a slightly higher proportion of older people in these two age groups for the area under study, the difference is certainly not too great, especially in the case of the 70 year and over group, where the difference is only 1.4%. However, this is very significant when examining the amount of hospital care provided this latter group in the survey area, as compared to the same age group for the province as a whole. (See Table II).

TABLE II

| | Per 1,000 Population | | | |
|---|---|---|---|---|
| | 50 Years and Over | | 70 Years and Over | |
| | Cases | Days | Cases | Days |
| Hospital District | 247 | 3,919 | 362 | 7,084 |
| Province | 190 | 3,008 | 262 | 4,872 |

BY COMPARING THE INCIDENCE DATA TO THE POPULATION DATA, it is evident that in the 70 year and over group, while there is only a 1.4% difference in the population distribution between the survey area and the province as a whole, there is a tremendous difference in the incidence rate for both cases and days per thousand population.

THE CASE RATE PER THOUSAND POPULATION for the hospital area under study is 362, as compared to 262 cases per thousand population for the province as a whole. This is a case rate of 100 cases more per thousand population, which is almost 40% higher than the rate experienced by the same age group for all of the province.

A SIMILAR TREND is apparent for the number of days of care per thousand population, being 7,084 for the hospital survey area, as compared to 4,872 for this same age group for the province.

INSOFAR AS THE LENGTH OF STAY IS CONCERNED, it is found to be higher for the hospital under survey than hospitals of comparable size, etc., and for the province as a whole. The hospital also has a very much higher percentage of its patients 50 years and over, in comparison to its total patient load.

WHAT IS THE EXPLANATION OF THE HIGHER HOSPITALIZATION experience of this group, as compared to that of the province? The quantitative statistical analysis of the data that is so generally used in surveys of this type does not appear to provide the answers. These will likely involve a qualitative evaluation of the case load by qualified professional personnel.

IS THIS ABNORMALLY HIGH INCIDENCE OF CASES AND DAYS being experienced by the older section of the population under study actually the result of more illness being experienced in this area, in comparison to the rest of the province, or is it because these cases are staying in longer than they should, and could have been discharged earlier if they could adequately be cared for in other types of accommodation? The fact that there are not supportive facilities, such as nursing homes or home care programs, available within the hospital service area could well be having an appreciable effect on the handling of this older age group. The absence of an active rehabilitation program could also add to their problem.

ONCE THIS SITUATION IS POINTED OUT TO THE HOSPITAL, it should then take steps to implement a professional qualitative survey of its patient load.

IF THE SURVEY RESULTS SHOW that the hypothesis developed on the basis of the quantitative survey is correct, and it is nursing home beds rather than acute beds that are required, the community and the province will have been spared the expense of constructing and operating the most expensive bed in the hospital field. On the other hand, if the study shows that there is a need for this volume of care for this group in the area, then it is acute care beds that are required. However, if the latter does prove to be the case, then it suggests further studies to determine why there is this very significant difference in the care requirements of comparable age groups in the area population, as compared to that segment of the population of the province as a whole.

IT WOULD APPEAR that, as research and bed survey studies are refined, the need for professional evaluation of the patient load and patterns of care become more apparent. To date, hospital programs have done well in the developing of regional and master hospital plans. For the most part, these surveys have tended to deal mainly with the acute and rehabilitative or chronic care

program, which is understandable, as this has been the extent of coverage of most of the prepayment programs. However, one cannot help but wonder if we have not reached the stage where we may be in danger of over-building acute beds, at the expense of other types; namely, rehabilitative, chronic, and nursing home, simply because of the financial structure of our hospital plans. Further, it seems that no matter how many beds are constructed, they will be used. This has been amply demonstrated in one province, where a diminishing population in some areas has resulted in bed ratios per thousand that go as high as 14 or 16, and the beds were still filled with patients, although these are unusual circumstances. This is a sort of adaptation of Say's Law. "Within limits, supply creates its own demand." When hospital beds are in short supply, the length of stay usually drops and more patients are treated in the same number of beds. When beds are plentiful, the reverse takes place and fewer patients are treated, with the length of stay likely going up.

LET MEDICAL PROGRESS find a cure for a disease that decreases the length of stay, and the demand for beds should drop. Conversely, if a cure is discovered for a disease which requires, say, two months' continuous hospitalization, this could create an unprecedented demand for hospital beds overnight.

THEORETICALLY, it should be possible to determine the hospital bed requirement at a specific time. However, medicine is not static, and what appears to be the last word in treatment of a disease to-day, could well be obsolete to-morrow. This is fortunate from the point of view of the people but makes it difficult to determine the needs of the community.

PERHAPS WE HAVE TENDED TO BE TOO OBJECTIVE in the planning of hospital facilities for the community, and have not paid sufficient attention to the organization of medical care as a whole but to just that part that is covered in hospitals. This is not to suggest that we should let up in our efforts to obtain accurate quantitative studies involving the demand for hospital facilities in each area, but rather, having determined this demand, to go further and attempt to integrate the hospital pattern of care and facility development more closely with the medical patterns of practice that are evolved by the profession.

FURTHER, it would seem, in some provinces at least, that the time has arrived to place greater emphasis on facilities for other levels of care, such as rehabilitative facilities, home care programs, etc., which will include not only nursing services but homemaker services as well, so that the physician will not always have to use the hospital for the treatment of his patient because he sees no effective alternative at his disposal.

LET US LOOK BEYOND THE ACUTE HOSPITAL BED in our planning, for it may well be that in these other levels of care also lie important needs of the community. The hospitals can give leadership in exploring these areas, and provide invaluable advice and counsel to those who are drafting the hospital programs of the future.

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# AREA PLANNING OF HOSPITAL FACILITIES

Sections 91 and 92 of the "British North America Act" set forth the areas of responsibility of the Federal and Provincial Governments in Canada. In the interpretation of these sections, the field of health has been designated as a provincial responsibility. While the Federal Government has also provided professional and financial support in the construction of hospitals and the operation of hospital programs, it is important to note that its role has been one of assistance and counsel and not of direction and control. This division of authority and responsibility between the two levels of government is basic in the operation of the Federal-Provincial Hospital Insurance Plan. It was the topic of a discussion by the Minister of National Health and Welfare in the Federal House last year, when commenting on the report of the Standing Committee on Estimates on the subject. The Committee had suggested an immediate review, on a nation-wide basis, of the availability of beds for the people, such survey to be under Dominion auspices. The Minister of National Health and Welfare observed, however, that, since the Provinces were now administering their own hospital insurance plans, which were dependent, both now and in the future, on adequate hospital accommodation, they should determine where there were shortages of hospital beds and initiate studies to review their own provincial situation.

At the same session, the field of hospital administration

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was discussed, with special reference to the question of open and closed hospitals. On referring to certain hospitals in particular, the Committee reported that since "these hospitals are recipients of financial aid from the Government of Canada" they might properly be subject to some type of Federal supervision. The Minister of National Health and Welfare commented on this statement in the following manner:

> "As I interpret this statement the fact that the dominion government provides hospital grants to provincial governments should imply the right to say how individual hospitals should deal with matters of this kind.
>
> "This I believe is a dangerous principle to put forward. Having in mind the constitutional and traditional development of responsibilities in the health field in Canada, the tying of this kind of federal control to financial aid would jeopardize the whole system of co-operation built up over the years between federal and provincial health authorities.."

With these statements, the Minister of National Health and Welfare has made it quite clear that, in his opinion, the role of the Federal Government should be to assist Provincial Governments

through the contribution of financial, as well as technical aid, rather than to assure direct responsibility for these fields, simply because the Federal Government was providing assistance.

Within the Provinces themselves, the relationship between each provincial government and the local community is similar, in many respects, to that which exists between the Federal and Provincial Governments. Provincial Ministers of Health in many Provinces have adopted the philosophy that communities should retain the primary responsibility for the provision of hospital facilities in their areas and further that their governments support the concept of the community hospital with its self-governing independent autonomous Board of Trustees. While these Provincial Governments may share in the construction cost of the hospital unit and will undoubtedly exercise some degree of supervision in its placement, size, etc., nevertheless, the basic policy adhered to by them is the continuation of the autonomous community hospital at the local level. This concept was very concisely summarized by one of the Provincial Ministers of Health when dealing with this matter in a speech to the Legislature:

> "The provision of hospital facilities has always been a community responsibility. It is up to each local area to decide what its requirements are, or in other words to assess its needs, and to take

appropriate action to ensure that this is translated into action. The speed with which a hospital project is developed is strictly up to the local community.."

This policy of retaining the autonomous community hospital and having it function in an environment where the main payment authority is the provincial hospital plan raises the question as to how far the Provincial Government hospital plans can go in delegating to the local community authority and responsibility for hospital construction and operation. In the final analysis, the Provincial Governments must meet not only a varying cost of the construction of these hospitals, according to the different provincial formulae, but to an even greater degree their operational cost. Therefore, the central prepayment plan must exercise some degree of control over these factors, which will likely be in direct proportion to the ratio of provincial funds involved. If this is not done, it is tantamount to handing a blank cheque to the local hospitals with no responsibility for the raising of the funds. While this concept is applicable, to some degree, to the Federal Government in its relationship with the Provinces, there are some circumstances which result in a very significant difference and, as a result, there appears to be less likelihood of

excessive construction and operating costs being incurred. In the matter of capital construction costs, since the Federal Government's share is often much smaller than that of the provincial authority, this ratio will likely protect the Federal interests. On the operational side, since approximately half of the costs of the various plans are met by the Provincial Governments themselves, this acts as a sort of built-in control, and should curtail excessive expenditures for costs of operation.

In this matter of local autonomy, it is interesting to note that, while the majority of Provinces state they support the concept of the local autonomous hospital, even in those Provinces where this policy is being followed, there are usually provisions in their provincial hospital legislation which require that any additions, alterations, or improvements, etc. that may be contemplated by a hospital must receive the approval of some specified provincial authority before they may be carried out. The existence of these requirements would suggest that there is some question as to the degree of responsibility and authority that is truly delegated to the local areas insofar as their hospital construction programs are concerned.

Granted, it appears that there is conflict in these points of view; namely, local autonomy and central control.

Perhaps this is not as serious a situation as it appears at first glance. While the provincial authority may accept the responsibility for developing a co-ordinated hospital system throughout the Province and must exercise control to achieve this, the fact that the local community must first take the initiative to have a hospital built suggests that a compromise situation exists rather than a completely one-sided one. Rather than an atmosphere of direction and control being followed on the part of the provincial authority, it is more one of review and supervision, to make certain that the most efficient hospital plan possible will emerge from the collective efforts of the local communities. In instances where the central authority may suggest that a new hospital is required in a particular area or an addition is desirable to an existing one, there are very few, if any, instances where the provincial authority has actually taken the initiative to construct the hospital, contrary to local desires, where there are adequate community resources to meet the situation at the local level.

It may be of interest to note that this same problem is being experienced in the United States under their construction programs and, while there is a similarity between the situation in the United States and Canada, there is one area of significant difference.

In the United States, where there are many prepayment programs in operation and no single one is providing coverage for the total population of an area, there is a financial incentive for hospitals to solve these problems themselves. If they do not, the individual hospital boards are faced with fiscal problems of deficits resulting from a lowered occupancy and higher operating rates because of the over-building that has taken place. On the other hand, under our Provincial Government plans in Canada, these problems of higher per diem costs are passed on to the central provincial prepayment authority, since the majority of the income of the hospitals comes from the government sponsored programs. Thus, instead of having several hospitals with deficits, the provincial plan is faced with the prospect of accepting the deficits of the hospitals under its jurisdiction. The stand might even be taken that the over-building was the direct responsibility of the provincial plan if it had approved the projects which brought about the situation.

Further, with the introduction of government, new problems arise in attempting to deal with all the hospitals through one agency. What may be a logical hospital development for one area may not be suitable for another; yet the latter may feel discriminated against if it does not receive the same treatment as its counterpart.

This often leads to charges of discrimination, and presents difficult problems for those administering provincial programs.

As each hospital board and medical staff has certain standards and goals which it would like to achieve, and since these programs will have a direct bearing on the overall cost of the provincial scheme, the central authority must, in some way, co-ordinate and integrate these aims and objectives with its financial resources. By doing so, it should ultimately be able to develop a plan by which as many as possible of the aims and objectives of the individual hospital boards and medical staffs can be achieved, and yet keep the cost within the financial resources of the people.

In Canada, prior to the introduction of the provincial plans, hospitals were in a position to act independently and introduce new programs and services in their hospitals as they saw fit, subject to their ability to support them. Either the patients who received these additional services paid directly through increasing hospital levies, or the community in which the hospital was located subsidized the operation by meeting the deficits.

However, with the introduction of provincial hospital plans, each Province is now charged with developing a hospital plan and has a responsibility to make certain that the plan is efficient

and properly operated. The types and volumes of hospital care required should be decided upon, and this will involve surveys. If, as a result of a particular survey, it is determined that there are sufficient facilities to provide a specific service, this could result in a hospital requesting that it be permitted to add to this particular service, not receiving provincial support for the expansion program, because there were ample facilities already. To add more would mean less efficient operation of those existing. It is at this point that problems begin to develop between the central authority, the hospital, and the professions involved.

While the refusal to support an extension of service may be the logical approach for the central authority, such a decision is likely to be a great disappointment to the hospital and medical staff of the hospital concerned. The question then arises as to whether the patients and medical staff and others connected with the hospital planning the development of the new service should be denied this service in their own hospital and be required to go to another institution in another area. It could well be that the hospital which has just applied for the development of the specialty, and has been refused, is, in reality, better qualified physically and professionally to provide this service than the one where it is already located.

If both hospitals were operated in a purely local environment and were not receiving funds from a central authority which embraced these communities, it might well be that the hospital desiring to establish the new service would proceed with its plans and possibly bring about an over-development of this specialty in the particular area. How far this over-development would go would depend upon the Boards of Trustees and medical staffs of the hospitals concerned. It could reach - and in a good many communities on this Continent has reached - serious proportions before the forces of competition and public opinion began to make themselves felt, ultimately bringing about a reduction and co-ordination of facilities providing this service. However, in this process it could well be that, in the final analysis, the hospital which first introduced the service might not be the one to retain it. This would depend on the medical staff, the ultimate aims and objectives of the hospital, its clientele, community support, etc. Experience, here and elsewhere, has shown how difficult it is to integrate and co-ordinate the basic concepts and principles of some of the groups involved in the medical and hospital care fields. In many instances, these differences have defeated some of the proposed overall hospital programs because of the interests of individual hospital boards and medical staffs.

Theoretically, it should be possible to determine the health needs of an area at a specific time. However, medicine is not static, and what appears to be the last word in treatment of a disease to-day could well be obsolete because of a new discovery to-morrow. Usually, it is neither practicable nor economical to support all specialized services in all hospitals, although a very high standard can be achieved by the process of referral of work and patients. Surveys conducted in rural areas, while attempting to determine the same needs for these people as those in metropolitan areas, must take into account the ability of the area to support the services, and usually recommend some sort of compromise. A higher degree of integration is possible in metropolitan areas, where there are several hospitals within a short distance, as compared to the rural area where there are long distances between each institution.

The foregoing was the environment which existed prior to the commencement of a survey of the metropolitan area of the Lower Mainland of British Columbia in early 1959. At that time requests had been received by the B. C. Hospital Insurance Service from various hospital groups in the area for expansion of beds and hospital services.

An examination of these requests revealed that hospitals

were acting independently and, in some instances, appeared to be duplicating facilities requested by other individual hospitals. It was discovered that there was no co-ordination in the planning of facilities in the area, and that present plans would result in the duplication of expensive facilities. It was, therefore, decided to undertake a survey of the hospital needs in the Lower Mainland area as rapidly as possible.

Preliminary work served to confirm that the planning of hospital facilities for the metropolitan area of the Lower Mainland was proceeding on an individual hospital basis and would result in services being constructed which duplicated each other. It was obvious that, unless steps were taken to develop some sort of integrated plan, an expensive and not necessarily efficient hospital program could result in the Lower Mainland area.

It was also apparent that, in some Vancouver hospitals, there was a marked pressure for hospital beds, whereas in others there was not the same pressure for beds, although at times there was a shortage. It was, therefore, decided that detailed statistics should be prepared which could analyze patient loads of the hospitals in the area. These detailed statistical runs were subsequently developed by the Research Division of the B. C. Hospital Insurance Service.

When the first statistical tabulations were completed, the picture presented clearly indicated the criss-crossing of patient load within the metropolitan area itself. Residents of one municipality were being referred into other municipalities and, in addition, patients were being sent into the area from all over the Province. It also appeared that doctors with staff privileges in several hospitals were referring their patients back and forth between hospitals.

Because of this situation, it was decided to try and bring together the groups in the Lower Mainland that were interested in the hospital field. A meeting was sponsored by the B. C. Hospitals' Association during their convention, held in Vancouver in October, 1959. The Metropolitan Hospital Committee (now known as the Metropolitan Hospital Planning Council) was established as a result of this initial meeting. In response to a request to the Minister of Health Services and Hospital Insurance for terms of reference, the Minister suggested that advice on the following areas of study would be of assistance to the B. C. Hospital Insurance Service and the Government:

(1) The type of beds to be built and the diagnostic and treatment services to be provided in the area;

(2) The location at which beds should be built; and

(3) The method of financing the community's share of hospital construction.

The Metropolitan Hospital Committee (The Council) established a professional sub-committee composed of representatives from the B. C. Division of the Canadian Medical Association, the Faculty of Medicine of the University of British Columbia, the Vancouver Medical Association, the Metropolitan Health Committee, the B. C. Hospitals' Association, one of the metropolitan hospitals, the Health Branch, and the B. C. Hospital Insurance Service of the Department of Health Services and Hospital Insurance.

The first survey to be undertaken was a study of referred cases into the metropolitan area. This decision was a direct result of an analysis of the statistical data mentioned earlier, compiled by the B. C. Hospital Insurance Service, and which also indicated that a much smaller percentage of cases were being referred than had been thought to be the case in the past.

Another area that required attention was that of bed utilization, as it had been suggested that there was an acute bed shortage in the area although there appeared to be a reasonable number of acute hospital beds in relation to the population. Perhaps the greatest factor involved in the evaluation of acute bed needs, is the effect which the Rehabilitation, Chronic Treatment and Convalescent Care Program will have on bed demands. Estimates have indicated that 10% to 30% of the cases in some of the acute hospitals

could be cared for in proper chronic hospitals or nursing homes. If, with the implementation of the Rehabilitation, Chronic Treatment and Convalescent Care Program, these cases are transferred out of the acute hospitals into chronic hospitals, this will release a comparable number of beds for acute care. However, some of the acute general hospital beds may be utilized to look after some of these cases, by converting acute beds to chronic care wings or wards.

Further, there is a bed problem in the metropolitan area of the Lower Mainland, which is the result of the geographic distribution of facilities and other factors, rather than a shortage in the total number of acute beds in the area. Concentrations of population in certain areas will increase the demand for hospital beds, but this demand is also due to the fact that some of these hospitals have excellent facilities available for treatment, have a great many doctors on their medical staffs, and receive the largest proportion of the difficult referral cases. It seems that, as hospitals grow in size and add new services to their facilities, they attract more doctors and more patients, which, in turn, pyramids the problem of bed pressures almost in direct relationship to their growth. Let a hospital become the medical centre, and there are bound to be problems in seeking accommodation for patients at such an institution.

On the other hand, while there have been pressures for beds in the areas and hospitals referred to above, oftentimes the opposite situation is to be found in other areas of the metropolitan Lower Mainland. It is a fact that at one time when it was stated that there were long lists of waiting patients at certain hospitals, hospitals in other sections of the Lower Mainland were looking for patients. One hospital opened a new wing in response to requests for beds, but found that it later had to close down a part of this wing, not because of a shortage of staff, but because of lack of patients. Here is a rather anomalous situation of having a shortage of beds in one part of the metropolitan area of the Lower Mainland and a dearth of patients in the other at this particular time.

The bed situation is not an easy problem to solve. It involves not only the geographic location of the hospital but methods of staff appointments, the services that are available in the various institutions, the desires of the patient, and a myriad of other factors that affect the doctor's and patient's decision to request admission to a certain hospital.

Because of the influence which the type of medical care provided both within and without the hospital, has upon the hospital program (and especially in the matter of referrals), it is felt the

time has arrived for a closer integration of medical and hospital planning, in order to establish patterns of practice in both areas, which will complement, rather than supplement, each other. The necessity for this type of integrated planning, to provide total area programs, is becoming quite apparent, both generally and in certain of the specialty fields such as paediatrics, emergency services, chronic care, etc.

If, through the professional studies of the Metropolitan Hospital Planning Council, it is possible to trace out the medical care patterns for the area, and in some instances go beyond the Lower Mainland when necessary, and apply these results to hospital planning, a better integrated hospital program should be possible.

On the other hand, care must be taken that the program is not so inflexible that it cannot meet changing demands on individual hospitals, thereby stifling local initiative.

The first study conducted by the Council (which was an analysis of referral patterns into the metropolitan area) has been completed. Rather than summarize all of the recommendations, perhaps it would be sufficient to comment on one or two of the more important ones as they relate to the area.

The report recommended the construction of some 850 beds in the periphery of the area by 1965, in order to maintain the 5.7 beds per 1,000 population ratio which exists at the present time.

It also recommended the construction of a University hospital which would act as a referral centre for the Province, and these beds were included in the 850-bed figure. It is significant that the Government has acted upon the recommendations and has already approved the contruction of the referral hospital at the University and a new hospital for Richmond, one of the municipalities in the periphery area. Other projects are currently under review.

At the present time, several hospitals in the metropolitan area have submitted briefs to the Government, requesting approval of expansion programs. The Government has, in turn, suggested to these groups that they present their plans to the Metropolitan Hospital Planning Council so that it can be aware of the proposals of the hospitals and take them into consideration in their studies. Not only do these proposals present problems in expanding the total number of acute beds in the area, but can affect the future patterns of development of certain specialties. To have professional advice available through the Metropolitan

Hospital Planning Council in determining these future patterns, and to be able to receive its recommendations is of great assistance to the B. C. Hospital Insurance Service and the Government. In this regard it is interesting to note that, if all of the requests for expansion presently received from hospitals in the metropolitan area of the Lower Mainland were implemented, an acute bed ratio of close to 7 beds per thousand population would result.

When the basic data of these hospital briefs are analyzed, there are several instances where the same population groups are being used by two hospitals to justify their request for expansion. In one instance, the population of an area is used by three, and possibly four, hospitals to support their requests for additional beds. Some of the briefs draw a comparison of the number of hospital beds per thousand in their respective districts or municipalities to the average for the metropolitan area, or the Province as a whole, stating that, because their ratio is perhaps below the average, their citizens are not being adequately hospitalized.

However, an analysis of the hospitalization experience of the municipalities that make up the area under study shows that such a statement is contrary to fact. For the years 1959 and 1960,

one district presently requesting additional beds, on the basis that its ratio of beds per thousand is almost one-half that of the Province, or the metropolitan area, has, in fact, an incidence rate of cases admitted per thousand population that is higher than the Province as a whole, the total metropolitan area under study and, in fact, higher than any other municipality included in the survey. A review of the days of care provided the areas under study follows almost an identical pattern to the case analysis.

This situation is understandable, for a population that is growing on the outskirts of a metropolitan area is bound to be serviced by the latter until the peripheral district is large enough to commence providing its own facilities. Once this has been started, there is usually a gradual change in the pattern of hospitalization and patient flow, until ultimately the municipality which formerly relied on the metropolitan area for hospitalization may, in fact, be providing care for some residents of the adjacent metropolitan area.

A closer examination of the hospitals under study revealed that perhaps an answer to their problem of high occupancy and bed shortages would be found in a study of the way in which the beds of the hospital were being utilized. It was felt that, in

in some instances, some of the cases might be cared for in accommodation other than the acute general hospital and, therefore, should not be occupying an acute bed. As this involves professional decision, it was obvious that this matter should be referred to the appropriate medical body in the Province. Discussions were held with representatives of the B. C. Division of the Canadian Medical Association, to see if a professional survey could be carried out, especially in view of a resolution recently passed by the Executive of that body, which reads as follows:

> "We recommend that a survey be carried out under the aegis of the Canadian Medical Association, B. C. Division, the purpose of this survey being to determine factors affecting utilization of hospital beds. This survey to be done with the co-operation of the medical staffs of the hospitals surveyed. The Metropolitan Hospital Planning Council could be approached to obtain funds and assist in the research."

The first project leading to this type of survey is currently under way and includes two of the hospitals located in the periphery area of the metropolitan area of the Lower Mainland that are requesting expansion of their facilities. This action on the part of the B. C. Division of the Canadian Medical Association

is most significant and is further evidence of the excellent co-operation being received from the Medical Profession.

In addition, the Council has just completed an emergency survey which will serve as a guide in the development of emergency service departments in the metropolitan area.

The paediatric survey, commenced on April 1st of this year, will be used as a guide for the development of paediatric care throughout the Province. In this regard, the Council recommended the suspension of all paediatric construction until after the completion of the survey. This has been done so as not to jeopardize the future development of this specialty.

A study of the method of financing construction of hospital facilities will also be commenced this year.

To date, the record of the Metropolitan Hospital Planning Council has been impressive. It has been successful in bringing together medical, hospital, and municipal groups to examine the problem of integrated planning. Above all, it has brought professional medical knowledge into the planning of hospital facilities, and has helped to build the excellent relationship which exists between the groups concerned. The Council is supported financially by all three levels of government. Future administrative

expenses and some research programs are expected to be met by a per capita payment from the municipalities located in the area and funds from the Provincial Government. The latter will be paid to the Council by the B. C. Hospital Insurance Service making an allowance in the per diem rate of hospitals of the area which, in turn, will be paid over to the Council on a per bed basis. The Federal Government has provided funds through research grants, which have been used to sponsor the specialized surveys.

The future plans of the Council and its place in the program of hospital facilities is rapidly becoming apparent. The successful integration of patterns of medical care with the planning of hospital facilities by a voluntary body at the community level makes it unique. Although it is the first development of this type in the Province, others are expected to follow.

While the Federal Government has made it quite clear that the responsibility for hospital matters lies with the Provincial Governments, and the Provinces, in turn, have delegated certain responsibilities to the hospitals, the question of local autonomy and central control is still unresolved in many respects. The existence of policies which, on the one hand, profess to preserve the autonomy of hospitals at the community level, and yet take away

some of the effectiveness of community decision on the other, presents a challenge to those responsible for the future development of our provincial hospital plans.

It is encouraging to note that this basic problem of autonomy and control is being studied across Canada. In the field of area planning, it is very significant that the B. C. Provincial Government has sought the advice and counsel of the professional groups and local authorities interested in these matters, and provided them with an opportunity of taking part in the development of hospital facilities in their area through the Metropolitan Hospital Planning Council. Perhaps this method will prove to be one way of solving one part of this problem so that we may retain the advantages of the autonomous hospital at the community level, and yet support its operation with government funds. In any event, the progress made up to the present time is most encouraging and suggests that this newly developed concept of local and provincial integration and co-operation in hospital planning will provide some of the answers to the vexing problem of hospital development in the future.

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# Need control stifle initiative?

**The federal-provincial insurance program has provided hospitals with the stability of income needed to give adequate care to the whole population; but they are subjected to more government control. Did they gain or lose?**

**by Larry Fraser**

Perhaps the most striking feature of the federal provincial hospital insurance program is its avowed aim to retain the independent, autonomous community hospital while simultaneously raising the funds necessary for its operation through a provincial pre-payment plan and (or) provincial government support.

To date, the plans have been very successful. Not only has the worry of crippling hospital bills been lifted from the minds of the sick, but hospitals have been provided with a more stable source of income than ever before; and as long as the provincial treasuries can provide sufficient funds to meet the costs incurred by the hospitals in providing care, no serious situation is likely to arise.

How the hospital could continue to operate as an autonomous unit, serving the needs of its community and at the same time be subject to the direction and control of a central authority is something that has yet to be worked out. On the one hand, it would be folly to suggest that hospitals should be given a blank cheque on the treasury of any province. On the other, too strict financial measures could result in stifling medical and hospital development and in lower standards of care. Yet, there must be a limit to the portion of the economy that can be devoted to medical care, and the determination of this balance is the difficult task facing provincial governments today.

Prior to the introduction of government sponsored hospital plans in Canada, the major part of the expenditure for hospital care was determined through the process of competition and jurisdictional decision at the community level. Each area decided individually the standard of care desired in its hospital. Decisions were made locally to accept or reject requests for new services, building projects, wage increases, etc., all of which ultimately had an effect on the daily rate of the hospital. Since this rate, in turn, was to be paid by the patient or by the prepayment agency insuring the patient, decisions concerning expenditures were made in the light of the ability of the community to meet the resulting patient charges.

As pre-payment plans grew, it was found that this third party, the insuring agency, was having more and more to say about the costs of running the hospitals, this having a direct effect on the premium which the insuring agency levied to keep the insurance fund solvent. Where an insuring agency was not a local company, but national or international in operation, it had less interest in the services being provided to the community and was more concerned with its financial problems.

And so a direct conflict of community service and financial interests arose. Companies providing hospital coverage could, and in many instances did, go to the extent of suggesting to the hospitals that they curtail expenditures or services in order that their (the companies') financial structures would not be threatened.

Today, some governmental plans, due to the unprecedented demand by the people for universal, comprehensive coverage for hospital care and the concern of their governments over the mounting costs of providing this care, find themselves in a similar situation. With the introduction of provincial hospital plans, the decision regarding the amount of money to be spent for hospital care is now made in the provincial legislature, in the light of expenditures for other governmental services, such as education, roads, law enforcement, etc. The process is not unlike that previously carried out by the boards of trustees of local community hospitals when considering the hospital budget for the coming year.

**Under present circumstances,** hospitals have no way of making basic, independent decisions which involve increased expenditures, without acknowledgement by the central authority that the expense will be accepted in their budget. As a result of this, the community hospital as we have known it, responding to the pressures and influences of the community, could well become a thing of the past unless positive steps can be taken to restore its full autonomy.

While there are many who even now deplore the situation, it must be conceded that the new policies and practices which are being developed have much to commend them. With proper control and planning, it should be possible to develop an integrated hospital system under central authority. All too often, in the past, the desire to advance one hospital, for reasons of local pride, has resulted in the duplication of expensive facilities and equipment rather than their sensible integration for the hospital service area.

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Sickness is no respecter of geographical areas. If a person cannot receive proper treatment at the local hospital, he is referred to the larger medical center where more complicated and usually more expensive equipment and services are available. This makes good sense but at the same time it does present problems to the local physician who may be qualified to perform the operation but cannot because the necessary equipment and trained staff are not available in the community where he is located. It is quite possible if the physician finds that he and other members of the medical staff are having to refer an ever increasing number of patients elsewhere, that recommendations will be made to the board that certain new services be added to the hospital. But however desirable from a local point of view, this can emerge as a duplication of facilities when the region is examined as a whole.

**Prior to the introduction** of the provincial plans, such requests would have been dealt with by the local hospital board of trustees, which may or may not have accepted the recommendation. If they did, and it involved additional expense, the administration would have taken steps to raise additional revenue. This might have resulted in an increase in room rate, operating room charges, etc., depending on the service being added. The important point is that the local hospital authorities were able to make these decisions independently. Today, under the provincial plans, they are no longer able to do this; instead, in most provinces, they must submit such decisions to the central plan authority, which may or may not approve of their recommended action. But in spite of the situation and the continual cry that our hospitals are "better run at the local level" or "autonomy must be preserved", the hospitals themselves continue to press governments to cover more and more of the total hospital bill. Governments for their part have stated repeatedly that they do not want to take over the hospitals, and there is every reason to believe that this is the case.

However, if hospitals continue to obtain an increasing proportion of their revenue from the central authority, the inroads by government into hospital affairs will increase correspondingly. Eventually, full control and support of the hospitals will come from the central agency and the hospital system becomes another governmental service program.

There is yet another important ramification of these financial policies and controls in the field of medical care. While governments continue to state they wish to leave the management of the treatment of the patient in the hands of the medical profession, they are nevertheless having a great deal of influence, through their control of the hospital budget, on treatment provided. The fact that in most hospitals new services cannot be added, or existing ones expanded, without the approval of the central authority means that it is the decision of the latter as to the type of care provided in that hospital.

This is probably the most important problem facing the hospital, and in some ways the medical profession, in Canada today. If their autonomy and freedom of action is to be retained in the future, some mechanism whereby decisions may be made by the hospital authorities should be established. Denied the right to conduct their affairs on such a basis, hospital boards of trustees in the future could, more and more, become figureheads only, carrying out government policy. True, they may retain a certain degree of autonomy, such as medical staff appointments, administrative procedures, but they would have lost the power to initiate basic policy. Unable, for example, to invest in necessary medical equipment they may find themselves limited in the capacity to develop their medical services.

**The community hospital responsive to the pressures and influences of the community faces extinction unless positive steps are taken to restore its autonomy. Governments repeatedly state that they do not want to take over the hospitals; yet as long as hospitals continue to press them to cover more and more of the total hospital bill, increased control by hospital commissions is inevitable. The remedy suggested here is a mechanism which will tie a portion of the costs of hospital care above a certain minimum standard to local fund raising initiative.**

**With the above observations in mind,** then, let us examine concept of the direct patient charge or local levy, not as a means of controlling abuse or raising funds, *but as a mechanism to enable independent decision on the part of the boards of trustees of the hospitals.*

In the past, most people have looked upon a co-insurance patient levy as a deterrent charge. It was expected to prevent abuse of a service by making an impost against the patient, requiring him to consider the cost he would incur in receiving treatment in relation to the benefits obtained. It was hoped, in those cases where the patient did not really require the service, that its cost would influence his decision not to seek it. Similar reasoning would apply to a physician who might be hospitalizing patients more for his personal convenience than for medical necessity. True, no person should be refused or denied medical treatment for financial reason; but unfortunately, experience has shown that some degree of abuse has inevitably resulted when full payment is provided to general public.

In other instances, the co-insurance or direct patient charge has been looked upon as a source of revenue to assist in providing the service. This can be a very successful way of raising funds and may take the form of a payment of so much per day in hospital, an amount deductible from the total bill,

**Under the co-insurance scheme, the locality makes the policy decision on the amount of additional hospital care it wishes to support financially**

a percentage of coverage of the account, and so on.

No matter how the funds are raised, if they are collected only when the patient is hospitalized, it is the sick person who is bearing this additional levy. Some people would argue that this is wrong, since the individual should receive care when he requires it with no additional impost; others would support the concept that the patient should bear a portion of the cost since he is a direct beneficiary from the service. There is merit in both points of view. The ideal situation is a workable compromise between the two.

Another method of raising funds is to levy a charge on the community receiving the service. This usually involves setting up districts or areas for taxation of some type to be imposed, usually a levy on the land.

In this instance, it is the community as a whole which pays for the additional services received instead of the individual patient. One advantage is that there is no individual financial impost which might be considered a deterrent to necessary treatment. One disadvantage is that it removes the deterrent effect which a financial impost might have on unreasonable demands for care.

The discussion so far has been concerned with the financial–that is, the point of view adopted by both private insurance underwriters and government prepayment plans in the past. However, another, and perhaps more basic, problem is beginning to be recognized; namely, the position of hospitals in our society under the *prepayment* concept. Perhaps the direct patient charge or local levy is the mechanism that will modify the trend towards centralization of control and permit the continuation of the autonomous hospital at the local community level in the future, with most of its financial support coming from government funds.

Let us again consider the two proposals discussed previously. First, the imposition of a variable co-insurance charge by the hospital, with a maximum amount payable each year by the individual or family unit. (In a family unit we will include all individuals financially dependent upon the head of the household. It is assumed that all persons receiving any sort of welfare assistance whatsoever from any level of government will have the co-insurance charge met by the appropriate authority.) Second, an impost through a district which would cover hospital expenses, otherwise not accepted by the central authorities.

The hospital district proposal is actually in effect in many of the provinces throughout Canada, and, in some instances, works fairly well. It holds the community responsible for costs of care which are beyond those acceptable by the central authority, and decisions on expenditures are made by someone at the district level. In essence, the hospital board must turn to another authority–the district trustees –for approval of a decision made by the board of trustees. The district trustees and not the hospital trustees are the final authority in deciding whether or not the expense incurred in providing a new service or additional staff will be accepted by the district. This situation would apply to all of the hospitals operating in the district.

One disadvantage of this scheme is that although decision in these matters has been brought closer to the local level, it still remains outside the jurisdiction of the body recommending the expenditure. However, the community benefiting by the additional service coincides more, at this level, with the people providing the funds, and hence would appear to be a move in the right direction.

This is not to suggest that the basic level of hospital care as provided through the prepayment and (or) government plan, should be abolished, but rather, it should be continually reviewed and, when possible, broadened in scope to include as many of the additional special services as the central authority's finances will permit.

It might also be well for the various provincial programs to consider the financial problems which are going to confront government officials in future in raising the funds necessary to support the provincial scheme. It has been said many times that there is almost no limit on the amount of money that can be spent on medical care. When one examines the experience of a provincial hospital plan that has been in operation for several years and contemplate the expanded programs for the future, it is little wonder that the authorities responsible for raising the provincial revenue pale at the size of the task facing them. Yearly increases from 5% to 10% per annum for the next four years in the cost of hospital and medical care being currently forecast. Since hospital costs have risen faster than any other item in the consumer price index in recent years, and there is no suggestion that this will change, it is not difficult to imagine the effect that these trends will have on the overall cost in our hospital plans in the foreseeable future.

With prospects such as these should not a wise government consider some way of buffering itself against these future costs so that it could still guarantee an acceptable level of hospital care through its provincial plan, at the same time not be committed to finance what might be considered exorbitant demands on the part of some communities in the province? It is doubtful that treasury officials are fully aware of the problems that lie ahead in this field, and it is suggested that they, as well as the hospital authorities, would be well advised to consider some way of sharing the future expense of their hospital coverage program.

**Suppose, then, it is agreed** that the body which decides to provide a level of care in the hospital beyond that included in the budget set by the central authority should be held responsible for rais-

ing the funds necessary, and that the mechanism to accomplish this be made available direct to this authority rather than through some other channel. It is clear that by implementing such a procedure, the responsibility for such expenditures is clearly fixed on the body incurring them. There is no passing of this responsibility on to another authority and the group concerned must answer to its community if these costs get out of line. Because of this, the authorities concerned will likely consider additional services and expenses much more carefully than if they were not held responsible for them by the local community.

The implementation of a variable co-insurance charge to patients with a yearly maximum cost per individual or family unit has a great deal to commend it, not only as a deterrent to overuse of service and as a means of raising additional revenue to finance the plan, but most important of all, as a way of returning to hospitals that which is claimed to be their most important asset—their autonomy, and hence authority.

With such a mechanism, boards of trustees could once again make independent decisions concerning the care provided in the hospital and act on those decisions without having to refer them to another authority for approval. It would be expected that a basic standard of care would continue to be provided through a provincial insurance plan, as has been the case in the past, but the boards of trustees would be held responsible and answerable to their respective communities for care provided over and above this standard. The community would become aware of the extent of this additional care by the amount of the co-insurance charge per patient. If one hospital in a district levied a co-insurance charge that was considerably higher than a neighbouring hospital, there would, no doubt, be questions raised as to the necessity of the difference in rates. Patients would become more interested in where they were sent and would likely question their doctor on the necessity of being admitted to the hospital with the higher co-insurance rate. He in turn would have to be prepared to justify the charge to the patient and might be more cautious in demanding additional services at his hospital, since these services might result in a higher patient charge which might be criticized by the community. Competition would return to the hospital field and replace the delegations to the central authority to cover these "extra" costs. There would be less tendency to "let the government do it" since the government could no longer be used as a reason for the non-compliance to requests for additional services, for the board would have a way of supplying these services if it deemed them desirable, that is, by raising the co-insurance charge to meet the expense involved. It would be the duty of the central authority to make certain that the basic level of care provided at the ward level and finance to the plan was adequate and kept up with the developments in the hospital field. The co-insurance charge should not be used as a way of passing back the substantial portion of the cost of the plan to the patient and hence the community, an oft heard criticism of this type of program.

**A variable co-insurance program** could well be the mechanism which would ultimately preserve the economy of the hospital at the local level and still permit the provision of the majority of its funds from government sources. Unless some such program is adopted, soon, by our provincial hospital insurance plans, the community hospital as we know it today, and have known it in the past, may cease to exist.

It might well be that the hospital and medical groups will accept the decision of the people to have hospital affairs directed from the central provincial authority, not feeling it necessary to regain the independence they once enjoyed, and being of the opinion of what they have lost has been more than offset with the assurance of a steady source of income and a more stable environment in which to operate. The fact that in some provinces where hospital plans have been in operation for over ten years the hospitals have not been taken over by the government and the plans appear to be running fairly well suggests that this compromise is the pattern which may emerge from the federal-provincial hospital insurance plan. But if this should be so, let the authorities concerned then cease to press for the "preservation of their autonomy", acknowledge it was high time to drop this old cliche, and admit that there exists now a better environment than ever did before. •

# How are they paid who pay the piper?

**Actuarial principles alone cannot govern the operation of a provincial hospital plan to provide universal and comprehensive care. Provinces must supplement income from premium payments with general revenue financing**

**by Larry Fraser**

Quebec's entry into the Federal-Provincial Hospital Insurance Plan at the beginning of this year brought to a conclusion the first stage of the health program envisaged by the Prime Minister of Canada in 1948 when he introduced the health grants legislation of that session as "in effect, the fundamental prerequisites of a nation-wide system of health insurance."

To-day, every political party in Canada has included a proposal for a health program in its political platform, and while various groups, both professional and otherwise, have expressed opposition, nevertheless, with the completion of a national hospital insurance plan, an irrevocable first step toward a nation-wide health insurance program has in fact been taken.

The United States, too, is facing the problem of extending health services to meet public demand. But in that country, the program is manifesting itself in a different way. The demand springs mostly from industrial and commercial fields and it is a subject for labour-management negotiations. Thus the extension of health services usually takes the form of additional fringe benefits under labour contracts. The insurance coverage is provided through voluntary prepayment plans administered by insurance companies, although an increasing degree of governmental participation is becoming evident.

**In Canada, on the other hand, the demand for extended health benefits is making itself felt more through political channels.** This has resulted in the implementation of various governmental health programmes at all levels, the most significant of which is the Federal-Provincial Hospital Insurance Plan. The explanation would appear to lie in the greater propensity of Canadians to accept government participation in their affairs than is common among the people of the United States.

While the majority of provincial governments in Canada utilize tax measures in varying degrees to raise funds to support their hospital insurance plans, it is a stated policy of most of the governmental authorities that they do not wish to take over the hospitals. They remain of the opinion that better patient care will result if the hospitals are operated as autonomous units at the local level.

This is quite different from the type of hospital plan existing in most other countries where the hospitals are usually owned and operated by the central government.

In Canada, however, because of the division of authority and control in hospital matters, the initiating powers of the federal government are limited. Problems and conflicts are bound to arise as to the most appropriate way to finance and administer the provincial hospital insurance plans and the hospitals. For this reason, there is no single financial program in effect across the country, although two basic patterns (premium payment and general revenue financing) are evident, with modifications being adopted in each provincial plan.

The premium principle of prepayment, similar to that utilized by commercial insurance companies in providing coverage to policy-holders, tends to support the concept that health is an individual responsibility, although in some provinces this is modified and both compulsory and voluntary prepayment requirements are embodied in the provincial hospital insurance scheme.

The compulsory aspect applies to some section of the population — usually those people who are on payroll — and the self-employed group may join the plan if they choose to do so, but they are not required to take part by law. This, however, gives one group a right which is denied to the other. In most provinces where the premium payment concept has been adopted, it has been made compulsory for all residents to join the scheme. Often this results in some rather difficult administrative problems of the type which are generally encountered in the enforcement of any compulsory individual tax levy.

Whichever approach is used in this type of plan, it is basic that, if an individual does not participate by paying a premium and incurs a hospital bill, he is personally responsible for the charges incurred, unless he is sponsored by some governmental agency. Under these circumstances, then, there will likely be some section of the population continually not covered by the hospital insurance plan. The size of this group will vary in direct proportion to the stringency of the rules governing the contributions and eligibility for coverage.

**The use of governmental revenues to provide the funds necessary for the provincial hospital scheme embodies the concept that hospital services to the individual should not depend upon individual de-**

**cision to participate but should be available as a right to all residents of the province.**

There is no uniform way in which the provincial government revenues are raised, some utilizing sales tax, others royalties, and one province the income tax. In two provinces where their hospital program started with a premium payment plan, this method of financial support was replaced by a sales tax which subsequently proved to be a more acceptable means of financial support for the universal and comprehensive benefit policies. Provision of such broad coverage had proven to be incompatible with the premium prepayment plan. This was the basic issue in provincial elections in both provinces, and resulted in the governments in office being defeated in favour of the party proposing the change.

*While there are long-range implications in the professional fields in adopting a general revenue method of financing, its success to date and the interest shown in it by some of the provinces still using the premium method suggest that the trend is toward expansion of its use.*

One of the basic differences between the actuarial principle (premiums) on the one hand and taxation measures (general revenues) on the other, is the philosophy of coverage. The profit motive is the underlying reason for the existence of a commercial venture, whereas service to the people takes precedence in a governmental program.

In the planning stages of most insurance plans, devices are often adopted which will protect the program from unthinking or selfish individuals who may attempt to obtain more than their rightful share of benefits. For example, in the commercial insurance field, coverage is usually restricted to individuals who meet certain prepayment requirements and is extended to a limited number of individuals who may be classed as dependents.

This concept is quite acceptable if one is not attempting to achieve universal coverage and will accept the fact that a certain percentage of the population will likely never be covered for one reason or another. However, if universal coverage is the ultimate goal, such as is the case in the majority of governmental plans, the individual prepayment does present problems, especially when viewed along with the question of dependency.

**The goal of universal and comprehensive coverage** presents some very difficult problems in the application of the insurance principle to finance the program. If a flat rate basis is employed, so that all individuals or heads of families pay a premium, be there two rates or a single premium rate, there is the very real administrative problem of continually having to adjust the premium rate as ages change or relationships are altered.

Levying a self-adjusting premium, such as a percentage of income, would eliminate the administration adjustments for age, relationship, etc. However, while it would ensure that most of the population would receive coverage in industrial areas because of payroll deduction programs, it would not be nearly so successful in agricultural areas where there are fewer companies — and hence fewer payrolls — unless it were combined with some other type of fund collecting mechanism, such as the land tax program utilized in Saskatchewan. One of the greatest problems in levying an income for the self-employed or agricultural population is the determination of the amount of the individual's income to be taxed.

If an individual levy (premium) of some kind is to be used, then, from an administrative point of view, the most successful way of applying it is to have it on a compulsory basis for that section of the population that may be reached by payroll deduction, and have it collected on a voluntary basis from the self-employed. However, while it ensures that a sizable section of the population will be under coverage at all times, a new problem of non-insured accounts in hospitals may arise, which can become serious unless offset by some other source of revenue, such as governmental grants.

Similar problems are encountered in considering the type of benefits available. Generally speaking, these may be divided into two classes: indemnity benefits and service benefits.

**Indemnity benefits may be described as fixed payments** which are designed to cover part of the cost of certain pre-established and specified hospital risks. A fixed amount is paid toward the cost of hospital care incurred by a beneficiary, regardless of the total cost of such care. Usually, separate payments are provided to cover different items of expense. For instance, there is often a schedule for payments to be made for the cost of room and board in a hospital; a separate provision for the cost of the operating room; and another for X-rays and laboratory work, and so on. The patient pays all costs in excess of the minimum average cost of the services provided. When extensive special services are required, his share can be quite large.

Indemnity benefits are often paid to the beneficiary rather than to the hospital, and this tends to complicate administration and often leads to abuse of the system. The controls and administrative measures necessary to check these abuses are in themselves objectionable to both the hospital and the patient. Finally, under a program of indemnity benefits, there is no guarantee that full payment for care will be made to the hospital.

**Service benefits usually provide payment for the total cost** of the period of hospitalization at a specified level — ward, semi-private, or private. The cost of room and board and all the special services provided by the hospital are included. Thus, the hospital bill is paid in its entirety, or almost so, and the beneficiary has no substantial part of the cost to share. This is the most satisfactory type of insurance from the viewpoint of the beneficiary and it is the service benefit obtainable under the provincial plans, where the cost of acute general hospital care is met at the ward level.

Seen from the point of view of the insuring agency rather than the individual receiving coverage, the question of benefits presents a different set of problems. From the point of view of commercial

**General revenue financing is proving more popular than the premium method. Provinces which can tap both sources may be the most fortunate. They can relate health care to individual responsibility as well as ensure universal coverage**

insuring companies, it is reasonable to apply controls by writing limitations into the contract, in order that the insuring agency can establish its premiums with these points in mind: (1) Provision of a contract developed on the basis of experience and predictable and known costs, and (2) Establishment of a premium rate which will make it possible to sell the contract on a commercial basis. This obviously is a perfectly legitimate point of view. On this basis, the insuring agency has a limited responsibility, which can be calculated in terms of dollars and cents, and when it has met its commitment, it has no further liability either to the insured person or to the hospital. The net result is that the individual is protected against the cost of an average period of hospitalization but is left to his own resources when the duration of stay goes beyond an arbitrary period.

**When the government enters** the insurance field, it must, of necessity, approach the problem from a different point of view. Limitation of benefits, for actuarial reasons, will not solve the government's problem if it is to provide universal and comprehensive coverage to the people. Such limitation could add appreciably to uncollectable hospital accounts and hospital deficits, which in the long run, the government would still be expected to meet.

In practice, therefore, the government would be paying for necessary hospital care on a non-limited basis. In contrast to the private insuring agency, then, if the government promises universal and comprehensive hospital care, it is not only justified in providing this wide coverage, but it has no alternative other than to do so, subject only to actual need for hospital services as such.

**Under the Federal-Provincial** Hospital Insurance Plan, there is uniformity throughout the country in so far as the type of benefits to be provided is concerned since, with few minor exceptions such as charges for room differentials and certain drugs, all provinces have adopted the service principle.

Likewise, the provisions for dependency have been kept very broad. In those plans where residency is the determining factor for eligibility, persons are either eligible themselves or are dependents of the head of the household under regulations which do not result in many groups being excluded. Generally speaking, a three-month qualifying period is all that is required for individuals residing permanently in the province or who are dependents of the head of the household who has met this requirement.

In the provinces employing premium payment plans, more generous dependency requirements have been invoked than in most commercial plans, but, nevertheless, there are still some groups that are excluded as dependents and are not able to obtain coverage because they are not able to pay the premiums themselves. These groups would include the older persons who are dependent upon the head of the household but cannot be claimed as dependents because of age or relationship. In one province, since it is not mandatory for all individuals to participate in the plan, it is conceivable that, in addition to those excluded as a result of dependency regulations, there may be a sizable section of the self-employed population who may elect not to participate in the plan and, therefore, do not have coverage when they require hospitalization. However, up to the present time, this group has not been large and has not presented any great problem. In most instances, the expenses incurred on its behalf have been met by some governmental authority.

**As a general principle, it may be observed that the greater the degree of coverage received from any prepayment agency, the greater the degree of influence and control that agency is bound to have on the body providing the service for which the coverage is carried.** With this in mind, it is interesting to examine the various provincial plans across Canada and contemplate possible developments in the future.

**Nova Scotia and British Columbia** have adopted the general revenue method of financing the hospital service and the sales tax as a means of raising this revenue. Hospitalization in these provinces will likely be looked on as another government sponsored service in the future, with coverage being extended as their political parties promise greater benefits in their election campaigns.

**In New Brunswick**, the people have voted to adopt the same policy, this basic change being the main issue in their last provincial election.

**Newfoundland** has always financed its plan out of the general revenues of the province.

**Quebec** is obtaining the revenue required for its plan by increasing its corporation income tax rate and reducing the basic exemption allowed its residents when calculating their provincial income tax. It is the only one of the ten provinces which has chosen the provincial income tax field to finance its hospital insurance scheme.

*In all of these provinces, any possibility of operating their hospital programs as insurance plans has disappeared, and they are now, and will continue to be, part of the provincial governmental welfare program. There is no place for actuarial insurance principles in schemes of this nature.*

**Of the other five provinces, Ontario, Manitoba, and Prince Edward Island** utilize a premium payment plan to raise the major portion of the provincial cost of their hospital insurance programs, while **Saskatchewan** levies both a sales tax and a premium in order to raise its share of the funds necessary.

**Alberta** raises its share of the cost through a combination of revenues raised through other govern-

*(Continued on page 50)*

(Continued from page 4)

Where does this leave the citizens of Metropolitan Toronto? There is currently a shortage of 2200 beds and the entire shortage is in the suburbs. The north-west suburbs have about 1 bed per 1,000 of population, as contrasted to the established provincial need standard of 5 beds per 1,000.

The population and industrial shift is to the suburbs, and it is the suburbs that need hospital beds. In these areas, there are many young married nurses, willing and wanting to work close to their subdivision homes. Yet three new hospitals to serve the northern suburbs are having trouble getting off the ground financially—due to inadequate voluntary and municipal financial support.

The hospitals which need the money the most seem to have the least appeal to big business philanthropy which tends to be more generous with the established teaching and downtown institutions. Most Metro tax-payers are unaware of the problem until a member of their family needs admission to hospital, complete with government hospitalization plan, and then the facts of hospital life are discovered in a hurry. Most are prepared to pay for adequate hospital construction programmes, but their elected representatives don't seem to think so.

While Metro Chairman Gardiner may be remembered for Toronto's expressway and for heading a new form of government which gets things done, he may also be remembered as the one person most singly responsible for Metropolitan Toronto's hospitalization dilemma.

## Advertisers' Index


| | |
|---|---|
| American Sterilizer Co. | 3 |
| Automatic Electric Sales (Canada) Ltd. | 17 |
| Babcock-Wilcox & Goldie McCulloch | 10 |
| Becton, Dickinson & Company (Canada) Ltd. | 11, 12 |
| British Oxygen Canada Ltd. | 38 |
| Colson Ltd. | IFC |
| Cyanamid of Canada Ltd. | 33 |
| Dixie Cup Company of Canada Ltd. | 43 |
| Dominion Oilcloth & Linoleum Co. Ltd. | 8 |
| Dunham-Bush (Cda) Ltd. | 7 |
| Thomas A. Edison Industries | 6 |
| Edwards of Canada Limited | 9 |
| General Electric Co. | 34-37 |
| Hollister Limited | 48 |
| Humber Memorial Hospital | 29 |
| Imperial Surgical | 21 |
| Gordon A. MacEachern Ltd. | IBC |
| Minnesota Mining & Manufacturing Co. of Canada Ltd. | OBC |
| Norman S. Wade Company | 49 |


(Continued from page 46)

mental sources such as oil royalties and municipal taxation revenues.

Finally, it should be remembered that in all provinces, the funds raised by the provincial governments are supplemented by federal grants, which account for approximately one-half of the cost of the hospital plan. This is the only feature of the financing of the plans that is uniform throughout the country.

Six of the provinces appear to support the premise that general taxation measures should be used to support their hospital insurance programs (five utilize provincial sources and one a municipal source). Three other provinces utilize the premium payment principles as their main source of revenue, while one (Saskatchewan) utilizes both methods. This is especially interesting, since Saskatchewan was first province to implement a province-wide hospital insurance program and introduced the first compulsory premium payment program in Canada.

**It would appear that if a policy of universal and comprehensive hospital coverage for all of the people is adopted on the service principle, this cannot be completely achieved under a premium payment program alone.** Experience has shown that such a benefit policy and premium payment combination inevitably results in the adoption of some other form of revenue supporting program, either through sales tax, additional general revenue support, or the abolition of the premium program altogether. To date, the trend has never been in the direction of reducing the benefits to meet the limitations of the payment program. Instead, changes have always been in the other direction.

[illegible] concern has been expressed that since the Federal Government is paying one-half of the cost of the Federal-Provincial Hospital Insurance Plan, there is a good possibility that this will result in more uniformity in the financing and operating of the provincial plans in the future. However, in view of the very significant differences between the financial structures of the provincial plans arising out of the different economic and social conditions pertaining to each individual province, the likelihood of complete centralization at the federal level does not seem too imminent.

*Perhaps the continuation of these different methods of financing the provincial schemes, with generous support from the Federal Government, will prove to be one of Canada's important contributions to the hospital insurance field in the future: that is, ten different provincial hospital insurance plans subsidized by the Federal Government rather than one single federal program, financed and administered by the central federal authority.*

This is not unlike maintaining the autonomy of the community hospital, owned and operated at the local level, even though its financial support is derived almost completely from government funds. If, in this new environment, it is possible to retain the local community hospital as we know it to-day, with its advantages of local initiative and control, and yet provide the financial support necessary for efficient operation from provincial and federal governmental sources, Canada will steer a course in the hospital field which is mid way between the state control of Britain and the free enterprise concept of the United States. We may perhaps reap the benefits of both without suffering the handicaps of either.

# Be prepared for the bubble to burst

**Prepaid hospital care at an ever higher standard will eventually claim a disproportionate share of government expenditures. The need to seek other sources of funds may present hospitals with an opportunity to ensure continued autonomy**

**By Larry Fraser**

Autonomous community hospitals, financially supported through government sponsored prepayment plans, still appear to be the objective of groups associated with the Federal-Provincial hospital insurance plan. While there have been some major changes in the method of financing the hospital program in some of the Provinces, generally speaking the basic policies originally adopted have continued to date. It is significant that no hospital or provincial authority has suggested that the program be abandoned. On the contrary, they have proposed extension of coverage not only in the hospital field but in other allied fields as well, as evidenced by the expected introduction of a province-wide medical care plan in Saskatchewan next year. Obviously then, government sponsorship of this type of service is acceptable to the general public as well as the majority of the professional groups associated with it.

When one reflects on the history of the hospital plans in Saskatchewan and British Columbia, which have been in existence for the longest period, and the situation as it is in the majority of the Provinces to-day, there is no doubt that the experience gained over the past fourteen years in Canada has been of benefit to those Provinces who have recently implemented programs. While there may be further changes in the method of financing the provincial programs, probably the most difficult problems will be in professional areas. These will likely involve the reconciliation of the loss of independence, autonomy and authority which the community hospital and its medical staff enjoyed in the past with the direction and control that is inherent in any prepayment hospital program. The conflicts which have arisen, both in Canada and the United States, as a result of the growth of third party prepayment plans have not yet been fully recognized or overcome.

This question of direction and control has been the subject of many discussions in the past between provincial, hospital, and medical authorities, and is being viewed much more rationally by all concerned than previously. In this regard, it was interesting to note at the O.H.A.—A.C.H.A. meeting last year and this that hospitals in Ontario felt their autonomy had not been too severely jeopardized. However, one cannot help but wonder, in the light of previous experience in British Columbia and now in Saskatchewan, if the outlook of the Ontario hospitals might not change drastically if the Ontario Hospital Services Commission is required to adopt a firm or fixed budget policy at a future date, similar to that implemented by British Columbia and Saskatchewan. The rapid increase in hospital costs in Ontario, as in other Provinces, is causing concern to those responsible for finding the funds necessary for the operation of the hospital plan. Whether or not the respective provincial legislatures will continue to pay the heavy financial price for political peace in this field, only time can tell.

Experience suggests that some sort of limitation of funds, through the medium of a restricted budget, may have to be imposed by provincial prepayment authorities to curtail the spiralling hospital costs. If this should be done, however, a basic problem of prepayment plans would become apparent: namely, the incompatibility of the desired retention for the community hospital of complete autonomy, authority, and control with the expectation that the funds which it requires will be provided by the government without any, or at least a minimum amount of, direction and control by the prepayment plan. By its very nature, government must be in a position to report back to the people on the expenditure of public moneys and, at the same time, exercise some degree of control in accordance with the wishes of the representatives of the people.

The question then arises as to whether or not it will be possible to develop a mechanism which will meet a major part of the objectives of both the hospitals and the government without completely sacrificing the ideals of one or the other. The recognition of this anomalous situation by hospitals and prepayment plans is essential in order to work out the compromise necessary for the successful operation of the Federal-Provincial hospital insurance plan in the future.

On the one hand, the government is promising

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**In considering special revenue mechanisms to supplement deficient government payments, Saskatchewan is again leading the way among the Canadian provinces**

the people hospital services in return for their political support. In some Provinces it has offered universal and comprehensive hospital coverage and in others the scope of the plan has not been as broad. In any event, the taxpayer or beneficiary has been promised the highest possible standard of hospital care. To suggest otherwise would be unacceptable politically.

The government, through its prepayment program, has turned to the producer of the service — the hospitals — and directed them to provide the people with the high standard of service which the government has promised. In many instances, this will mean not only improving present services offered by the hospitals but the addition of new ones, all of which requires additional funds. (It must be remembered that, in most instances, the hospitals are not owned and operated by the provincial authority, but by independent hospital societies at the local level. This is one of the unique advantages of the Canadian program, but does complicate matters).

As long as the government is prepared to provide the funds which the hospitals state are necessary to provide the standard of care promised by the government, there is no problem. Standards will continue to be raised, as long as this situation exists and hospital budgets are covered. However, experience has usually shown that a point is reached finally where the government or prepayment body responsible for raising the money feels that it can no longer meet the financial demands of the hospitals. It then must change its financial policy, and curtails the hospitals' budgets. While such action could mean a levelling out of the standard of care, it is not likely that the government will acknowledge this, since this would not be popular with the people. On the other hand, such action is probably quite justified, since a disproportionate amount of the Province's budget, at least in the opinion of the government, may have gone into the hospital program at the expense of other governmental services.

In any event, it is up to those groups associated with hospital affairs to make certain that the provincial authority does not retain such a freeze too long, so that hospital services begin to fall behind those provided elsewhere. They must convince the government and the people that it is desirable for all concerned to provide sufficient funds to maintain a reasonable standard of hospital service that is in line with experience in other areas. Hospitals across Canada are beginning to appreciate this situation.

One difficulty in all of this is that the government will likely continue to promise the highest possible standard of care for the people, since it is politically wise to do so, but may not provide the producer of the service — the hospitals — with sufficient funds to meet this commitment. The government is promising "Lincoln" service but paying the producer only enough to provide a "Ford".

One point may be injected here. From the point of view of the general public, substandard hospital care would likely go unnoticed, since the average person is not capable of evaluating the standard of care which he receives. However, the patient's physician, a co-partner in the production of the hospital service, and well qualified to judge, can make comparisons with the statements made by members of the government. He resents being told that the best possible services are available to his patients when, in some instances, he knows they are not. Doctors may openly discuss this situation, but incur the displeasures of the government if the observations are critical and affect the government adversely. In some Provinces, these matters are no longer discussed publicly but, instead, are dealt with in committees between the parties concerned.

It is encouraging to note that the problems of autonomy, control, standards, etc., appear to be more apparent to an increasing number of people in the various fields associated with the hospital plans. The inclusion of such topics as "Who Sets Hospital Standards?" and "Budgetary Control Problems" in the agenda of hospital meetings, as well as the many study groups that have been established to deal with these matters, suggest that these areas will receive even greater attention in the future.

This is fortunate, for the time is fast approaching when the policies that have been established since the beginning of the Federal-Provincial hospital insurance plan may be so entrenched that it will be difficult to change them. For example, hospitals must either accept extensive control from the prepayment authority, if all the funds necessary for their operation are to come from this source (as has been the case in most Provinces up to the present), or some sort of revenue mechanism must be adopted which will enable their independent decision and consequent action. This is especially true if the decision involves money. If such a mechanism were developed, it would restore a large measure of the authority and autonomy of hospitals which has passed to the Provinces' prepayment plans. This has been expressed by the writer in a previous article (see HAC, Jan. 1961, p. 6) and it is interesting to examine some recent developments in one Province, which may influence future policy in this area.

Saskatchewan led the way in this country by introducing the first provincial hospital insurance prepayment plan, and it appears that it has again taken the lead in recognizing the problem that exists in operating hospitals under the policies of their hospital program.

Up until this year, the Saskatchewan Hospital Services Plan has been able to meet the demands of hospitals, since the provincial legislature has

voted sufficient funds to do so. However, this spring, in a directive to hospitals, the Saskatchewan Hospital Services Plan informed them that they had to hold the line on costs and that the Saskatchewan Hospital Services Plan will not . . . "in general reimburse hospitals for the full costs of efficient operations in 1961."

Instead of merely following the usual pattern of issuing releases which condemned the Government for such a policy, the Saskatchewan Hospital Association held a special session to discuss the situation and draft a course of action. While nothing as yet has developed by way of major policy changes in the plan's operation, it is significant to note that many, if not the majority, of the solutions that were proposed at this special session had to do with *revenue mechanisms* which, if implemented by the hospitals, would provide them with the funds necessary to supplement the government payments – payments which will fall short of their anticipated costs of operation.

Resolutions suggesting the levy of utilization fees, co-insurance charges and the sale of various hospital items were proposed, and many of them were adopted. Such action is a welcome change in the attitude of many of the hospital people, as compared to previous suggestions to pressure the government for more funds in the hospital per diem rates. Utilization fees, co-insurance charges, etc., will enable the hospitals to help themselves and, at the same time, will return some of the authority, responsibility and autonomy which they have lost.

While it might be sound administratively and professionally to take such a step, the one major objection to the imposition of these measures is political. One cannot help but wonder how long such a policy would be in operation before the opposition party would claim that the government in office had failed in its administration of the plan and now had found it necessary to pass back part of the cost to the people. The opposition would also likely promise that if it were elected to office, it would remove all of these charges and others as well.

On the other hand, if it were possible to collect these new hospital charges, it could be of great benefit to all concerned. Not only would hospitals regain something they have lost, but the Provincial Governments would be relieved, in part, of the full obligation of meeting skyrocketing hospital costs. It would share this responsibility with the patients and local communities who, in the final analysis, are the parties responsible for the costs in the first place.

The hospitals of Saskatchewan, through the Saskatchewan Hospital Association, are to be commended for at least considering this sort of approach in meeting the problems developing as a result of the budget freeze in that Province. It is to be hoped that the exploratory discussion will be followed by some sort of positive action, thereby overcoming one of the major problems in the development of a sound provincial hospital insurance program. ●

A B R I E F

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# COMMUNITY HOSPITAL AUTHORITY AND AUTONOMY IN CANADA

By

Larry Fraser

February 1962

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## SUMMARY AND RECOMMENDATIONS

With the developments of modern medicine, the needs of yesterday are being changed into the demands of to-morrow. One has but to consider the scope of treatments and cures now available to the population to appreciate why the tremendous demand has been created by the consuming public for these new discoveries.

In the United States, the demand for extended health services springs mostly from the industrial and commercial fields and is the subject for labour-management negotiations. The result is the extension of health services as additional fringe benefits under a labour contract. The insurance coverage is provided through voluntary prepayment plans, administered by insurance companies, although an increasing degree of governmental participation is becoming evident. In Canada, this demand for extended health benefits is making itself felt more through political channels, and has resulted in the implementation of various governmental health programs at all levels, the most significant of which is probably the Federal-Provincial hospital insurance plan.

The explanation of the difference in the approach to the problem of increased health services in the two countries would appear to be in the greater propensity of Canadians to accept government participation in their affairs than is common among the people of the United States. This is no doubt due to the influence of the Mother Country in drafting and administering programs of this type.

While there is no doubt that the Federal-Provincial hospital insurance plan has been most successful from the viewpoint of the general public, there are some aspects of its operation which leave something to be desired from a professional point of view. Usually, these professional matters are overshadowed by financial ones in the early years of any health plan, but they are the ones which could well prove to be the more important in the long run. It is some of these basic policies which warrant careful study at this time, in order to make certain that they are proper in the light of stated objectives of the plan.

Unfortunately, very little has been done in the way of basic research in the hospital field since the first provincial hospital insurance plan was commenced in Saskatchewan some fifteen years ago. This is surprising when one considers the millions of dollars that have been spent for the construction of hospitals and their day-to-day operation. However, this situation is not peculiar to the hospital field but applies to many others such as education and even federal-provincial relations, where agreements are drafted and signed and are more the result of political manoeuvres than basic administrative considerations. From the points of view of the student of

political economy, this is perhaps regrettable but it is, nevertheless, the sign of the time. We are living in an age of the advancing welfare state, and it behooves us in Canada to examine very carefully every step we take in this direction.

Our Federal-Provincial hospital insurance plan has gone very well and is, in fact, the envy of many in other areas on this Continent. However, there are faults that are beginning to show through the success which we have enjoyed to date. One of the more noticeable of these is the incompatibility of the basic doctrine of the autonomous community hospital at the local level with the consequences of centralized control by a governmental prepayment authority.

Some independence and autonomy must be given up for the financial security provided by the prepayment authority. Where the balance lies between the two extremes has yet to be determined. It is the hope that this brief will suggest one way in which we may enjoy the benefits of both concepts and still not suffer from the major shortcomings of either. If this can be done, Canada will have made a major contribution to governmental hospital insurance programs throughout the world.

This brief is directed to your Commission and particularly to those sections in which it is charged to:

> "The methods of financing health care services as presently sponsored by management, labour, professional associations, insurance companies or in any other manner;
>
> "The methods of financing any new or extended programs which may be recommended."

IT IS RECOMMENDED:

(1) THAT the provincial hospital insurance programs continue their present operation, thereby guaranteeing a minimum standard of hospital care for the people, and that this standard be examined from time to time so as to provide adequate standards of hospital care;

(2) THAT a system of variable co-insurance or utilization fees be adopted, which would return the right of decision making and autonomous action to the hospitals at the local level, thereby enabling local areas to provide services over and above those supported by the provincial plan, if this were the wish of the local authorities;

(3) THAT every encouragement be given to the establishment and strengthening of local authorities in the hospital field, such as metropolitan and regional hospital planning councils, so as to disperse some of the planning, operation, authority, and responsibility from the government hospital authority;

(4) THAT the provincial and national hospital associations increase their activities so as to become strong and effective representatives of the hospitals in their discussions with government and other agencies;

(5) THAT steps be taken to have basic professional and sociological studies conducted by a competent independent authority, to continually review the changing policies of our hospital plans and their ultimate long-range effect in the hospital field, especially where professional matters are concerned.

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## COMMUNITY HOSPITAL AUTHORITY AND AUTONOMY IN CANADA

Quebec's entry into the Federal-Provincial hospital insurance plan last year brought to a conclusion the first stage of the health program envisaged by the Prime Minister of Canada in 1948, when he introduced the health grants legislation of that session as "in effect the fundamental prerequisites of a nation-wide system of health insurance."

To-day, every political party in Canada has included a proposal for a health program in its political platform, and while various groups, both professional and otherwise, have expressed opposition, nevertheless, with the completion of a national hospital insurance plan, an irrevocable first step toward a nation-wide health insurance program has, in fact, been taken.

In the interpretation of sections 91 and 92 of the "British North America Act", which set forth the areas of responsibility of the Federal and Provincial Governments in Canada, the field of health has been designated as a provincial responsibility. This has been confirmed on several occasions by the Minister of National Health and Welfare. On the other hand, while the Federal Government has provided financial assistance in the health field, its role has been one of advice and counsel and not of direction and control, simply because the Federal Government was providing funds for health programs.

It has been suggested that a somewhat similar arrangement exists between the various provincial governments and their local communities, in most health matters, although there are circumstances in some areas, for example, the hospital field, which result in a very significant difference in the relationship. Where the provincial authority has accepted the responsibility of providing a health service to the people (hospital coverage) and, therefore, must meet the cost, it finds itself in the position of having to exercise a considerable amount of central control in order to keep the cost of the scheme within the willingness and ability of the people of that province to pay for it. The question of direction and control has been the subject of many discussions in the past, between governmental, hospital, and medical authorities, not only here in Canada but elsewhere on this Continent. The growth of the third party prepayment system, be it governmental or voluntary, has brought with it an influence not hitherto present in the field of consumer-producer relationships. As a result, a new environment is emerging in the health prepayment field which will involve the reconciliation of the loss of independence, autonomy, and authority, which the local community health sources have enjoyed in health matters in the past,

with the central control that is inherent in any prepayment program. Perhaps the necessity for control by the central agency that is guaranteeing coverage to its policyholders or an electorate, is the greatest threat to the survival of the autonomous local health agency. On the other hand, there are signs that suggest that this danger is recognized and is being guarded against by those concerned with the administration of some of the prepayment health programs and the providers of the health service.

Last year, some provincial hospital groups expressed the opinion that their autonomy had not been too severely jeopardized. However, in other provinces, the hospital authorities were being faced with increased financial control from the central prepayment authority, and a subsequent further inroad on their autonomy and authority. The latter group were being faced with the implementation of a firm or fixed budget policy, as a result of budget reductions of the hospital program by the provincial legislatures. This had not yet been experienced by the former group of hospitals, and one could not help but wonder what the reaction would be when their budgets were cut, due to lack of funds to cover the hospital program.

Experience suggests that some sort of limitation of funds, through the medium of a restricted budget, may have to be imposed by provincial prepayment authorities to curtail the spiralling hospital costs. If this should be done, however, a basic problem of prepayment plans would become apparent; namely, the incompatibility of the desired retention for the community hospital of complete autonomy, authority, and control with the expectation that the funds which it requires will be provided by the government without any, or at least a minimum amount of, direction and control by the prepayment plan. By its very nature, government must be in a position to report back to the people on the expenditure of public moneys and, at the same time, exercise some degree of control in accordance with the wishes of the representatives of the people.

The question then arises as to whether or not it will be possible to develop a mechanism which will meet a major part of the objectives of both the hospitals and the government without completely sacrificing the ideals of one or the other. The recognition of this anomalous situation by hospitals and prepayment plans is essential in order to work out the compromise necessary for the successful operation of the Federal-Provincial hospital insurance plan in the future.

On the one hand, the government is promising the people hospital services in return for their political support. In some provinces it has offered universal and comprehensive hospital coverage and in others the scope

of the plan has not been as broad. In any event, the taxpayer or beneficiary has been promised the highest possible standard of hospital care. To suggest otherwise would be unacceptable politically.

The government, through its prepayment program, has turned to the producer of the service - the hospitals - and directed them to provide the people with the high standard of service which the government has promised. In many instances, this will mean not only improving present services offered by the hospitals but the addition of new ones, all of which requires additional funds. (It must be remembered that, in most instances, the hospitals are not owned and operated by the provincial authority, but by independent hospital societies at the local level. This is one of the unique advantages of the Canadian program, but does complicate matters).

As long as the government is prepared to provide the funds which the hospitals state are necessary to provide the standard of care promised by the government, there is no problem. Standards will continue to be raised, as long as this situation exists and hospital budgets are covered. However, experience has usually shown that a point is reached finally where the government or prepayment body responsible for raising the money feels that it can no longer meet the financial demands of the hospitals. It then must change its financial policy, and curtails the hospitals' budgets. This has already taken place in some provinces, as mentioned previously. While such action could mean a levelling out of the standard of care, it is not likely that the government will acknowledge this, since this would not be popular with the people. On the other hand, such action is probably quite justified, since a disproportionate amount of the province's budget, at least in the opinion of the government, may have gone into the hospital program at the expense of other governmental services.

In any event, it is up to those groups associated with hospital affairs to make certain that the provincial authority does not retain such a freeze too long, so that hospital services begin to fall behind those provided elsewhere. They must convince the government and the people that it is desirable for all concerned to provide sufficient funds to maintain a reasonable standard of hospital service that is in line with experience in other areas. Hospitals across Canada are beginning to appreciate this situation.

One difficulty in all of this is that the government will likely continue to promise the highest possible standard of care for the people, since it is politically wise to do so, but may not provide the producer of the service - the hospitals - with sufficient funds to meet this commitment. The government is promising "Lincoln" service but paying the producer only enough to provide a "Ford".

One point may be injected here. From the point of view of the general public, substandard hospital care would likely go unnoticed, since the average person is not capable of evaluating the standard of care which he receives. However, the patient's physician, a co-partner in the production of the hospital service, and well qualified to judge, can make comparisons with the statements made by members of the government. He resents being told that the best possible services are available to his patients when, in some instances, he knows they are not. Doctors may openly discuss this situation, but incur the displeasures of the government if the observations are critical and affect the government adversely. In some provinces, these matters are no longer discussed publicly but, instead, are dealt with in committees between the parties concerned.

It is encouraging to note that the problems of autonomy, control, standards, etc., appear to be more apparent to an increasing number of people in the various fields associated with the hospital plans. The inclusion of such topics as "Who Sets Hospital Standards?" and "Budgetary Control Problems" in the agenda of hospital meetings, as well as the many study groups that have been established to deal with these matters, suggest that these areas will receive even greater attention in the future.

This is fortunate, for the time is fast approaching when the policies that have been established since the beginning of the Federal-Provincial hospital insurance plan may be so entrenched that it will be difficult to change them. For example, hospitals must either accept extensive control from the prepayment authority, if all the funds necessary for their operation are to come from this source (as has been the case in most provinces up to the present), or some sort of revenue mechanism must be adopted which will enable their independent decision and consequent action. This is especially true if the decision involves money. If such a mechanism were developed, it would restore a large measure of the authority and autonomy of hospitals which has passed to the provinces' prepayment plans. In this regard, it is interesting to examine some recent developments which may influence future policy in this area.

Saskatchewan led the way in this country by introducing the first provincial hospital insurance prepayment plan, and it appears that it has again taken the lead in recognizing the problem that exists in operating hospitals under the policies of their hospital program. British Columbia is following close behind.

Up until this year, the Saskatchewan Hospital Services Plan has been able to meet the demands of hospitals, since the provincial legislature has voted sufficient funds to do so. However, last spring, in a directive to hospitals, the Saskatchewan Hospital Services Plan informed them that they had to hold the line on costs and that the Saskatchewan Hospital Services Plan

will not ...."in general reimburse hospitals for the full costs of efficient operations in 1961."

Instead of merely following the usual pattern of issuing releases which condemned the Government for such a policy, the Saskatchewan Hospital Association held a special session to discuss the situation and draft a course of action. While nothing as yet has developed by way of major policy changes in the plan's operation, it is significant to note that many, if not the majority, of the solutions that were proposed at this special session had to do with revenue mechanisms which, if implemented by the hospitals, would provide them with the funds necessary to supplement the government payments - payments which will fall short of their anticipated costs of operation.

Resolutions suggesting the levy of utilization fees, co-insurance charges, and the sale of various hospital items were proposed, and many of them were adopted. Such action is a welcome change in the attitude of many of the hospital people, as compared to previous suggestions to pressure the government for more funds in the hospital's per diem rates. Utilization fees, co-insurance charges, etc., will enable the hospitals to help themselves and, at the same time, will return some of the authority, responsibility and autonomy, which they have lost.

While it might be sound administratively and professionally to take such a step, one major objection to the imposition of these measures is political. One cannot help but wonder how long such a policy would be in operation before the opposition party would claim that the government in office had failed in its administration of the plan and now had found it necessary to pass back part of the cost to the people. The opposition would also likely promise that if it were elected to office, it would remove all of these charges and others as well.

On the other hand, if it were possible to collect these new hospital charges, it could be of great benefit to all concerned. Not only would hospitals regain something they have lost, but the provincial governments would be relieved, in part, of the full obligation of meeting skyrocketing hospital costs. It would share this responsibility with the patients and local communities who, in the final analysis, are the parties responsible for the costs in the first place.

In British Columbia, at the annual meeting of the B. C. Hospitals' Association held in October last year, a resolution was passed resolving "THAT the Executive give consideration to the principle of variable co-insurance as a means of continuing and promoting hospital autonomy." As has so often been the case in the past, this move was interpreted as a

financial proposal rather than as a mechanism to preserve hospital autonomy, as was intended.

The misinterpretation of this resolution by the press and others serves to illustrate how complicated the provincial hospital insurance programs have become and how difficult it is to propose changes, especially those associated with government. Usually the political point of view so completely overshadows the administrative one that the intent of the proposal is lost. Granted the decision of the government must always be final; nevertheless, one cannot help but wonder if political expediency of the moment might not be unwise in the long run. Sound administrative policies are often disregarded under these circumstances.

On the other hand, the emergence of the variable co-insurance or utilization fee proposal in the two provinces that have been in the field for the longest period of time, suggests that perhaps some of the basic policies on which our provincial hospital insurance plans are founded should be reviewed.

These developments are not surprising when one considers the avowed aid of the Federal-Provincial hospital insurance plan to retain the independent autonomous community hospital while simultaneously raising the funds necessary for its operation through a provincial prepayment plan and/or provincial government support.

How the hospital could continue to operate as an autonomous unit, serving the needs of its community and at the same time be subject to the direction and control of a central authority is something that has yet to be worked out. On the one hand, it would be folly to suggest that hospitals should be given a blank cheque on the treasury of any province. On the other, too strict financial measures could result in stifling medical and hospital development and in lower standards of care. Yet, there must be a limit to the portion of the economy that can be devoted to medical care, and the determination of this balance is the difficult task facing provincial governments to-day.

Prior to the introduction of government sponsored hospital insurance plans in Canada, the major part of the expenditure for hospital care was determined through the process of competition and jurisdictional decision at the community level. Each area decided individually the standard of care desired in its hospital. Decisions were made locally to accept or reject requests for new services, building projects, wage increases, etc., all of which ultimately had an effect on the daily rate of the hospital. Since this rate, in turn, was to be paid by the patient or by the prepayment agency insuring the patient, decisions concerning expenditures were made in the light of the ability of the community to meet the resulting patient charges.

As prepayment plans grew, it was found that this third party, the insuring agency, was having more and more to say about the costs of running the hospitals, this having a direct effect on the premium which the insuring agency levied to keep the insurance fund solvent. Where an insuring agency was not a local company, but national or international in operation, it had less interest in the services being provided to the community and was more concerned with its financial problems.

And so a direct conflict of community service and financial interests arose. Companies providing hospital coverage could, and in many instances did, go to the extent of suggesting to the hospitals that they curtail expenditures or services in order that their (the companies') financial structures would not be threatened.

To-day, some governmental plans, due to the unprecedented demand by the people for universal, comprehensive coverage for hospital care and the concern of their governments over the mounting costs of providing this care, find themselves in a similar situation. With the introduction of provincial hospital plans, the decision regarding the amount of money to be spent for hospital care is now made in the provincial legislature, in the light of expenditures for other governmental services, such as education, roads, law enforcement, etc. The process is not unlike that previously carried out by the boards of trustees of local community hospitals when considering the hospital budget for the coming year.

Under present circumstances, hospitals have no way of making basic, independent decisions which involve increased expenditures, without acknowledgement by the central authority that the expense will be accepted in their budget. As a result of this, the community hospital as we have known it, responding to the pressures and influences of the community, could well become a thing of the past unless positive steps can be taken to restore its full autonomy.

While there are many who even now deplore the situation, it must be conceded that the new policies and practices which are being developed have much to commend them. With proper control and planning, it should be possible to develop an integrated hospital system under central authority. All too often, in the past, the desire to advance one hospital, for reasons of local pride, has resulted in the duplication of expensive facilities and equipment rather than their sensible integration for the hospital service area.

Sickness is no respecter of geographical areas. If a person cannot receive proper treatment at the local hospital, he is referred to the larger medical centre where more complicated and usually more expensive

equipment and services are available. This makes good sense but at the same time it does present problems to the local physician who may be qualified to perform the operation but cannot because the necessary equipment and trained staff are not available in the community where he is located. It is quite possible if the physician finds that he and other members of the medical staff are having to refer an ever increasing number of patients elsewhere, that recommendations will be made to the board that certain new services be added to the hospital. But however desirable from a local point of view, this can emerge as a duplication of facilities when the region is examined as a whole.

Prior to the introduction of the provincial plans, such requests would have been dealt with by the local hospital board of trustees, which may or may not have accepted the recommendation. If they did, and it involved additional expense, the administration would have taken steps to raise additional revenue. This might have resulted in an increase in room rate, operating room charges, etc., depending on the service being added. The important point is that the local hospital authorities were able to make these decisions independently. To-day, under the provincial plans, they are no longer able to do this; instead, in most provinces, they must submit such decisions to the central plan authority, which may or may not approve of their recommended action. But in spite of the situation and the continual cry that our hospitals are "better run at the local level" or "autonomy must be preserved", the hospitals themselves continue to press governments to cover more and more of the total hospital bill. Governments for their part have stated repeatedly that they do not want to take over the hospitals, and there is every reason to believe that this is the case.

However, if hospitals continue to obtain an increasing proportion of their revenue from the central authority, the inroads by government into hospital affairs will increase correspondingly. Eventually, full control and support of the hospitals will come from the central agency and the hospital system becomes another governmental service program.

There is yet another important ramification of these financial policies and controls in the field of medical care. While governments continue to state they wish to leave the management of the treatment of the patient in the hands of the medical profession, they are nevertheless having a great deal of influence, through their control of the hospital budget, on treatment provided. The fact that in most hospitals new services cannot be added, or existing ones expanded, without the approval of the central authority means that it is the decision of the latter as to the type of care provided in that hospital.

This is probably the most important problem facing the hospital, and in some ways the medical profession, in Canada to-day. If their autonomy

and freedom of action is to be retained in the future, some mechanism whereby decisions may be made by the hospital authorities should be established. Denied the right to conduct their affairs on such a basis, hospital boards of trustees in the future could, more and more become figureheads only, carrying out government policy. True, they may retain a certain degree of autonomy, such as medical staff appointments, administrative procedures, etc., but they would have lost the power to initiate basic policy. Unable, for example, to invest in necessary medical equipment they may find themselves limited in the capacity to develop their medical services.

With the above observations in mind, then, let us examine the other concept of the direct patient charge or local levy, not as a means of controlling abuse or raising funds, but as a mechanism to enable independent decision on the part of the boards of trustees of the hospitals.

In the past, most people have looked upon a co-insurance patient levy as a deterrent charge. It was expected to prevent abuse of a service by making an impost against the patient, requiring him to consider the cost he would incur in receiving treatment in relation to the benefits obtained. It was hoped, in those cases where the patient did not really require the service, that its cost would influence his decision not to seek it. Similar reasoning would apply to a physician who might be hospitalizing patients more for his personal convenience than for medical necessity. True, no person should be refused or denied medical treatment for financial reason; but unfortunately, experience has shown that some degree of abuse has inevitably resulted when full payment is provided to general public.

In other instances, the co-insurance or direct patient charge has been looked upon as a source of revenue to assist in providing the service. This can be a very successful way of raising funds and may take the form of a payment of so much per day in hospital, an amount deductible from the total bill, a percentage of coverage of the account, and so on.

No matter how the funds are raised, if they are collected only when the patient is hospitalized, it is the sick person who is bearing this additional levy. Some people would argue that this is wrong, since the individual should receive care when he requires it with no additional impost; others would support the concept that the patient should bear a portion of the cost since he is a direct beneficiary from the service. There is merit in both points of view. The ideal situation is a workable compromise between the two.

Another method of raising funds is to levy a charge on the community receiving the service. This usually involves setting up districts or areas for taxation of some type to be imposed, usually a levy on the land.

In this instance, it is the community as a whole which pays for the additional services received instead of the individual patient. One advantage is that there is no individual financial impost which might be considered a deterrent to necessary treatment. One disadvantage is that it removes the deterrent effect which a financial impost might have on unreasonable demands for care.

The discussion so far has been concerned with the financial - that is, the point of view adopted by both private insurance underwriters and government prepayment plans in the past. However, another, and perhaps more basic, problem is beginning to be recognized; namely, the position of hospitals in our society under the prepayment concept. Perhaps the direct patient charge or local levy is the mechanism that will modify the trend towards centralization of control and permit the continuation of the autonomous hospital at the local community level in the future, with most of its financial support coming from government funds.

Let us again consider the two proposals discussed previously. First, the imposition of a variable co-insurance charge by the hospital, with a maximum amount payable each year by the individual or family unit. (In a family unit we will include all individuals financially dependent upon the head of the household. It is assumed that all persons receiving any sort of welfare assistance whatsoever from any level of government will have the co-insurance charge met by the appropriate authority). Second, an impost through a district which would cover hospital expenses, otherwise not accepted by the central authorities.

The hospital district proposal is actually in effect in many of the provinces throughout Canada, and, in some instances, works fairly well. It holds the community responsible for costs of care which are beyond those acceptable by the central authority, and decisions on expenditures are made by someone at the district level. In essence, the hospital board must turn to another authority - the district trustees - for approval of a decision made by the board of trustees. The district trustees and not the hospital trustees are the final authority in deciding whether or not the expense incurred in providing a new service or additional staff will be accepted by the district. This situation would apply to all of the hospitals operating in the district.

One disadvantage of this scheme is that although decision in these matters has been brought closer to the local level, it still remains outside the jurisdiction of the body recommending the expenditure. However, the community benefiting by the additional service coincides more, at this level, with the people providing the funds, and hence would appear to be a move in the right direction.

This is not to suggest that the basic level of hospital care as provided through the prepayment and (or) government plan, should be abolished, but rather, it should be continually reviewed and, when possible, broadened in scope to include as many of the additional special services as the central authority's finances will permit.

It might also be well for the various provincial programs to consider the financial problems which are going to confront government officials in future in raising the funds necessary to support the provincial scheme. It has been said many times that there is almost no limit on the amount of money that can be spent on medical care. When one examines the experience of a provincial hospital plan that has been in operation for several years and contemplates the expanded programs for the future, it is little wonder that the authorities responsible for raising the provincial revenue pale at the size of the task facing them. Yearly increases from 5% to 10% per annum in the cost of hospital and medical care are being currently forecast. Since hospital costs have risen faster than any other item in the consumer price index in recent years, and there is no suggestion that this will change, it is not difficult to imagine the effect that these trends will have on the overall cost in our hospital plans in the foreseeable future.

With prospects such as these, should not a wise government consider some way of buffering itself against these future costs so that it could still guarantee an acceptable level of hospital care through its provincial plan, and, at the same time, not be committed to finance what might be considered exorbitant demands on the part of some communities in the province? It is doubtful that treasury officials are fully aware of the problems that lie ahead in this field, and it is suggested that they, as well as the hospital authorities, would be well advised to consider some way of sharing the future expense of their hospital coverage program.

Suppose, then, it is agreed that the body which decides to provide a level of care in the hospital beyond that included in the budget set by the central authority should be held responsible for raising the funds necessary, and that the mechanism to accomplish this be made available direct to this authority rather than through some other channel. It is clear that by implementing such a procedure, the responsibility for such expenditures is clearly fixed on the body incurring them. There is no passing of this responsibility on to another authority and the group concerned must answer to its community if these costs get out of line. Because of this, the authorities concerned will likely consider additional services and expenses much more carefully than if they were not held responsible for them by the local community.

The implementation of a variable co-insurance charge to patients with a yearly maximum cost per individual or family unit has a great deal to

commend it, not only as a deterrent to overuse of service and as a means of raising additional revenue to finance the plan, but most important of all, as a way of returning to hospitals that which is claimed to be their most important asset - their autonomy, and hence authority.

With such a mechanism, boards of trustees could once again make independent decisions concerning the care provided in the hospital and act on those decisions without having to refer them to another authority for approval. It would be expected that a basic standard of care would continue to be provided through a provincial insurance plan, as has been the case in the past, but the boards of trustees would be held responsible and answerable to their respective communities for care provided over and above this standard. The community would become aware of the extent of this additional care by the amount of the co-insurance charge per patient. If one hospital in a district levied a co-insurance charge that was considerably higher than a neighbouring hospital, there would, no doubt, be questions raised as to the necessity of the difference in rates. Patients would become more interested in where they were sent and would likely question their doctor on the necessity of being admitted to the hospital with the higher co-insurance rate. He, in turn, would have to be prepared to justify the charge to the patient and might be more cautious in demanding additional services at his hospital, since these services might result in a higher patient charge which might be criticized by the community. Competition would return to the hospital field and replace the delegations to the central authority to cover these "extra" costs. There would be less tendency to "let the government do it" since the government could no longer be used as a reason for the non-compliance to requests for additional services, for the board would have a way of supplying these services if it deemed them desirable, that is, by raising the co-insurance charge to meet the expense involved. It would be the duty of the central authority to make certain that the basic level of care provided at the ward level was adequate and kept up with the developments in the hospital field. The co-insurance charge should not be used as a way of passing back the substantial portion of the cost of the plan to the patient and hence the community, an oft heard criticism of this type of program.

It might well be that the hospital and medical groups will accept the decision of the people to have hospital affairs directed from the central provincial authority, not feeling it necessary to regain the independence they once enjoyed, and being of the opinion that what they have lost has been more than offset with the assurance of a steady source of income and a more stable environment in which to operate. The fact that, in some provinces where hospital plans have been in operation for over ten years, the hospitals have not been taken over by the government and the plans appear to be running fairly well suggests that this compromise may be the pattern which may emerge from the Federal-Provincial hospital insurance plan. If

this should be so, let the authorities concerned then cease to press for the "preservation of their autonomy", acknowledge it was high time to drop this old cliche, and admit that there exists now a better environment than ever before.

On the other hand, the recent action on the part of the Saskatchewan and British Columbia Hospitals' Associations, in asking for the consideration of a variable co-insurance charge or utilization fee, in order to preserve local autonomy and control, suggests that this latter concept is something worth preserving. It may be worthwhile noting that many of the medical and hospital plans in other countries utilize a co-insurance charge in one form or another. The much publicized Australian plan covers only 80% of the majority of charges, and is the type of program that is being suggested for Saskatchewan in the medical care field. If this concept has been found successful in other countries and has withstood the test of time, then would it not be wise to at least consider it for our Canadian programs?

Preservation of the autonomy of the community hospital, owned and operated at the local level, even although its financial support is derived almost completely from government funds, appears to be a worthwhile goal for our Federal-Provincial hospital insurance plan. If, in this new environment, it is possible to retain the local community hospital as we know it to-day, with its advantages of local initiative and control, and yet provide the financial support necessary for efficient operation from provincial and federal governmental sources, Canada will steer a course in the hospital field which is mid way between the state control of Britain and the free enterprise concept of the United States. We may perhaps reap the benefits of both without suffering the handicaps of either.

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